MEDICO-LEGAL ASPECTS OF THE 'RIGHT TO DIE' LEGISLATION IN AUSTRALIA

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[*This article analyses the Australian 'right to die' legislation in the context of the legal and medical principles which underlie the doctor-patient relationship. The main focus of the analysis is upon the differences in legal and medical interpretations of the concept of 'sound mind', which is the statutory requirement for a valid refusal of treatment. The article also examines the adequacy and suitability of the sound mind criterion when it is applied in the context of patients affected by illness, and the effect of imposing concepts developed within a strictly legal framework upon clinical practice. Medico-legal and ethical ramifications of the right to die legislation upon the legal and professional rights of medical practitioners are also discussed, as are such related issues as the management of pain relief in cases of refusing patients, the meaning of 'current medical condition' in the refusal of treatment certificate, and the powers of agents.*]

'To cure seldom, to relieve often, to comfort always.'

Anonymous

In 1983 the State of South Australia enacted the Natural Death Act (NDA)[1] granting terminally ill adult patients of sound mind the right to direct that extraordinary measures for prolonging life be discontinued. In 1988 the Victorian Parliament enacted the Medical Treatment Act (MTA)[2] which enables an adult person of sound mind to refuse medical treatment for a current condition, thus legislatively safeguarding the right of patients to refuse consent to medical treatment (including life-saving treatment). This right to refuse life-saving medical treatment is often called the 'right to die'. Other Australian States have either already enacted statutes modelled upon the South Australian legislation,[3] or are considering following the Victorian model.[4] Tasmania is endeavouring to combine the two.[5]

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1 Natural Death Act 1983 (S.A.).

2 Medical Treatment Act 1988 (Vic.) as amended by Medical Treatment (Enduring Power of Attorney) Act 1990 (Vic.) and Medical Treatment (Agents) Act 1992 (Vic.). In order to avoid repetitive use of the full titles of these statutes, I shall refer to the Natural Death Act 1983 (S.A.) as the NDA, and to the Medical Treatment Act 1988 (Vic.) as the MTA.

3 Natural Death Act 1988 (N.T.), elucidated by the Natural Death Regulations 1989 (N.T.), is similar to the South Australian legislation, though it provides that a medical practitioner responsible for treatment of the patient cannot act as a witness to the direction of refusal. The New South Wales Department of Health has issued *Dying with Dignity Interim Guidelines on Management* (1 March 1993) which govern the treatment of dying patients. These must be followed by the attending medical officer responsible for care of a terminally ill patient. In their thrust and scope, the guidelines are similar to the South Australian model allowing dying patients to refuse extraordinary measures to prolong life.

4 The Western Australia Law Reform Commission *Report on Medical Treatment for the Dying* (1991) 32-6, contains recommendations for legislative changes which favour the use of the Medical Treatment Act 1988 (Vic.) as a model. The Commission makes a further recommendation that doctors should not be civilly or criminally liable for administering drugs to control pain, even where those drugs may have the effect of shortening the patient's life. At the same time, the report proposes that there should be no distinction between provision of palliative care and other medical treatment and that the patient should have the right to refuse the former as well as the latter.

5 Medical Treatment and Natural Death Bill 1990 (Tas.).

In this article, I shall examine some medico-legal aspects of the NDA[6] and the MTA in the context of the legal and medical principles which underlie the therapeutic doctor-patient relationship, and the practical impact of imposing concepts developed within a strictly legal framework upon clinical practice. The Victorian legislation will be discussed in greater detail because it seems to be, at present, the more influential of the two legislative models. The analysis will focus upon the different ways in which law and medicine interpret the concept of sound mind which, in Australia, is the statutory requirement for a valid refusal of treatment. The adequacy and suitability of the sound mind criterion when applied in the context of patients affected by illness or disability will be examined in some detail, as will such related issues as the management of pain relief in cases of refusing patients, the issue of refusal of treatment and suicide, and the meaning of 'current medical condition' in the refusal of treatment certificate. I shall also discuss the issue of the power of agents of the incompetent patient to refuse medical treatment.[7] Interwoven throughout the discussion will be an analysis of the impact of the legislation on the professional autonomy of medical practitioners and the associated legal and ethical ramifications.

Among the fundamental objectives of the common law is the furtherance of the legal rights of individuals in society, based upon the certainty and predictability of the legal rules and principles which fashion and define these rights. To this end, the law operates by developing general jurisprudential principles within which it endeavours to encompass actual individual cases. When a lawyer analyses the grievance of an individual client he or she is not looking for features that are unique to the case. Rather, the object is to delineate those characteristics of the case that will bring it within some recognised principle of the law and thus establish a legal foundation, in the form of a legal right, for which a remedy may be granted. Thus, in the cause of action for battery, the plaintiff must show that a direct act of the defendant, committed intentionally or recklessly and without lawful justification, caused or had the effect of causing contact with the plaintiff's body.[8]

[6] On May 6 1992, the *Second Interim Report of the Select Committee on the Law and Practice Relating to Death and Dying 1992* was tabled in the South Australian Parliament. The *Interim Report* includes the Consent to Medical Treatment and Palliative Care Bill 1992 (S.A.) as Appendix G. This Bill intends to repeal the Natural Death Act 1983 (S.A.) and the Consent to Medical and Dental Procedures Act 1984 (S.A.). It will enable 'any person over 16 years of age' to appoint an agent with power to consent to or to refuse a medical procedure on the persons's behalf. The medical power of attorney will operate to the exclusion of powers that the Guardianship Board would otherwise have in relation to the treatment of the donor (s.5(5)). The Bill is silent on the required mental state of the donor and there are no provisions for revocation of the grant of the enduring power of attorney. The Bill provides that a medical practitioner 'responsible for the treatment or care of a patient suffering from terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision' will incur no civil or criminal liability for administering a medical procedure for the relief of pain even though an incidental effect of the procedure is to accelerate the death of the patient. Section 10 of the Bill states that 'the administration of a medical procedure for relief of pain to a person suffering from a terminal illness by a medical practitioner or a person acting under a medical practitioner's supervision, in good faith and without negligence, and in accordance with prevailing standards of palliative care, does not constitute a cause of death.' The wording of this immunity provision is wide enough to include both medically assisted suicide and euthanasia.

[7] This article will not discuss issues associated with consent to medical treatment by minors, nor will it discuss issues associated with never-competent patients.

[8] *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B. (Marion's Case)* (1992) 175 C.L.R. 218, 311, *per* McHugh J. Consent may make the act lawful, but if there is no evidence on the issue, the tort of battery will be made out. In Australia it is also possible to sue upon negligent trespass.

The tort of trespass to the person — battery and assault — protects the right of an adult person with full mental capacity to be free of uninvited physical contact, including medical treatment. The non-consensual invasion of the patient's right to personal physical integrity is regarded as a wrong in itself.[9] Mr Justice McHugh of the High Court of Australia defined the law's approach to non-consensual contacts in *Marion's Case*:

> It is the central thesis of the common law doctrine of trespass to the person that the voluntary choices and decisions of an adult person of sound mind concerning what is or is not done to his or her body must be respected and accepted, irrespective of what others, including doctors, may think is in the best interests of that particular person.[10]

The law considers the tort of trespass to the person as safeguarding not only the personal interest in one's physical integrity, but also as protecting the individual against any interference with his or her person that is offensive to a reasonable sense of dignity and autonomy. Such a legally impermissible offence to an individual's autonomy may be sustained when a competent, adult patient is denied the right of choice to refuse or to consent to a medical intervention. In this context, the patient's right of choice is identified with the legal right to self-determination; to quote the famous statement of Justice Cardozo in *Schloendorff v. Society of New York Hospital*:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[11]

Generally in a medical context, the conduct of the treating medical practitioner will be intentional, and will have an effect of causing contact with the adult patient's body. Therefore, unless there is evidence of a valid consent,[12] lawful justification,[13] or statutory authorisation,[14] any medical intervention, no matter how benevolent in motivation, may constitute battery.[15] Similarly, in criminal law, any non-consensual, intentional and direct interference with the body of another may amount to criminal assault.[16]

9 The private action in trespass to person was originally based on the principle that, through the misuse of force, the wrongdoer committed a fault by offending against the King's peace. Since forcible trespass involved a breach of the royal peace and thus was in itself wrongful, personal damage was not a necessary element of liability: Fleming, J., *The Law of Torts* (7th ed. 1987).

10 *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 309. His Honour excludes from the ambit of legal protection any infliction of consensual injury amounting to a 'grievous bodily harm' unless it is done for 'good reason'. The phrase 'good reason' refers to the statement by Lord Chief Justice Lane that 'it is not in the public interest that people should try to cause or should cause each other bodily harm for no good reason.': *Attorney-General's Reference (No 6 of 1980)* [1981] 1 Q.B. 715, 719.

11 105 N.E. 92 (1914), 93.

12 In Australia, consent goes to the justification of an otherwise wrongful contact — it must be pleaded and proved by the defendant: *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 311, *per* McHugh J.

13 The defence of lawful justification operates in cases of emergency, where the patient is unconscious, his or her wishes are unknown, and no legally authorised representative is available. In these circumstances, consent to life-saving procedures is implied either by common law (*Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 310, *per* McHugh J.), or by statute (Medical Act 1939 (Qld) s.52; Voluntary Aid and Emergency Act 1973 (Qld) s.3; Consent to Medical and Dental Procedures Act 1985 (S.A.); Emergency Medical Operations Ordinance 1973 (N.T.) s.3.).

14 Mental Health Act 1986 (Vic.) ss 12, 13, 73 and 85. See also Migration Regulations 182C and 182D in respect of 'medical treatment' designed to enable authorities to force-feed hunger strikers in detention centres.

15 *T. v. T.* [1988] Fam. 52, 67, *per* Wood J.

16 It appears that hostility is not an essential element of criminal battery, although it is a factor

Lord Donaldson of Lymington, M.R. provided the most insightful explanation of the importance and purpose of consent to medical treatment when he said that:

> [Consent] has two purposes, the one clinical and the other legal. The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient's faith or at least confidence in the efficiency of the treatment is a major factor contributing to the treatment's success. Failure to obtain such consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment . . . The legal purpose is quite different. It is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person. It does not, however, provide them with any defence to a claim that they negligently advised a particular treatment or negligently carried it out.[17]

Consent to treatment, and its obverse — the refusal of treatment — is a critical factor in good clinical practice and will materially affect the patient's future physical and mental condition. Furthermore, as Lord Donaldson pointed out, a patient's decision to consent to or refuse medical treatment has important legal ramifications for the treating doctor.

The Natural Death Act (S.A.)

The common law of trespass to the person was an adequate guardian of patients' rights to autonomy and self-determination before the developments in medical technology and medical science revolutionised modern medical practice. The inadequacy of the common law in dealing with these developments first became apparent in connection with patients who had become continuously comatose as a result of traffic accidents.[18] In the past, administering medical treatment to a patient who had lapsed into a deep coma was often considered futile and thus not undertaken, because the comatose patient had very little chance of survival. Today, patients who have lapsed into deep coma due to a disease or an injury can be treated, often effectively in the sense that their lives are thereby prolonged (although in a state of permanent unconsciousness).[19] Some of the issues as to when, by whom, and in what circumstances the decision to withhold or withdraw treatment to prolong the patient's life should be taken were considered by the South Australian Parliament during the debates preceding the enactment of the NDA in 1983.[20]

The NDA is regulatory and protective in nature, and has two major goals. Its first aim is to regulate procedures which enable terminally ill patients, in strictly-defined circumstances, to direct the doctor to discontinue life supports, thus

which may convert an ordinary incident of social intercourse into a criminal offence: *Boughey v. The Queen* (1986) 161 C.L.R. 10, 25, *per* Mason, Wilson, and Deane JJ. See Lanham, D., 'The right to choose to die with dignity' (1990) 14 *Criminal Law Journal* 401, 404.

[17] *In re W. (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam. 64, 76. For a discussion of theoretical, legal, and medical doctrines of informed consent, and a proposal for a new practical medico-legal doctrine, see Sprung, C. and Winick B.J., 'Informed consent in theory and practice: legal and medical perspectives on the informed consent doctrine and a proposed reconceptualization' (1989) 17 *Critical Care Medicine* 1346; Winick, B.J., 'Voluntary Hospitalisation after *Zinermon v. Burch*' (1991) 21 *Psychiatric Annals* 584; Winick, B.J., 'Competency to Consent to Voluntary Hospitalisation: A Therapeutic Jurisprudence Analysis of *Zinermon v. Burch*' (1991) 14 *International Journal of Law and Psychiatry* 169.

[18] *In the Matter of Karen Quinlan, An Alleged Incompetent* 348 A.2d 801 (1975); *In the Matter of Karen Quinlan, An Alleged Incompetent* 355 A.2d 647 (1976).

[19] See Schneiderman, L.J., Jecker, N.S. and Jonsen, A.R., 'Medical futility: its meaning and ethical implications' (1990) 112 *Annals of Internal Medicine* 949.

[20] South Australia, *Parliamentary Debates*, House of Assembly, 4 May 1983.

protecting the civil right of terminally ill patients to refuse to be kept alive through 'extraordinary measures'. The second goal of the legislation is to ensure immunity from civil and criminal liability for doctors who, without negligence, comply with validly-created directions.

The NDA is very narrow in its application, since it applies only to persons who suffer from 'terminal illness'. This term is defined as:

> any illness, injury or degeneration of mental or physical faculties-
> (a) such that death would, if extraordinary measures were not undertaken, be imminent; and
> (b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.[21]

This definition of 'terminal illness' makes it clear that in order to come within the ambit of the NDA, the patient's medical condition must be incurable and irreversible, such that the application of the extraordinary measures would only serve to prolong the process of dying. In these circumstances, the NDA empowers a terminally ill person of sound mind to direct, in the prescribed form, that he or she should not be subjected to any 'extraordinary measures' for prolonging life.[22] The term 'extraordinary measures' is defined as:

> medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation.[23]

Application of artificial ventilation, intravenous hydration or alimentation, dialysis to overcome the effect of renal failure, an artificial heart, and transplants of such vital organs as heart and liver would probably be included among the extraordinary measures covered by the definition. The NDA does not specify whether the direction to refuse extraordinary measures must be given before the diagnosis of terminal illness has been made (as the wording of sub-section 4(1) suggests), or whether the direction may validly be made at any time.[24]

The meaning of 'sound mind' in the NDA

The NDA authorises a person of sound mind and above the age of eighteen years to make a direction stating his or her refusal to be subjected to extraordinary measures.[25] The direction of the patient must be witnessed by two people, neither of whom must be a doctor.[26] Where the complying medical practitioner did not witness the creation of the patient's direction, he or she will be under a duty to ascertain that the patient did not revoke the direction after it was made, and that, at the time of making the direction, the patient was of sound mind. The directing patient need not be of sound mind at the time when the direction is being complied with. The validity of the original direction by the terminally-ill patient who, while mentally competent, directs that no extraordinary life-prolonging measures be

21 Natural Death Act 1983 (S.A.) s.3.
22 Natural Death Act 1983 (S.A.) s.4.
23 Natural Death Act 1983 (S.A.) s.3.
24 Lanham, D. and Fehlberg B., 'Living wills and the right to die with dignity' (1991) 18 M.U.L.R. 329, 338. The form may be completed either before the patient goes to the hospital, or while he or she is in hospital.
25 Natural Death Act 1983 (S.A.) s 4.
26 Natural Death Act 1983 (S.A.) s.4(2).

applied, will not be vitiated by reason of that patient becoming unconscious or delirious soon afterwards.

The NDA provides that the complying doctor must determine the soundness of the patient's mind at the time of that patient making the direction to terminate treatment. Yet from the medical point of view, the expression 'of sound mind' is meaningless. The *DSM-III-R*[27] does not refer to it, nor is this phrase used in any modern psychiatric textbook or manual. The NDA does not specify whether a patient who is of sound mind should be equated with a person who does not suffer from a mental disorder within the meaning of the mental health legislation, or whether it is the civil law test of sound mind which should be applied. The statutory definition of mental illness in the South Australian Mental Health Act (1977) as 'any illness or disorder of the mind' provides little assistance.[28] The Victorian Mental Health Review Board, on the other hand, has recently defined the term 'mental illness' for statutory purposes more expansively:

> A person appears to be suffering from a mental illness if he/she has recently exhibited symptoms which indicate a disturbance of mental functioning which constitutes an identifiable syndrome or if it not be possible to ascribe the symptoms of such disturbance of mental functioning to a classifiable syndrome, they are symptoms of disturbance of thought, mood, volition, perception, orientation or memory which are present to such a degree as to be considered pathological.[29]

This definition of mental illness focuses upon disturbance of affect,[30] thought, volition, perception, and orientation, as much as cognition in the sense of intellectual function. On the other hand, at common law the concept of competence refers to cognitive capacity alone.[31]

The issue of what constitutes sound mind in law has been of great importance in testamentary law. In Banks v. Goodfellow a legally competent person was defined in the following way:

> It is essential. . .that no disorder of the [testator's] mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties — that no insane delusions shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.[32]

In *Banks v. Goodfellow* the testator was convinced that he was pursued by evil spirits. He was, however, capable of looking after his financial affairs and had given clear and rational instructions for his will, which left the greater part of his fortune to the niece who had looked after him. The Court held that the will was valid because although the testator was suffering from an insane delusion, it did not influence his testamentary dispositions. Thus, the civil law test of a person's mental competence — *i.e.* whether or not he or she is of sound mind — is based on the cognitive criteria which measure the person's capacity to understand the nature of the possible courses of action.[33]

27 *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. 1987) — known as *DSM-III-R*.

28 Mental Health Act 1977 (S.A.) s.5.

29 *In the appeal of Garry Webb (also known as Garry David) a security patient at Aradale Hospital.* Mental Health Review Board. Heard in January, February and March of 1990; no 230190 (unreported).

30 The term *affect* denotes the outward manifestation of a person's feelings, tone, or mood: Werner, A., Campbell, R.J., Frazier, S.H. and Stone, E.M., *A Psychiatric Glossary* (5th ed. 1980) 3.

31 The law presumes an adult person — in Australia.a person of eighteen years of age or more — to be competent unless such person is shown to be unable to understand the nature and quality of his or her actions.

32 *Banks v. Goodfellow* (1870) 5 Q.B. 549, 565, *per* Cockburn C.J.

33 In criminal law, *M'Naghten's Case* (1843) 10 Cl. & F. 200; 8 ER 718 provides the legal test for the insanity defence: Mawson, D., 'Specific defences to a criminal charge: assessment for court' in

Competence, in the sense of cognitive ability to make a contract, to plead, to make a will, or to consent to treatment, is a legal concept and can only be determined by a judge or by the Guardianship Board, although a psychiatrist or psychologist may be called to assist in determining the standard of a person's competence. In a clinical context, competence refers to the patient's capacity to make competent decisions about proposed therapy. Generally, the assessment of a patient's competence to consent to or to refuse medical treatment will be made, not by a judge, but by the attending physician or by a psychiatrist. Appelbaum and Gutheil point out that although, strictly speaking, medical practitioners cannot make a determination of competence, their determination on a patient's functional capacity has the same practical effect as a legal ruling on competence, because a patient will lose decision-making power.[34] It would appear that, in an effort to distinguish the concept of legal competence from the medical assessment of the patient's decisional capacity based on the assessment of his or her affective function, some medical practitioners have coined the term 'clinical competency'. In this article, the term 'competence' will be used to refer to the legal concept and the expression 'clinical competency' to refer to the assessment of affective function.

Under the NDA, the treating medical practitioner will have to apply the civil law test to determine the mental status of a terminally ill patient who does not wish to be subjected to extraordinary measures. Elucidation of what the legislators intended the term 'of sound mind' to mean is found in paragraph 4(3)(b) of the NDA which allows the doctor to disregard the direction of a terminally ill patient if the medical practitioner believes, on reasonable grounds, that the patient was not, at the time of giving the direction, capable of understanding the nature and consequences of the direction to discontinue the treatment. Moreover, the provision which imposes upon the doctor the duty to inform about treatment alternatives, refers to the patient as one who

> is conscious and capable of exercising a rational judgment of all the various forms of treatment that may be available in his particular case so that the patient may make an informed judgment as to whether a particular form of treatment should, or should not, be undertaken.[35]

It is arguable that the notion of 'sound mind' as the cognitive ability of the patient to understand what is being said to him or her, and to make an informed decision in a strictly intellectual sense, is not the most suitable way of ascertaining that person's mental state in the context of refusal of life-sustaining treatment.[36] Medical studies published throughout the last decade have drawn attention to cognitive disorders as a complication of cancer.[37] These studies show that patients

Bluglass, R. and Bowden, P., (eds), *Principles and Practice of Forensic Psychiatry* (1990); Wood, O. and Certoma, G.L., *Succession: Commentary and Materials* (1990).

34 Appelbaum, P.S. and Gutheil, T.G., *Succession: Clinical Handbook of Psychiatry and the Law* (2nd ed. 1991) 226.

35 Natural Death Act 1983 (S.A.) s.4(4).

36 Gutheil, T.G., Bursztajn, H.J., Brodsky, A. and Alexander, V., *Decision Making in Psychiatry and the Law* (1991) Ch. 8.

37 Coyle, N., Adelhardt, J., Foley, K.M. and Portenoy, R.K., 'Character of Terminal Illness in the Advanced Cancer Patient: Pain and Other Symptoms During the Last Four Weeks of Life' (1990) 5(2) *Journal of Pain Symptom Management* 83; Foley, K.M., 'The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide'(1991) 6 *Journal of Pain Symptom Management* 289; Ramsay, N., 'Referral to a Liaison Psychiatrist from a palliative care unit' (1992) 6 *Palliative Care* 54.

with advanced terminal cancer often experience repeated episodes of cognitive failure[38] as recorded on the Mini-Mental State Questionnaire, a screening test used for cognitive assessment.[39]

In an acute organic brain syndrome (delirium) the patient develops a global impairment of cognitive functioning which, in mild cases associated with only a slight degree of 'clouding of consciousness' (impaired state of consciousness, which in severe delirium progresses to stupor or coma), may not be recognised by the clinician. Such cognitive failure usually manifests itself as disorientation in relation to time, place and person. Its particular manifestations also include inability to sequence recent events, odd and inconsistent behaviour, irritability and suspiciousness. A well-developed syndrome may include impaired concentration and memory, together with reduced awareness of and responsiveness to the environment.[40] The speech of a person suffering from acute cognitive failure may be characterised by restriction of content, repetition and perseveration.[41]

Perhaps the most important aspects of acute cognitive failure for the purpose of making vital decisions in respect of medical treatment are the changes which occur in thought content and organic mood changes. These may involve impoverishment of intellectual function manifesting itself as concrete thinking (the inability to abstract the sense of what is said from its literal meaning) as well as a sense of bewilderment, which may verge on fear or terror. In extreme cases of delirium, the patient may develop delusions, as well as manifesting cognitive impairment and clouding of consciousness.

Cognitive failure in patients with advanced cancer may be caused by medications, sepsis, brain metastases, liver failure, renal failure, hypercalcemia and hypoglycaemia, amongst other possible precipitants. However, in the study by Bruera,[42] no cause of cognitive failure could be established in 56% of cancer patients.[43] The available data suggests that cognitive failure is extremely frequent in patients with advanced cancer approximately 16 days before death.[44] Therefore, it has been postulated that cognitive failure may be part of an organic brain syndrome which represents the final emotional stage in many dying patients.[45]

The South Australian legislature had to balance the terminally ill patient's

[38] Bruera, E., Miller, L., McCallion, J., Macmillan, K., *et al.*, 'Cognitive failure in patients with terminal cancer: a prospective study' (1992) 7 *Journal of Pain and Symptom Management* 192.

[39] The Mini-Mental State test is specifically designed, through a series of 11 questions, to examine memory registration and immediate recall, orientation, attention and calculation, short-term memory, and certain aspects of the use of language. The test also evaluates the patient's ability to follow verbal or written commands and his or her constructional ability. The patient's answers are scored, and the level of impairment assessed on the basis of the score out of 30 points: Mendelson, G., *Psychiatric Aspects of Personal Injury Claims* (1988) 44. For a commentary on the use of the Mini-Mental State test in comparison and in conjunction with other tests of cognitive function, see Folstein, M., Fetting, J., Lobo, A. *et al.*, 'Cognitive assessment of cancer patients' (1984) 53 *Cancer* 2250; Anthony, J., Leresche, L., Niaz, V. *et al.*, 'Limits of the "Mini-Mental State" as screening test for dementia and delirium among hospital patients' (1982) 12 *Psychological Medicine* 397.

[40] Fulford, W., 'Organic Psychiatric Disorders' in Rose, N., (ed.) *Essential Psychiatry* (1988) 110.

[41] *Ibid.* 111.

[42] Bruera, E., Miller, L., McCallion, J., Macmillan, K. *et al.*, *op. cit.* n.39.

[43] *Ibid.* 194.

[44] More than 80% of cancer patients developed cognitive failure before death in a study reported by Bruera, E., Fainsinger, R.L., Miller, M.J. and Kuehn, N., 'The Assessment of Pain Intensity in Patients with Cognitive Failure: A Preliminary Report' (1992) 7 *Journal of Pain and Symptom Management* 267, 269.

[45] Bruera, E., Miller, L., McCallion, J., Macmillan, K. *et al.*, *op. cit.* n.39, 195.

physical state of health against his or her emotional state of mind. Ultimately, the Parliament decided that, in the circumstances of terminal illness, it would be counter-productive or even cruel to deny the patient the right to die on the grounds that such a person's direction to refuse treatment may be motivated by an underlying major affective disorder.[46] Therefore, as long as the other criteria set out by the NDA are fulfilled, and provided the terminally ill patient is cognitively rational, as opposed to intellectually incompetent, and is not suffering from a severe psychiatric disturbance, the fact that his or her judgment may be affected by an underlying depressive disorder will not render the decision invalid on the ground that it was made by a person not of sound mind. Nevertheless, particularly in cases of persons with advanced cancer, a prudent medical practitioner, before disconnecting the life supports, will need to consider the likelihood of cognitive failure being present at the time of the patient's direction.[47]

The NDA has been criticised as being too narrow in its ambit of operation, which is limited to those adult patients of sound mind who come within the statutory definition of terminal illness.[48] However, the South Australian legislature set out to remedy a particular lacuna in the law without thereby infringing the common law rights of other persons to refuse medical treatment.

The impact of The NDA on the legal rights of medical practitioners

The NDA extends protection from criminal liability to the doctor who acts in compliance with the patient's direction. The non-application of extraordinary measures to a patient suffering from a terminal illness or the withdrawal of such measures from the patient is stated not to constitute a cause of death. This means that a medical practitioner who acts in compliance with the patient's direction, as a result of which the patient dies, is not liable at law for causing the patient's death.[49] Moreover, the NDA also grants an immunity from criminal liability to a doctor who, in good faith and without negligence, makes the decision as to whether:

> (a) a patient is, or is not, suffering from terminal illness;
> (b) a patient revoked, or intended to revoke, the direction not to have the extraordinary measures applied or undertaken;
> (c) a patient was, or was not, at the time of giving direction, capable of understanding the nature and the consequences of the direction.[50]

Since the NDA expressly excludes from its protection the complying doctor's liability in negligence, it would be advisable for the doctor involved with the

46 Major affective disorders are characterised by a prominent and persistent disturbance of mood (depression or mania). The disorder is usually episodic but may be chronic. Werner, A., Campbell, R.J., Frazier S.H. and Stone, E.M., *op. cit.* n.30, 87.

47 One method of testing for cognitive failure is through the administration of a structured mental state evaluation, such as Folstein's Mini-Mental State examination: Folstein, M.F., Folstein, S.E. and McHugh, P.R., '"Mini-mental state": a practical method for grading the cognitive state of patients for the clinician' (1975) 12 *Journal of Psychiatric Research* 189.

48 Western Australia, Law Reform Commission *Report on Medical Treatment for the Dying* (1991) no.84, 12-5; Lanham, D. and Fehlberg, B., *op. cit.* n.24, 344, point out that persons suffering from debilitating but not terminal conditions such as multiple sclerosis, Alzheimer's disease, or brain damage resulting from stroke or accident, cannot make a valid direction under the NDA; nor can patients wishing to refuse treatment such as blood transfusions on religious or other grounds.

49 Natural Death Act 1983 (S.A.) s.6.

50 Natural Death Act 1983 (S.A.) s.5(3).

patient at the time of direction to call for an examination and a written opinion by at least one other practitioner as to the patient's state of health and cognitive capability. Preferably, the diagnosis in both cases should be made by specialists in the relevant fields of medicine.[51]

Medico-legal ramifications of pain relief under the NDA

In the past, pain and suffering were accepted as part and parcel of the human condition; one was born in pain, lived in pain and expected to die in pain. Pain and suffering were compensable only in situations where they followed an unlawfully inflicted direct physical injury.[52] If in an effort to prolong life pain and suffering had to be endured, so be it. The medical goal of enabling patients to live the maximum life span at any cost was in harmony with the common law which has always held the sanctity of life above all else.

Today, just as people need not be born in pain, many patients do not want to live out their technologically-possible optimum life-span in agony and distress. There has been a concomitant shift of focus by doctors from a technological-scientific orientation in which the prolongation of the patient's life is seen as an end in itself, towards a holistic approach whereby the patient is seen as an individual whose emotional well-being is as much an aim of the medical care as his or her physical welfare. This shift of focus in medical practice has given rise to a legal and medical dilemma in cases where pain-relieving substances may have the incidental effect of accelerating the patient's death.

Patients whose disease has progressed beyond the point where treatment can cure or arrest it, but who suffer severe pain which cannot be alleviated with routine analgesics, may be given morphine in very high doses to relieve pain.[53] In some patients, administration of morphine in high doses may lead to some respiratory depression which, combined with dehydration and cachexia (emaciation), eventually predispose the patient to pneumonia which may lead to death. At common law, pain management of this kind would not be regarded as the cause of death either in criminal law[54] or in the law of negligence. According to Deane J. of the High Court of Australia:

> For the purposes of the law of negligence, the question of causation arises in the context of the attribution of fault or responsibility whether an identified negligent act or omission of the defendant was so connected with the plaintiff's loss or injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it.[55]

[51] The complying medical practitioner should also keep any documents pertaining to the patient's direction.

[52] This has since been extended to include 'nervous shock' although this term no longer has clinical meaning: see Mendelson, D., 'The defendants' liability for negligently caused nervous shock in Australia — quo vadis?' (1992) 18 *Monash Law Review* 16.

[53] Mendelson, G. and Mendelson, D., 'Legal aspects of the management of chronic pain' (1991) 155 *The Medical Journal of Australia* 640, discusses the legal implications of administering pain-relieving drugs in potentially addictive dosages.

[54] According to Devlin J. (as he then was) a doctor 'was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he takes might incidentally shorten life.' His Honour said that 'a doctor who was aiding the sick and dying [did not have] to calculate in minutes or even hours, perhaps not in days or weeks, the affect on a patient's life of the medicines which he would administer' *R. v. Adams* [1957] Crim L.R. 365, 375.

[55] *March v. E. & M.H. Stramare Pty Ltd & Anor* (1991) 171 C.L.R. 506, 522.

It is likely that 'as a matter of ordinary common sense and experience' Australian courts will tend to regard the terminal illness, rather than the pain-relieving medication administered by the doctor, as the patient's cause of death. Similarly, for the purposes of trespass the patient's death will not be regarded as a direct result of pain management unless the medication was given in one lethal dose which, as an act of killing, is by definition outside medical treatment as traditionally understood.[56]

Under the protective provisions of the *NDA*, only the withholding or withdrawal of extraordinary measures from a terminally-ill patient is deemed not to constitute a cause of death.[57] The legislation is specific in its focus, and does not authorise, or extend to

> any act that causes or accelerates death, as distinct from an act that permits the dying process to take its natural course.[58]

Therefore, the protective provisions of the NDA which relate to the withdrawal or withholding of medical treatment do not, by definition, extend to the provision of pain-relieving substances which may accelerate death. At the same time, it is arguable that administration of pain relief to a terminally ill patient does no more than permit the dying process to take its natural course, though without the suffering which would otherwise occur.

According to Bruera and Schoeller,[59] the usual clinical regimen of administration of analgesic opioids at the time the NDA became law was rigid and insensitive to the needs of terminally-ill patients, who were unable to obtain relief from often excruciating pain and suffering which marred the last months or weeks of their life. The opiate doses were frequently too low and the intervals between doses were too long because the medical and nursing staff often had an exaggerated fear of patients becoming addicted.[60] As a result, pain was not controlled in approximately two-thirds of cases.[61]

Regrettably, some of the outmoded practices still continue, as does the fear that terminally-ill patients will become addicted to the narcotics administered for pain relief. However, at present, except in rare cases, cancer pain can be effectively relieved through treatment which involves medications combined with psychosocial support.[62] The aim of modern multi-modal therapy is to achieve pain relief through the administration of adequate dosage and timing of analgesics,[63] pallia-

56 In *Reg v. Cox* (unreported), 8 September 1992, Ognall J., directing the jury, said that there is an 'absolute prohibition on a doctor purposefully taking life as opposed to saving it': cited in *Airedale N.H.S. Trust v. Bland* [1993] 2 W.L.R. 316, 319. Dr Nigel Cox, a consultant physician, was convicted of attempted murder on the charge of injecting a terminally ill patient with potassium chloride.

57 Natural Death Act 1983 (S.A.) s.6(1).

58 South Australia, *Parliamentary Debates*, House of Assembly, 4 May 1983, 1167.

59 Bruera, E. and Schoeller, T., 'Current status of pain' (1992) 31 *Triangle* 9; Vere, D.W., 'The hospital as a place of pain' (1980) 6 *Journal of Medical Ethics* 117. Some studies conducted at the time commented on the competing pressures of cure and care, and the tendency for the latter to be underplayed. In this part of the article, I concentrate on pain, because pain occurs in up to 80% patients with terminal cancer, and the severity of pain is determined by psychological as well as physical factors.

60 Mendelson, G. and Mendelson, D., 'The Requirements for Prescribing Opiates' (1992) 6 *The Australian Journal of Psychopharmacology* 31.

61 Twycross, R.G., 'Care of the terminally ill patient' (1992) 31 *Triangle* 1.

62 *Ibid.* 2; see also Moulds, R.F.W., Hemming, M.P., Aranda, S., Day, R.O. *et al.*, *Analgesic Guidelines* (2nd ed. 1992) 39, 41.

63 This includes the long-acting oral preparation of morphine, MS Contin.

tive radiotherapy, chemotherapy, surgery, hormone therapy, anaesthetic and neurosurgical techniques, physical treatment and psychological support for the patient and his or her family.[64] Patient-controlled analgesia, in the form of patient-controlled infusion pumps, allows for a constant infusion of opioid analgesics, with the patient controlling the rate of infusion as required.[65] Research has suggested that, during terminal illness, patients who receive adequate symptom relief are able to experience meaningful relationships, reminiscences, and humour, and to make sense of their own personal life story, making it 'a time when "being" becomes more important than "doing" (achieving).'[66]

The South Australian Parliamentary report *Care of Terminally Ill Patients: General Practitioners' Views and Experiences*,[67] which analysed responses of 117 general practitioners in South Australia to questions about their awareness and use of the NDA reported that while 63.2% of the respondents indicated familiarity with the legislation, only 19.4% related that at least one of their patients had signed a living will.[68] Knowledge that the extraordinary measures undertaken as an element of life-prolonging treatment will be combined with palliative care (which is highly likely to also relieve pain and suffering), together with the availability of patient-controlled analgesia which transfers the power to control pain from the physician to the patient, may account for the fact that relatively few patients elect to direct that the extraordinary measures be terminated as the NDA allows.

Members of the South Australian House of Assembly who commented on the draft of the Consent To Treatment And Palliative Care Bill 1992 noted that the NDA was not properly understood or promoted and therefore, presumably, not utilized by enough terminally ill patients to direct doctors to switch off the life supports. But could it be that once their physical pain is alleviated, most terminally-ill patients prefer to live with the support of extraordinary measures rather than to die?

However, the provisions of the NDA allow those patients who decide that they do not want to be kept alive through the application of extraordinary measures to exercise their right to have them discontinued. In general, the South Australian legislature has achieved a fine balance between the rights and obligations of a terminally ill patient and his or her doctor.

The Medical Treatment (Enduring Power of Attorney) Act (Vic.) 1990 as amended by the Medical Treatment (Agents) Act (Vic.) 1992

Unlike the South Australian NDA, which is a purely civil enactment, the Victorian MTA also contains penal provisions.[69] It aims to establish procedures for refusal of medical treatment and to punish those doctors who do not comply with a validly executed refusal of treatment certificate.[70]

64 Moulds, R.F.W., Hemming, M.P., Aranda, S., Day, R.O. *et al.*, *op. cit.* n.62, 41.
65 *Ibid.* 23.
66 Twycross, R.G., *op. cit.* n.61, 4.
67 South Australia, Select Committee on the Law and Practice Relating to Death and Dying, *Care of Terminally Ill Patients: General Practitioners' Views and Experiences* (1991) Appendix E.
68 *Ibid.* 7.
69 Medical Treatment Act 1988 (Vic.) s.6.
70 The long title for the Bill for the Medical Treatment Act 1988 (Vic.) was 'A Bill to create an

The following examination of the MTA includes a discussion of the major medico-legal issues directly created by or associated with the legislation. The main issue is the effect of the sound mind criterion on patients and clinical practice. This legal criterion will be examined in the context of the statutory right to execute a refusal of treatment certificate declining curative treatment by persons who are not terminally ill, and the problem of deciding in what circumstances the patient's decision to refuse life-saving treatment amounts to suicide. Consideration of the problem of the 'sound mind' criterion will be supplemented by an analysis of the application of the MTA in the context of clinical responses to the meaning of the term 'current medical condition', an examination of the impact upon clinical practice of the enduring power of attorney provisions, and some medico-legal issues associated with the MTA palliative care provisions. I shall also discuss the legal consequences of the new statutory offence of medical trespass created under the MTA.

In 1980 the Honorable Roderick Mackenzie introduced into the Victorian Legislative Assembly a Private Member's Bill entitled the Refusal of Medical Treatment Bill (1980). This Bill, though unsuccessful, may be regarded as the forerunner of the MTA.[71] However, the immediate impetus for the Victorian legislation was the publicity generated by the tragic case of a 28 year-old former water-skiing champion, John McEwan, who in January 1985 became a quadriplegic in a diving accident. While he was a patient in the spinal unit of the Austin Hospital, he signed a document drawn up by his solicitor declaring that he wished to die and asking that he not be revived if he became unconscious. Soon afterwards, McEwan attempted suicide by refusing all food and medication. He was certified under the then-operative provisions of the Mental Health Act,[72] on the grounds that severe depression had rendered him incapable of making a rational decision. The certification was revoked when McEwan agreed to take nutrition and anti-depressant medication. He was discharged from the Austin Hospital and went home. At home, he discontinued taking the anti-depressants. McEwan's respirator was disconnected on 3 April 1986. The coroner found that he died of cardio-respiratory failure caused by the diving accident.[73]

The case of John McEwan became a *cause celebre* for advocates of the right to die with dignity legislation. The traditional decision-making process within the doctor-patient relationship was challenged as too paternalistic, resulting in the denial of a patient's right to decide whether and in what circumstances she or he should die. The Victorian Parliament considered that the protection afforded to the patient's right to refuse treatment under civil and criminal law was inadequate, and in 1988 enacted the Medical Treatment Act[74] which set out statutory

offence of medical trespass, to make other provisions concerning the refusal of medical treatment and for other purposes'.

71 Lanham, D. and Woodford, S., 'Refusal by agents of life-sustaining medical treatment' (1992) 18 M.U.L.R. 659, 660; Lanham, D. and Fehlberg, B., *op. cit.* n.24, 330.

72 Mental Health Act 1958 (Vic.).

73 'Accidental death verdict on man who asked to die' *Age* (Melbourne), 5 December 1986; Victoria, *Parliamentary Debates*, Legislative Council, 19 April 1988, 699-700.

74 Two parliamentary reports were commissioned prior to enactment of the Medical Treatment Act 1988 (Vic.): Victoria, *First Report of the Social Development Committee upon the Inquiry into*

procedures for the execution by the patient of the refusal of treatment certificate, and created a statutory offence of medical trespass.[75]

The MTA becomes operative upon the creation of a valid refusal of treatment certificate signed by two witnesses: a medical practitioner and another person. The medical practitioner and the other person each have an absolute discretion whether or not to sign the refusal of treatment certificate. Each witness may sign the certificate when satisfied that the refusing patient is an adult person of sound mind, has appeared to understand the information about the nature of his or her condition, and has voluntarily and clearly expressed or indicated the decision to refuse medical treatment (generally or of a particular kind) for a current condition.[76] The refusal of treatment certificate must be verified by the patient, if physically able to do so, and by the signature of the medical practitioner who has described and explained the current medical condition of the refusing patient.[77]

Under the MTA a person can validly refuse medical treatment with the knowledge that the withdrawal or withholding of treatment will inevitably result in his or her death. This accords with the criminal law in Victoria where the patient who commits or attempts suicide, including by refusal of life-saving medical treatment, attracts no criminal liability.[78]

A justification for decriminalising suicide and attempted suicide was provided by Mr Justice Cardozo in *Shloendorff v. Society of New York Hospital*, that each person has an inalienable right to do with or to his or her body whatever he or she wishes.[79] Mr Justice Cardozo's statement gave jurisprudential imprimatur to John Stuart Mill's philosophical doctrine that

> the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. . . It is perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in *the maturity of their faculties*.[80]

The person's right to choose what should or should not be done to his or her body has been interpreted as including the right to choose to die. Once accepted, this principle of ultimate self-determination, whether in law or in philosophy, has to be predicated upon the notion that the person making the choice be an adult of sound mind. How do the law and medicine determine whether the refusing patient under the MTA is a person of sound mind?

Options for Dying with Dignity (1986); Victoria, *Second and Final Report of the Social Development Committee upon the Inquiry into Options for Dying with Dignity* (1987).

75 Medical Treatment Act 1988 (Vic.) s.6.

76 Medical Treatment Act 1988 (Vic.) s.5(1). According to s.5(3), for the purposes of s.5(1) the patient may clearly express or indicate a decision in writing, orally, or in any other way in which the person can communicate.

77 Medical Treatment Act 1988 (Vic.) s.5(1). Further to this, s.5E(2) provides that 'A medical practitioner who signs the verification in a refusal of treatment certificate for a person who is not a patient in a public hospital,denominational hospital, private hospital or nursing home *must* take reasonable steps to ensure that a copy of the refusal of treatment certificate is given to the Guardianship and Administration Board within 7 days after it is made.' The failure to comply with this provision will render the verifying medical practitioner strictly liable for breach of statutory duty, and — if the refusing patient suffers compensable damage as a result of the failure to lodge the certificate within specified time — liable to action in negligence at common law.

78 Crimes Act 1958 (Vic.) s.6A.

79 *Schloendorff v. Society of New York Hospital* (1914) 105 NE 92, 93.

80 Mill, J.S., *On Liberty* (1974) 9 (emphasis added).

The meaning of sound mind and its medico-legal ramifications in the MTA

The MTA does not provide definition of what constitutes 'sound mind' for the purposes of the refusal of treatment certificate. Presumably, the term refers to the person's cognitive capacity at the relevant time. The Social Development Committee's *Second and Final Report upon Inquiry into Options of Dying with Dignity* defined incompetence in the following way:

> An incompetent patient (whether adult or minor) is a patient who is not capable of understanding the nature, consequences and risks of the proposed medical treatment and the consequences of non-treatment, and who is thus incapable of consenting to, or refusing, medical treatment, but does not include an incompetent patient during a period of incompetency [*sic*].[81]

The Social Development Committee was emphatic that cognitive competence should be the sole criterion of the sound mind test for the purposes of the MTA:

> Refusal of life sustaining treatment by a terminally ill patient does not, in itself, constitute grounds for questioning the competency of the patient.[82]

The patient's affective disorder would need to be associated with cognitive impairment before he or she could be classified under the MTA as an incompetent person, that is, a person not of sound mind.[83] It should be noted, however, that the Final Report's terms of reference were strictly limited to terminally ill persons. This approach is similar to that adopted in the NDA which applies only to patients who are in the very last stages of their terminal illness and without any hope of recovery. However, in the MTA, the right to refuse medical treatment is not confined to terminal illness, but applies to any adult who suffers from a medical condition requiring treatment, including persons with treatable and even curable disorders.[84]

The legal definition of sound mind used for the purposes of both the NDA and the MTA would not exclude a person with a paranoid disorder who insists that he or she does not suffer from the given condition, and is therefore eager to declare that no treatment should be undertaken. It is common in paranoid conditions for the person's cognitive functioning to remain intact. Such a person can appear to have a thorough understanding of the risks and benefits of the treatment, or of alternative treatments, without actually being able to interpret this information as relevant in the context of his or her own situation.[85] In view of epidemiological studies which show that a disproportionate number (15%) of mentally ill persons commit suicide,[86] an exclusive focus on cognitive function may not be a very effective way of ascertaining whether the person refusing medical treatment is of sound mind for the purposes of the MTA.

81 Victoria, *Second and Final Report of the Social Development Committee upon the Inquiry into Options of Dying with Dignity* (1987) 174.

82 *Ibid.* 167.

83 During parliamentary debates on the Medical Treatment (Enduring Power of Attorney) Bill in the Legislative Council, it was suggested that the issue of competence is a matter of clinical judgment and should be left to the medical profession: Victoria, *Parliamentary Debates*, Legislative Council, 6 September 1989, 254.

84 The single reference to terminal illness in the Medical Treatment Act 1988 (Vic.) is contained in the Preamble which declares that the aim of the MTA is the encouragement of the 'community and professional understanding of the changing focus of treatment from cure to pain relief for terminally-ill patients'. However, this aim is merely one of the six 'desirable objects' enumerated in the Preamble.

85 Roth, L.H., Appelbaum, P.S., Sallee, R. *et al.*, 'The dilemma of denial in the assessment of competency to refuse treatment' (1982) 139 *American Journal of Psychiatry* 910.

86 Levey, S., 'Suicide' in Bluglass, R. and Bowden, P., (eds), *op. cit.* n.33, 601.

Medicine, and in particular psychiatry, recognise that a patient's clinical competency may be impaired by his or her own personality, by an affective disorder, by a painful condition, by medication, by external pressures or even by the clinical setting. Any one of these factors may lead to a refusal of treatment.

Disease is frequently accompanied by stress or pain which may cause depression, possibly leading to an impairment of the patient's ability to function competently in processing and understanding medical information and making treatment decisions. The prevalence of severe depression among patients who are medically ill has been estimated as being between 10-20%, with a prevalence rate of twice that among geriatric patients and those who are severely medically ill.[87]

Studies have demonstrated that patients, particularly those with serious injuries such as John McEwan's spinal cord injury, tend to suffer from depression in the early stages of their treatment often manifesting itself in an express wish to die.[88] Interviews (in the form of psychological or psychiatric autopsy) with relatives of people who have committed suicide have found that a very large proportion (between 50% and 100%)[89] of the deceased had suffered a psychiatric disorder, particularly depressive illness, in the period immediately preceding the suicide. As Susan Sorenson points out:

> The elderly, the emotionally stressed, and persons who lack stable connections with others appear to be the most frequent victims of suicide.[90]

It has been claimed that persons suffering from paranoid conditions, or from serious affective disorders, 'constitute the largest population of treatment refusers.'[91] Clinicians have also confirmed that subtle or overt pressure from family, and sometimes from medical personnel, may impair the affective function of a patient and morbidly distort his or her view of life.[92]

Moreover, there are some psychopathological conditions in which an individual suffers from illness behaviour considered to be 'abnormal', that is, out of keeping with the objective evidence for illness.[93] A person's illness behaviour may be characterised as 'abnormal' in cases where there is

> the persistence of an inappropriate or maladaptive mode of perceiving, evaluating or acting in relation to one's own state of health, despite the fact that a doctor (or other appropriate social agent) has offered an accurate and reasonably lucid explanation of the nature of the illness and the appropriate course of management to be followed, based on a thorough examination of all param-

[87] Meakin, C.J., 'Screening for depression in the medically ill. The future of paper and pencil tests' (1992) 160 *The British Journal of Psychiatry* 212.

[88] Burrows, G.D., Judd, F., Buchanan, J. and Brown, D., 'Does depression negate the right to die?' in Burrows, G.D., Copolv, D. *et al.* (eds), *The Major Psychoses and The Diversity of Psychiatry*, (1986) 55.

[89] Persons addicted to drugs or alcohol constituted a substantial minority: Levey, S., *op. cit.* n.86, 601-602.

[90] Sorenson, S.B., 'Suicide among the elderly: issues facing public health' (1991) 81 *American Journal of Public Health* 1109, 1110. According to Meehan, P.J., Saltzman, L.E. and Sattin, R.W., 'Suicides among older United States residents: epidemiological characteristics and trends' (1991) 81 *American Journal of Public Health* 1198, from 1980 through 1986, there were 36,789 suicides reported among U.S. residents over the age of 65 years.

[91] Bursztajn, H.J., Harding, H.P., Gutheil, T.G. and Brodsky, A., 'Beyond cognition: the role of disordered affective states impairing competence to consent to treatment' (1991) 19 *Bulletin of the American Academy of Psychiarty and Law* 383.

[92] Simon, R.I., 'Silent Suicide in the Elderly' (1989) 17 *Bulletin of the American Academy of Psychiatry and Law* 83; Howe, E.G., 'From the editor' (1991) 2 *The Journal of Clinical Ethics* 79.

[93] Pilowsky, I., 'Abnormal illness behaviour: a review of the concept and its implications' in McHugh, S. and Vallis, T.M. (eds), *Illness Behaviour — A Multidisciplinary Model* (1986) 391.

eters of functioning, and taking into account the individual's age, educational and sociocultural background.[94]

Abnormal illness behaviour can take several forms of illness denial.[95] Illness denial may be motivated by a desire to obtain employment, by guilt and shame (as associated with, for example, venereal disease and AIDS), by fear of the stigma and discrimination associated with psychiatric symptoms, or by a desire to avoid feared therapies such as chemotherapy and radiotherapy. Sometimes illness denial may have an unconscious motivation such as neurotic non-compliance following myocardial infarction, or a refusal to accept psychological diagnosis or treatment in the presence of neurotic illness, personality disorder, or drug-dependency syndromes. Persons suffering from psychotic depression, manic states, and schizophrenic disorders, often present with denial of illness, including somatic pathology. Patients with neuropsychiatric syndromes, such as Korsakoff's psychosis caused by alcohol abuse, also tend to present with confabulatory reactions to illness.[96]

The problem with the refusal of treatment certificate is that at the time of signing the certificate, the patient, though intellectually aware of his or her condition, may be too emotionally impaired by fear of pain or other dreaded experiences to appreciate effectively and to evaluate rationally the risks posed by the refusal.[97] By the time such a patient would be forced to reconsider the refusal in the light of the actual medical consequences of non-treatment or less desirable treatment, it may be too late because an unconscious patient is unable to change his or her mind.

The inadequacy of the sound mind criterion as the sole determinant of the person's competence to (possibly fatally) refuse treatment can be illustrated by a 1988 case study described by Dr Lynn Peterson.[98] A 65-year-old woman suffering from mild diabetes, Mrs B., was hospitalized with an infection in her foot associated with a diabetic neuropathy. In hospital, though febrile, she was free of pain, and was oriented and rational. When told by her doctor that she had gangrene which was so severe that an amputation of the infected foot was required, Mrs B. became upset and refused amputation despite the risk of death. She told the doctors and her family that living without her foot would be so disfiguring as to be intolerable. There was a history of foot amputation in her family: shortly before she died, Mrs B.'s mother had had her foot amputated. The patient said that although she did not wish to die, she preferred dying to amputation. She had thus made a competent decision to refuse amputation and die. In Victoria, Mrs B. would probably have signed the refusal of treatment certificate declining to consent to the particular medical treatment, the life-saving amputation, for her current medical condition, the gangrenous infection.

[94] *Ibid.* 393.

[95] There are also forms of abnormal illness affirming such as Munchausen's Syndrome, factitious disorders, somatoform disorders, hypochondriacal delusions, *etc.*

[96] Pilowsky, I., *op. cit.* n.93, 393. Anosognosia — the apparent unawareness of, or failure to recognise, one's own functional defect — is a well known neurological deficit which also comes within the category of abnormal illness behaviour.

[97] Brock, D.W. and Wartman, S.A., 'When competent patients make irrational choices' (1990) 322 *The New England Journal of Medicine* 1595, 1597.

[98] Peterson, L.M., 'Refusing medical treatment' (1988) 31 *Perspectives in Biology and Medicine* 454.

Despite treatment with antibiotics and local drainage, the patient developed septicaemia and subsequently renal failure as a result of which she became comatose. Her husband discussed the matter with their children and they all decided that they did not want Mrs B. to die. An urgent application was made to the court, which granted Mrs B.'s husband the status of a temporary legal guardian. The husband then gave written consent to the amputation. Within two weeks of the amputation the patient's sepsis cleared and her renal function returned to normal. When Mrs B. regained consciousness she was furious that the amputation had been performed against her wishes. She refused to talk to her husband, was angry with the medical personnel, and was profoundly depressed. Mrs B.'s depression lasted nearly a year and she never completely accepted the loss of her foot; however, she recovered sufficiently to say that she was grateful that her life had been saved.[99]

When Mrs B. had to make the vital decision whether or not to consent to the mutilating procedure, she was systemically ill and depressed, although her cognitive ability remained unimpaired. Prior to having to make the choice in respect of amputation she had no desire to die, and even when she understood that unless she consented to the life-saving procedure the infection would kill her, she still proclaimed her desire to live. As Peterson points out:

> Even though she completed the mental status exam satisfactorily, and she was aware she was making a decision, it is possible that her illness 'clouded' her thinking and made a less desirable alternative seem better.[100]

Presented with the choice between a life-saving amputation, and a treatment by antibiotics and local drainage which was virtually certain to fail, Mrs B. opted for the latter. Her gangrenous condition was not painful, and therefore her refusal to believe that the condition was life-threatening appeared rational and was respected as such by medical personnel. By the time she might have recognised the seriousness of her infection, Mrs B. had became unconscious as a result of renal failure and therefore had lost the ability to change her mind.

Legal and medical ramifications of witnessing the refusal of treatment certificate of a competent patient under the MTA

The MTA does not provide any legal criteria for assessing the refusing patient's competence at the time of creation of the refusal of treatment certificate. Nor does the legislation require an independent psychiatric assessment of the refuser's clinical competency. This is a serious deficiency, for there will be cases where both the doctor and the other witness who sign the refusal of treatment certificate may have an interest in the patient's death. In such cases, the subjective perceptions of the witnesses about the patient's affective function and cognitive capacity to make the final decision might be coloured by ulterior interests. For, it should be noted, persons with an interest in the patient's death, including beneficiaries under the will, and persons who have an interest in any instrument previously executed by the patient as a donor, settlor, or grantor, are not excluded from

[99] Mrs B. lived for another six years. She died from metastatic ovarian carcinoma.
[100] Peterson, L.M., *op. cit.* n.98, 458.

acting as witnesses to the refusal of treatment certificate. Persons who will be entitled to an interest in the estate of a treatment-refuser on the intestate death of that person are also entitled to act as witnesses to the certificate. Yet, any person in any of the above categories would have a very real interest in the patient's death.

Admittedly, the MTA states that any witnesses who fall within the above categories will forfeit any interest under the will, instrument or intestacy, if it is proven that the refusal of treatment certificate was directly or indirectly procured or obtained by fraud, deception, misstatement or undue influence.[101] However, since the information given to the patient at the time of execution of the certificate need not be recorded, it would be virtually impossible to prove that any deception, misstatement or undue influence did in fact occur.[102]

Moreover, the signing of the certificate by two witnesses may be pivotal in deciding the issue of the life or death of the patient. For, unlike the NDA, the MTA has no provision which grants the treating doctor the power to disregard the patient's direction to withdraw extraordinary measures of treatment on the basis that at the time of giving the direction the patient was incapable of understanding its nature and consequences. Any investigation into the patient's soundness of mind from the point of view of his or her clinical competency can only be undertaken before the creation of the refusal of treatment certificate.[103] Once presented with the certificate, the treating doctor is under a statutory duty to comply with the instrument. The patient alone has the power to cancel the certificate.[104]

The case of *In re T.*, which was recently considered by the English Court of Appeal,[105] illustrates the pressures which may impair the decision-making capacity of an adult patient. T., a woman of 20, was injured in a car accident when she was 34 weeks pregnant. Though not a Jehovah's Witness herself, T. had been raised by her divorced mother, a fervent member of the sect.[106]

The injured woman was admitted to hospital where, following diagnosis of pneumonia, she was given high doses of antibiotics, oxygen, and pethidine. After she went into labour, T. was transferred by an ambulance to the labour ward. By that time, T. had had two private conversations with her mother, and had subsequently informed the midwife and the doctor about her opposition to blood transfusions. The obstetrician assured her that a caesarian section did not usually necessitate a transfusion and, in response to her inquiry, said that other, less effective procedures were also available. As the doctor was leaving, the midwife

101 Medical Treatment Act 1988 (Vic.) s.5F(1).

102 Medical Treatment Act 1988 (Vic.) s.5F(2) specifies that forfeiture of interest would be in addition to any other penalty in respect of deception, fraud, mis-statement, or undue influence under any other Act or law.

103 The same applies to the creation of the enduring power of attorney (medical treatment) instrument.

104 Medical Treatment Act 1988 (Vic.) s.7(1).

105 *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95.

106 T.'s parents were separated when she was three years old, in part because of profound religious differences. Initially the child continued to live with her father, but six months later was removed by her mother without the father's consent. Eventually, in view of her young age, custody of T. was granted to her mother. However the custody order expressly forbade T. being brought up as a Jehovah's Witness. When she was 17, T. moved from her mother's home to live with her paternal grandmother. At the age of 19 she met and begun to live with her boyfriend, C., the father of the baby who was later to be stillborn.

produced a hospital form providing for the refusal of consent to blood transfusions which T. signed and the midwife countersigned. The form contemplated that it would also be countersigned by the medical practitioner, but it was not so signed. Although the form required that its contents and significance be explained to the patient, it was neither read nor explained to T.

Following an emergency caesarian section T.'s child was delivered stillborn. T.'s condition seriously deteriorated and she was transferred to an intensive care unit. The medical opinion was that T. required a blood transfusion. She was put on a ventilator and paralyzing medications were administered. T. remained sedated, though in a critical condition, while her father, supported by the father of the baby, applied to the court for a declaration that it would not be unlawful for the hospital to administer a blood transfusion in the absence of her consent.

Judge Ward concluded that because of her condition and the effect of the narcotic medication T. was not fully rational when she signed the refusal form. The judge also held that although T. originally told the doctors that she did not want a blood transfusion, she neither consented to nor refused a blood transfusion after her condition became critical. Ward J. made an interlocutory order in the terms sought, and a transfusion was given forthwith.

An appeal by the Official Solicitor as guardian *ad litem* for T. was dismissed.[107] The Court of Appeal affirmed the principle that an adult patient

> who . . . suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered.[108]

According to the Court of Appeal, the right to choose is a manifestation of the individual's right to self-determination and as such it is inalienable and has to be respected regardless of what others may think about the wisdom of the ultimate decision. However, to be binding upon others, the right to choose to refuse medical treatment must be validly exercised, and the final choice clearly articulated. This is an attempt to resolve the conflict between the patient's right to self-determination and the society's interest in upholding the concept that all human life is sacred and should be preserved if at all possible. The patient's right to choose will be held to be paramount only after 'a very careful examination of whether, and if so the way in which,' the patient was exercising that right.[109] Lord Donaldson M.R., who delivered the leading judgment, echoed Justice Fullagar's statement in *In re Kinney*,[110] when he concluded that:

[107] *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 111. The Court of Appeal acknowledged that apart from the narrow issue whether Ward J.'s declaration should be affirmed or dismissed, the appeal also had a wider purpose of providing guidance to hospital authorities and the medical profession on the appropriate response to an adult's refusal of treatment.

[108] *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 102. In his judgment, Lord Donaldson of Lymington M.R. pointed out that since there was no doubt that T. wanted to live, the issue before the Court of Appeal was not about the person's 'right to die', but whether the patient had the 'right to choose how to live'. This otherwise unconditional right of choice has to be qualified in cases 'in which the choice may lead to the death of a viable foetus.'

[109] *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 112. The form signed by T. and countersigned by the midwife was found to be invalid because it was not witnessed by a medical practitioner as required, and because its significance was not properly explained to the patient. The refusal of treatment form was criticised by Lord Donaldson M.R. as designed primarily to protect the hospital from legal liability. The refusal of treatment certificate under Medical Treatment Act 1988 (Vic.), with its long and convoluted clauses and small type print is hardly an exemplar of clarity.

[110] *In re Graham Michael Kinney* (unreported), Supreme Court of Victoria, 23 December 1988.

> In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms.[111]

The Master of the Rolls stressed that doctors faced with a refusal of treatment need to give very careful and detailed consideration to the patient's decisional capacity at the time when the choice to refuse consent was made. Several factors, including outside influences, may have an effect of vitiating the refusal of treatment:

> The real question in each case is 'Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?' . . .
>
> When considering the effect of outside influences, two aspects can be of crucial importance. First, the strength of the will of the patient. One who is very tired, in pain or depressed will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful. Second, the relationship of the 'persuader' to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger than would be the case in other relationships.[112]

Lord Donaldson M.R. added that arguments for refusal of treatment based upon religious beliefs, when deployed by someone in a very close relationship with the patient,

> should alert the doctors to the possibility — no more — that the patient's capacity or will to decide has been overborne. In other words the patient may not mean what he says.[113]

At the time she signed the hospital refusal of blood transfusion form, T. was still suffering considerable pain in her chest, as well as contractions in the first stage of labour, and was under the influence of repeated doses of pethidine. This last factor — the character, doses, and frequency of medicines administered to the patient — needs to be taken into consideration when patients express the wish to sign a refusal of medical treatment certificate.

When formulating the principles and criteria to serve as guidance for doctors and hospitals, Lord Justice Donaldson M.R. took into account the medical concerns about patients' true capacity to make decisions concerning life and death when he stated that:

> It may not be the simple case of the patient having no capacity because, for example, at the time he had hallucinations. It may be the more difficult case of a temporarily reduced capacity at the time when his decision was made. What matters is that the doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required. If the patient had the requisite capacity, they are bound by his decision. If not, they are free to treat him in what they believe to be his best interests.[114]

Unlike the English common law approach, the statutory provisions of the MTA effectively prevent the medical practitioner faced with a signed refusal of treatment certificate from considering whether, at the time of signing the certificate, the patient had the decisional capacity commensurate with the gravity of the decision which he or she purported to make.

However, since a doctor is not compelled to witness the certificate, it would be wise for the medical practitioner involved to consider Lord Donaldson M.R.'s

111 *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 112.

112 *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 113-4.

113 *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 114. In the case of T., the circumstances which were then prevailing — including her mental and physical state when she signed the form, the pressure exerted by her mother, and the misleading response by the doctor to her inquiry as to the availability of alternative treatments — made her refusal ineffective and the doctors were justified in treating her on the principle of necessity.

114 *In re T. (Adult Refusal of Medical Treatment)* [1993] Fam. 95, 113.

determinants which may invalidate the presumption that refusal of treatment made by a cognitively-competent adult patient must necessarily be valid in all circumstances. Specific medical tests for evaluating the patient's competence to consent to medical treatment and to assign an enduring power of attorney have been developed. These tests, in conjunction with a clinical competency examination[115] by a forensic psychiatrist, and Lord Donaldson M.R.'s guidelines, should be applied before a witnessing medical practitioner decides to sign the refusal of treatment certificate.

The case of *In re T.* emphasises two shortcomings of the MTA. The first is the inadequacy of the requirement that the refusing patient be merely cognitively competent when creating the refusal of treatment certificate, the ultimate result of which may lead to an unintended death in some circumstances, or to an act of a passive suicide in others. The second is that the legislation may effectively preclude the treating medical practitioner who is presented with a signed refusal of treatment certificate from ascertaining whether the patient's decision to withhold consent was his or her true and free choice. The treating doctors would have been unable to invalidate the refusal of treatment certificate unless they became aware of the patient's medical and family circumstances immediately preceding the execution of the certificate. If the concerned physician administers treatment while verifying these questions, he or she will commit the statutory offence of medical trespass.

The Meaning of 'current condition', 'medical condition', and 'medical treatment' in the MTA

According to both the Court of Appeal in the case of *In re T.*, and to the provisions of the MTA, a legally binding refusal of treatment must be directed to a particular medical condition in which the decision whether or not to undertake or to continue with the proposed treatment is relevant. Under the provisions of the MTA, the patient can only refuse medical treatment for a 'current condition'.[116] In medicine, the phrase 'current condition' applies to any currently diagnosed medical disorder. Although the Interpretation of Legislation Act provides that terms used in legislation in the singular may be read as referring also to the plural,[117] it is suggested that the phrase 'current condition', which is used throughout the MTA in the singular, should be read as denoting an isolated currently diagnosed medical disorder.

This interpretation is supported by the provision which states that the refusal of treatment certificate will cease to apply if the medical condition of the patient has changed to such an extent that the condition in relation to which the certificate was given is no longer current.[118] Therefore, the legal standing of the refusal of

[115] For one such competency test see Janofksy, J.S., McCarthy, R.J. and Folstein, M.F., 'The Hopkins Competency Assessment Test: a brief method for evaluating patients' capacity to give informed consent' (1992) 43(2) *Hospital and Community Psychiatry* 132.

[116] Medical Treatment Act 1988 (Vic.) s.5.

[117] Interpretation of Legislation Act 1984 (Vic.) s.37(c). It applies 'unless a contrary intention appears'.

[118] Medical Treatment Act 1988 (Vic.) s.7(3).

treatment certificate will need to be reviewed in circumstances where the patient's condition deteriorates so catastrophically as to overwhelm and absorb the prior current condition into some new, morbid entity.

However, the current condition to which the refusal of treatment certificate applies must also be a medical condition. The phrase 'medical condition' is not defined in the MTA. Therefore, presumably it applies to any symptoms or syndromes which amount to a diagnosable medical condition. Consequently the Act would not discriminate between a person with a curable or treatable condition and a person who will die in a relatively short time, whether the proposed treatment is administered or not.[119] Nor does the legislation distinguish between a patient who has an incurable condition but who is not terminally ill (such as a person suffering from chronic renal failure, chronic hepatitis or chronic lymphatic leukemia), and a person who is terminally ill as a result of an incurable condition which has not responded to therapy.

The traditional medical approach to the issue of whether it is ethical for doctors to abide by the wishes of an incurably-ill patient who refuses to undergo therapeutic treatment in a situation where he or she is not terminally ill, involves the consideration of many factors. Doctors take into account such matters as the long-term prognosis, the burdens and the benefits of the treatment as against the distressing effects of non-treatment, and the age and physical and psychological condition of the patient. Doctors also recognise that a person may be terminally ill even though his or her present functions are not impaired, as where a person suffers from bone cancer with widespread metastases.

At the other end of the spectrum there are patients who are hopelessly ill because their functions are seriously impaired, but who are not terminally ill. An example is a person in a persistent vegetative state who can be kept alive for decades while connected to a mechanical ventilator, a catheter, and a feeding tube. Advanced medical technology and artificial life-sustaining processes are both necessary and of great value in cases where there exists the possibility of cure. However, in the case of patients who have no possibility of returning to cognitive and sapient life, life-sustaining or life-preserving treatment is essentially futile and may be foregone.[120] As Hughes C.J. of the Supreme Court of New Jersey pointed out in the *Quinlan* case,

> physicians distinguish between curing the ill and comforting and easing the dying; . . . they refuse to treat the curable as if they were dying or ought to die, and . . . they have sometimes refused to treat the hopeless and dying as if they were curable.[121]

Medical procedures can be divided into:

(1) therapeutic treatment, that is, treatment which is healing or curative;

[119] Meisel, A., *The Right to Die* (1989) 89.

[120] *Ibid.* 94-5.

[121] *In the Matter of Karen Quinlan* 355 A.2d 647 (1976), 667. In this case, Hughes C.J. granted declaratory relief to the father who sought to be appointed guardian of his 21 year-old daughter, Karen Quinlan, who was in a persistent vegetative state. The father also sought an express power to authorize the hospital to discontinue 'all extraordinary procedures for sustaining his daughter's vital processes.' This case, like the most of the 'right to die' cases in the U.S.A., argues an important constitutional issue of the state interest in the preservation of life as enshrined in the *American Declaration of Independence* and the Constitution. In Australia, the state's interest in preservation of life does not have a constitutional foundation.

(2) palliative care, which aims at alleviating symptoms without curing; and
(3) non-therapeutic medical procedures.

Mr Justice Brennan of the High Court of Australia has distinguished between 'therapeutic' and 'non-therapeutic' medical treatment in the following way:

> I would define treatment (including surgery) as therapeutic when it is administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered. 'Non-therapeutic' medical treatment is descriptive of treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder for which the treatment is administered and of treatment which is administered chiefly for other purposes.[122]

Unless the phrase 'pathological condition' is understood as encompassing the full spectrum of medical or surgical disorders, Mr Justice Brennan's legal definition of medical treatment could be considered narrow.[123] Perhaps this was the reason for His Honour's more general statement that, for the purposes of the law,

> [p]roportionality and purpose are the legal factors which determine the therapeutic nature of medical treatment. Proportionality is determined as a question of medical fact. Purpose is ascertained by reference to all the circumstances but especially to the physical or mental condition which the treatment is appropriate to affect.[124]

Mr Justice Brennan's rule of proportionality would presumably apply to all life-prolonging procedures which are proportionate to the purpose of saving life, and therefore would warrant an inclusion within the definition of therapeutic treatment. It is arguable that a distinction should be made between life-saving treatment which is therapeutic, and life-sustaining or life-prolonging medical procedures which are not healing, curative or palliative, although they do have the purpose of keeping the patient alive. To quote Hughes C.J. again:

> Medical science is not authorized to directly cause natural death; nor, however, is it expected to prevent it when it is inevitable and all hope of a return to an even partial exercise of human life is irreparably lost.[125]

Partly in recognition of the above principle, and partly in response to the MTA, most hospitals have designed detailed guidelines for palliation, but not cardiopulmonary resuscitation, of patients whose condition following myocardial infarction or cardiogenic shock is judged to be irreversible, with poor or hopeless prognosis.[126] Medical personnel have been advised that decisions about the resuscitation of such patients should take into consideration not only medical capability to prolong life, but also the distress likely to be caused by the procedure, the likely benefits to be attained, the circumstances of the patient prior to the admission, and the wishes of the agents or guardians.[127]

In what circumstances do the wishes of agents and guardians appointed under the MTA attain statutory force?

[122] *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 269. The case involved the issue of whether the parents or the Family Court should have the power to consent to sterilization of a girl suffering from profound permanent intellectual incapacity.

[123] *Cf.* Deane J. in *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 296, who pointed out that 'the borderline between "therapeutic" and "non-therapeutic" surgery is far from precise and, particularly where psychiatric illness is involved, may be all but meaningless.'

[124] *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 274.

[125] *In the Matter of Karen Quinlan* 355 A 2d. 647 (1976), 659.

[126] Memorandum *Guidelines for Palliation but not Cardiopulmonary Resuscitation* Monash Medical Centre, 27 May 1991.

[127] *Ibid.* 2.

Statutory criteria for refusal of treatment by agents appointed under the MTA

As discussed above, the refusal of treatment certificate executed by a competent person is valid only in respect of his or her current condition, thereby excluding the possibility of its validity in relation to some future medical condition. Indeed, were competent persons who sign a refusal of treatment certificate able to direct that no treatment should be undertaken in respect of future medical contingencies, such an instrument would effectively be a 'living will'. A living will permits an advance expression of the patient's preferences about the withholding or withdrawal of therapeutic measures when the patient becomes unconscious.[128] It is arguable that, unlike a patient's refusal of treatment certificate, an instrument created by a donor under the enduring medical powers of attorney may be, in effect, a living will.[129]

The MTA enables an adult person of sound mind to appoint an agent (or an alternate agent)[130] who can refuse medical treatment on behalf of the patient if the patient becomes incompetent.[131] The MTA requires that the witnesses to the instrument (neither one of whom needs to be a medical practitioner)

> each believe that A.B. [the donor] in making this enduring power of attorney (medical treatment) is of sound mind and understands the import of this document.[132]

When a person who has appointed an agent in accordance with the requirements of the MTA loses mental capacity, the agent may request from a medical practitioner and another person a refusal of treatment certificate for the current condition of the incompetent patient.[133] The medical practitioner and the other person may issue the certificate if satisfied:

> (a) that the patient's agent or guardian has been informed about the nature of the patient's current condition . . .; and
> (b) that the agent or guardian understands that information.[134]

The agent can refuse either medical treatment generally, or treatment 'of a particular kind'[135] for the specified current condition of the incompetent patient only where 'the [medical] treatment would cause unreasonable distress to the patient',[136] or where there are reasonable grounds for believing that the donor, 'if competent . . . would consider that the medical treatment is unwarranted.'[137] An

128 Fisher, R.H. and Meslin, E.M., 'Should living wills be legalized?' (1990) 142 *Canadian Medical Association Journal* 23.

129 Lanham, D. and Fehlberg, B., *op. cit.* n.24; Lanham, D. and Woodford, S., *op. cit.* n.71.

130 Medical Treatment Act 1988 (Vic.) s.5A. An alternate agent will be able to make decisions about the medical treatment of the incompetent person when the agent appointed under the enduring power of attorney (medical treatment) instrument is unable or unavailable to act: s.5AA. Guardians appointed under the Guardianship and Administration Board Act 1986 (Vic.) are granted the same powers to refuse medical treatment on behalf of the represented persons as agents appointed under an enduring power of attorney.

131 At common law a person of sound mind has the right to appoint another person to manage his or her affairs. However, the power of attorney lapses after the donor becomes legally incompetent: Meisel, A., *op. cit.* n.119, 331.

132 Medical Treatment Act 1988 (Vic.) Schedule 2.

133 Medical Treatment Act 1988 (Vic.) s.5B.

134 Medical Treatment Act 1988 (Vic.) s.5B(1). As with refusal of treatment certificates for competent patients, a medical practitioner has an absolute discretion to decline signing a refusal of treatment certificate requested by an agent.

135 Medical Treatment Act 1988 (Vic.) s.5B(1)(d).

136 Medical Treatment Act 1988 (Vic.) s.5B(2)(a).

137 Medical Treatment Act 1988 (Vic.) s.5B(2)(b).

agent cannot refuse, on behalf of the patient, treatment which is appropriate and proportionate.[138]

A decision to refuse medical treatment made by an agent on behalf of an incompetent patient can be reviewed by the Guardianship and Administration Board of Victoria on an application made by either the Public Advocate, or by 'a person who . . . has a special interest in the affairs of the [patient]'.[139] Presumably, a 'person who . . . has a special interest in the affairs' of the patient includes the treating medical practitioner who is presented with the agent's refusal of treatment certificate.[140]

The two statutory criteria for refusal of medical treatment by an agent appointed under the enduring medical power of attorney instrument have all the hallmarks of advance directives. The first criterion refers to the agent or guardian being able to refuse treatment on behalf of an incompetent patient if the medical treatment would cause the incompetent patient 'unreasonable distress'.[141] Not only pain, but also vomiting, polyuria, incontinence and confusion, if they give rise to feelings of embarrassment and helplessness, may cause unreasonable distress. However, it is doubtful whether an incompetent patient would experience these emotions.

The unreasonable distress criterion is based upon the agent's, rather than the incompetent patient's, subjective perception of distress. Therefore, when used as the sole determinant for a surrogate judgment of whether medical treatment should be withheld or withdrawn, it is inadequate. Some treatments of significant curative value, such as organ transplantation, chemotherapy or radiotherapy, may have very distressing, though temporary, side-effects. The agent has the power to refuse medical treatment not only for a patient who is permanently incompetent and terminally ill, but also for a patient who is temporarily incompetent and has a treatable or even curable illness.

The second statutory criterion for refusal of treatment by an agent on behalf of an incompetent patient refers to

> the reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.[142]

This provision appears to adopt what is known as the 'substituted judgment'

[138] Andrews, K., 'The Medical Treatment Act and the incompetent patient' (1990) 8(3) *St Vincent's Bioethics Centre Newsletter* 1, 2.

[139] Medical Treatment Act 1988 (Vic.), s.5C(2)(b). Under s.5C(4) the decision of an agent to refuse treatment on behalf of the donor may be suspended by the Guardianship and Administration Board, if the Board is satisfied that it is not in the best interests of the donor. Section 5C authorises the Board to revoke, suspend or make any other determination in respect of the validity or effect of the alternate agent's enduring medical power of attorney on a number of grounds, each of which includes the criterion of the best interest of the donor. These grounds include completion of a false statutory declaration by the alternate agent, failure to comply with s.5AA, and conflicting decisions about the medical treatment of the donor made by the person's agent and the alternate agent.

[140] Medical Treatment Act 1988 (Vic.) s.5E(1) requires the Boards of public hospitals or denominational hospitals and the proprietors of private hospitals or nursing homes to take 'reasonable steps to ensure that a copy of any refusal of treatment certificate applying to a person who is a patient in the hospital or home and of any notification of the cancellation of such certificate —
(a) is placed with the patient's record kept by the hospital or home; and
(b) is given to the chief executive officer . . . of the hospital or home; and
(c) is given to the Guardianship and Administration Board within 7 days after the certificate is completed.'

[141] Medical Treatment Act 1988 (Vic.) s.5B(2)(a).

[142] Medical Treatment Act 1988 (Vic.) s.5B(2)(b).

standard for decision-making by the agent. It requires the agent to substitute his or her decision for that of the incompetent patient on the basis of evidence about the donor's presumed subjective intentions and preferences.[143] It is a subjective standard which relies upon assumptions about what the incompetent patient, as a reasonable person, would have decided in the circumstances, but it excludes from consideration what other reasonable persons in the same position as the incompetent patient would have decided.

There have been a number of investigations which assessed, in different clinical settings, concordance between elderly patients and their potential surrogates making hypothetical decisions in relation to various treatment scenarios.[144] These studies have demonstrated significant discrepancies in response between the patients' wishes and those of their chosen surrogates. In one study involving life and death decisions in respect of cardio-pulmonary resuscitation after the patient's loss of consciousness, the majority of patients chose to be resuscitated, whereas a very high proportion of chosen surrogates would have made the decision to withhold further treatment. These findings have suggested that:

> [t]he substituted judgment standards for decision making for patients of diminished mental capacity are compromised by their inability to truly approximate the patient's wishes.[145]

The findings suggest that a combination of best-interest considerations, the wishes of the proxy appointees, and any written directions of the patients before they became incompetent need to be taken into account when decisions are made to end the patient's life. In *Marion's Case* Mr Justice Brennan argued that

> to speak of an authorization given by a third party to administer treatment to an intellectually disabled child as substituted consent. . . . is semantic legerdemain.'[146]

Likewise, decisions concerning medical treatment made by third parties on behalf of incompetent adult patients under the substituted judgment doctrine should be approached with caution.[147] Again, one of the central factors in all such determinations should be whether the proposed medical procedure is futile, or whether it is in fact curative or at least will bring an improvement to the patient's sapient life and well-being.[148]

[143] Meisel, A., *op. cit.* n.119, 269-70.

[144] Uhlmann, R.F., Pearlman, R.A. and Cain, K.C., 'Physicians' and spouses' predictions of elderly patients' resuscitation preferences' (1988) 43(5) *Journal of Gerontology: Medical Sciences* 115-21; Uhlmann, R.F., Pearlman, R.A. and Cain, K.C., 'Understanding of elderly patients' resuscitation preferences by physicians and nurses' (1989) 150 *Western Journal of Medicine* 705; Tomlinson, T., Howe, K., Notman, M. and Rossmiller, D., 'An Empirical study of proxy consent for elderly persons' (1990) 30 *The Gerontologist* 54; Ouslander, J., Tymchuk, A.J. and Rahbar, B., 'Health care decisions among elderly long-term care residents and their potential proxies' (1989) 149 *Archives of Internal Medicine* 1367; Zweibel, N.R. and Cassel, C.K., 'Treatment choices at the end of life: a comparison of decisions by older patients and their physician-selected proxies' (1989) 29 *The Gerontologist* 615; Diamond. E.L., Jernigan, J.A., Moseley, R.A., Messina, V. and McKeown, R.A., 'Decision-making ability and advance directive preferences in nursing home patients and proxies' (1989) 29 *The Gerontologist* 622; Seckler, A.B., Meier, D.E., Mulvihill, M. and Cammer Paris, B.E., 'Substituted judgment: how accurate are proxy predictions?' (1991) 115 *Annals of Internal Medicine* 92.

[145] Seckler, A.B., Meier, D.E., Mulvihill, M. and Cammer Paris, B.E., *op. cit.* n.144, 97.

[146] *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 267-8.

[147] For a trenchant criticism of the doctrine of surrogate judgment see the judgment of Lord Mustill in *Airedale N.H.S. Trust v. Bland* [1993] 2 W.L.R 316, 396.

[148] Andrews, K., *op. cit.* n.138, 2, suggests that the mere assertion by the agent that the patient would consider the treatment unwarranted will be unlikely to satisfy the statutory criteria and that some clear evidence of what the patient wishes will be required.

Where a guardian or an agent with enduring medical powers of attorney, despite medical advice, decides to refuse life-saving treatment for an incompetent patient, a prudent treating medical practitioner would apply to the Guardianship and Administration Board or to the Supreme Court of Victoria[149] for a determination whether the agent's refusal is indeed in the patient's best interests.[150]

The best interest standard is the traditional standard used by courts for appointing guardians who must act in a way which will most effectively promote their ward's interests, and physical and emotional welfare. The standard is objective and the patient's best interest will be determined by such objective criteria as relief from suffering, the degree of bodily invasion required by the procedure, and the chances of preservation or restoration of functioning life, as well as the quality and extent of sustained life.[151] Mr Justice Brennan in *Marion's Case* argued that,

> in the absence of legal rules or a hierarchy of values, the best interests approach depends upon the value system of the decision-maker. Absent any rule or guideline, that approach simply creates an unexaminable discretion in the repository of the power.[152]

Although Brennan J.'s critical remarks were directed at decisions made in respect of sterilization of intellectually disabled children, they may also be applicable to judicial determinations made on behalf of other incompetent patients. It is arguable, however, that a determination made by an outside judicial tribunal, guided by objective criteria as to the best interests of the incompetent person, is less open either to abuse or to subjective bias than a decision by persons who are intimately involved with the seriously ill patient, even when these persons are grantees of the enduring power of attorney.

The virtually unconstrained power to appoint agents under the enduring powers of attorney instrument may have unfortunate clinical and legal consequences which the Victorian legislators failed to foresee, but which may be illustrated by reference to the following hypothetical example: a patient who is not terminally ill, but who had expressed a wish to die, and has signed a general refusal of treatment certificate in respect of the diagnosed depression from which he is suffering, needs a treatment of electroconvulsive therapy (E.C.T.). The Victorian Mental Health Act[153] requires written consent of the patient to E.C.T., except in cases of involuntary or security patients who are incapable of giving 'informed consent',[154] and in cases where

> the nature of the mental illness from which a patient is suffering is such that the performance of the electroconvulsive therapy is urgently needed.[155]

Since, as has been pointed out above, the criteria of mental illness for the purposes of the Mental Health Act[156] differ from the criteria of unsound mind for the purposes of the MTA, it is possible that a patient who is diagnosed as mentally

[149] Courts have an inherent jurisdiction 'to act for the benefit of the incompetent': *E. (Mrs) v. Eve* [1986] 2 S.C.R. 388, 410; (1986) 31 D.L.R. (4th) 1, 13-22, *per* La Forest J.

[150] Medical Treatment Act 1988 (Vic.) s.5C.

[151] Meisel, A., *op. cit.* n.119, 266.

[152] *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 271.

[153] Mental Health Act 1986 (Vic.) s.72.

[154] Mental Health Act 1986 (Vic.) s.73(3).

[155] Mental Health Act 1986 (Vic.) s.73(4).

[156] *In the appeal of Garry Webb (also known as Garry David) a security patient at Aradale Hospital.* Mental Health Review Board. Heard in January, February and March of 1990; no 230190 (unreported).

ill and in urgent need of E.C.T. can at the same time be regarded at law as being of sound mind, and thus legally capable of refusing this form of therapy. Assuming that the patient's psychiatric condition renders him decisionally incompetent, under the provisions of the Mental Health Act the administration of electroconvulsive therapy would be permitted where 'the consent of the primary carer or guardian has been sought and obtained'.[157] The Mental Health Act is silent on the position of an incompetent patient who has previously executed a medical power of attorney instrument in favour of an agent, who is neither his or her primary care-giver, nor a guardian, but who refuses electroconvulsive therapy on the patient's behalf, coming into conflict with the primary carer if the primary carer is in favour of granting consent.

Despite scientific evidence which documents at least the short-term efficacy of E.C.T. in appropriate cases,[158] and despite technological modifications in its application,[159] the use of this treatment is still controversial, particularly within the lay community. A 50 year-old man suffering from a chronic depression of mild severity may execute an enduring power of attorney (medical treatment) instrument appointing his daughter as his agent. The daughter may firmly believe that electroconvulsive therapy is unduly distressing and unwarranted having seen the film *One Flew over the Cuckoo's Nest*.[160] If the father has a severe episode of major depression, his wife, as the primary care-giver, may give her consent to the E.C.T. but the man's daughter, in her capacity as his agent, may override the wife's consent.

The treating medical practitioner who resolves to follow the wife's direction will not commit an offence under the Mental Health Act[161] but will be liable under the MTA. If the treating practitioner was to accede to the daughter's refusal, and the patient were to suffer an injury as a result of failure to administer the appropriate treatment, the medical practitioner will be protected by paragraph 9(1)(c) of the MTA from liability in any civil proceedings. This would leave the injured patient without a legal remedy.[162]

The case of the father with a psychiatric disorder exemplifies the restraints which may impinge upon the professional autonomy of medical practitioners to decide on the best course of treatment for the patient. The professional autonomy of medical decision-making is an important issue which needs to be discussed further, especially as it relates to the powers of agents and guardians under the MTA.

157 Mental Health Act 1986 (Vic.) s.73(3)(b).

158 Buchan, H., Johnstone, E., McPherson, K., Palmer, R.L. *et al.*, 'Who benefits from electroconvulsive therapy? Combined results of the Leicester and Northwick Park Trials' (1992) 160 *British Journal of Psychiatry* 355.

159 Scott, A.I.F., Rodger, C., Stocks, R.H. and Shering, A.P., 'Is old-fashioned electroconvulsive therapy more efficacious? A randomised comparative study of bilateral brief-pulse and bilateral sine-wave treatments' (1992) 160 *British Journal of Psychiatry* 360.

160 A film by Milos Forman based on a book by Ken Kesey.

161 Mental Health Act 1986 (Vic.) s.73(3).

162 The relevant amendments to the two Acts were passed by the Victorian Parliament in 1990, but the parliamentary debates provide no guidance to the resolution of the jurisprudential conflict which they have thereby created.

Professional decisions of medical practitioners and the powers of agents under the MTA

In the Preamble to the MTA the Victorian Parliament has recognised that it is desirable 'to encourage community and professional understanding of the changing focus of treatment from cure to pain relief for terminally-ill patients' and 'to ensure that dying patients receive maximum relief from pain and suffering.'[163]

The medical aim to ensure that a dying patient receives maximum relief from pain and suffering may result in a professional decision by the clinical personnel to remove intensive mechanical and biochemical supports from patients who have been reliably diagnosed as being in a permanent coma or in persistent vegetative state.[164] In some cases such decisions will be met with demands by agents or guardians[165] that the supports be maintained.[166] The MTA enables agents and, by necessary implication, alternate agents 'to make decisions about medical treatment on behalf of an incompetent person'.[167] The clause allowing agents 'to make decisions about the medical treatment' has generated some confusion as to the powers of the agents.

The enabling amendments acquire their proper statutory meaning only when read in the light of the stated objective of the MTA, namely, 'to give protection to the patient's right to *refuse unwanted* medical treatment.'[168] Given this aim, the agents' power to make decisions about medical treatment on behalf of an incompetent patient has to be seen as an extension of the statutory right of the competent patient to consent to or to refuse medical treatment. Therefore, an agent appointed under an enduring medical power of attorney is empowered to make decisions about the medical treatment of the incompetent patient[169] only in so far as those decisions relate to the refusal of medical treatment. It needs to be understood that 'consent by itself creates no obligation to treat. It is merely a key which unlocks the door.'[170] The agent has no statutory or common law right to insist that a

[163] Medical Treatment Act 1988 (Vic.) Preamble: (e) and (f).

[164] *I.e.*, patients who have no hope of regaining consciousness and who are totally dependent upon intensive mechanical and biochemical support.

[165] Relatives of persons who are over the age of maturity have no legal right either to consent or to refuse medical treatment. Lord Donaldson M.R. pointed out that '[t]here seems to be a view in the medical profession that in . . . emergency circumstances the next of kin should be asked to consent on behalf of the patient . . . This is a misconception because the next of kin has no legal right either to consent or to refuse consent.' *In re T.* [1993] Fam. 95, 103. In order to be able to consent to medical treatment, a relative needs to be appointed as guardian *ad litem*, or to be a grantee of power under the enduring medical powers of attorney instrument.

[166] On the issue of denial about the patient's condition and prognosis by close relatives, see Golenski, J.D., 'The power of denial' in Culver, C.M. (ed.), *Ethics at the Bedside* (1990). In many countries, cases of this nature repeatedly come before the courts. An example is the case of *In re Wanglie* (unreported decision of the Minnesota District Court, June 28 1991, discussed in Capron, A.M., 'In re Helga Wanglie' (1991) 21(5) *Hastings Center Report* 26). In that case, the Minnesota Court refused to appoint a professional conservator (guardian) to make life-support decisions for an unconscious 87 year-old woman in a persistent vegetative state when her husband rejected the medical advice that his wife's respirator be disconnected and insisted that life-prolonging treatment be continued. The sole issue before the Court was determination of the husband's suitability as guardian. The Court was not asked to determine the validity of the medical decision in respect of futility of treatment.

[167] Medical Treatment Act 1988 (Vic.) s.1(c).

[168] Medical Treatment Act 1988 (Vic.) Preamble (a).

[169] These may involve financial arrangements, transfers to different hospitals, wards, *etc.*

[170] *In re R. (A Minor) (Wardship: Consent to Treatment)* [1992] Fam. 11, 22, *per* Lord Donaldson

particular treatment or intensive care be provided to the patient when such therapy is not medically indicated.[171]

The common law rights of legal guardians and the courts[172] in respect of medical treatment were well expressed by Lord Donaldson M.R. in *In re J. (A Minor)*:

> The fundamental issue . . . is whether the court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioner . . . to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contra-indicated as not being in the best interests of the patient. I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to the patient. This, subject to obtaining any necessary consent, is to treat the patient in accordance with his own best clinical judgment, notwithstanding that other practitioners who are not called upon to treat the patient may have formed a quite different judgment or that the court, acting on expert evidence, may disagree with him.[173]

The above passage refers to a challenge made by a body with parental responsibility for a minor to a clinical decision which precluded further resuscitation of the child by way of mechanical ventilation. However, there is no reason why the general principles of the autonomy of clinical decision-making which were enunciated by Lord Donaldson should not apply to adult patients. In an earlier decision, his Lordship explained the legal relationship between doctors and those who have the right to make decisions on behalf of incompetent patients in the following way:

> No one can dictate the treatment to be given to the child — neither court, parents nor doctors. . . . The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist upon treatment C.[174]

Lord Justice Leggatt noted that the Court of Appeal has not given to doctors any right they did not previously have by ruling that the medical staff should be free, subject to consent not being withdrawn, to treat patients in accordance with their best clinical judgment. The decision 'has merely declined to deprive them [doctors] of a power which it is for them alone to exercise.'[175] The Australian courts will probably take a very similar approach.[176]

M.R. In a subsequent judgment Lord Donaldson M.R. qualified this key analogy: 'On reflection I regret my use *In Re R.* . . . of the keyholder analogy because keys can lock as well as unlock. I now prefer the analogy of a legal "flak jacket" which protects the doctor from claims by the litigious': *In re W.* [1993] Fam. 64, 78.

[171] If the agency provisions of the MTA were read in any other way, agents would acquire far greater powers of determining medical treatment of an incompetent patient than competent patients have in respect of their medical options.

[172] In Victoria, legal guardians, validly appointed agents, courts and the Guardianship Board have the right to consent to or to refuse treatment for incompetent patients.

[173] *In re J. (A Minor) (Child In Care: Medical Treatment)* [1993] Fam. 15, 26-7, Lord Justices Belacombe and Leggatt concurred. The case involved an 18 month-old child, J., who at the age of one month sustained serious head injuries which rendered him profoundly mentally and physically handicapped, suffering from microcephaly, cerebral palsy, cortical blindness and severe epilepsy. He was considered unlikely to develop greatly beyond his present state and had an uncertain but shortened life expectancy. J.'s intermittent convulsive attacks required resuscitative treatment in hospital. In December 1991 the consultant pediatrician considered that it was medically inappropriate to use mechanical ventilationprocedures for any future resuscitation. Asked to determine whether artificial ventilation and other life-saving measures should be administered to J., the Court of Appeal held that the court would not order a medical practitioner to treat his patient in a manner contrary to his clinical judgment and professional duty.

[174] *In re J. (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33, 41.

[175] *In re J. (A Minor) (Child In Care: Medical Treatment)* [1993] Fam. 15, 31, *per* Lord Justice Leggatt.

[176] It is unlikely, but possible, for disagreements to arise between medical personnel and agents

The meaning of 'palliative care' under the MTA

The MTA appears to make a sharp distinction between medical treatment and palliative care. If this were so, the legislation would have the effect of superimposing legal structures, which work by way of following clearly defined alternatives, upon medical practice. This is unrealistic. Modern medical practice operates within a framework which allows for many different choices and leeways for discretion within the one continuum of treatment. Since medical treatment is solely referable to clinical practice, it is within this context, rather than through social and philosophical theories, that any distinctions between medical treatment and palliative care should be elucidated.

Under the MTA, the patient can refuse, or empower his or her agent to refuse, medical treatment generally or a specific type of medical treatment.[177] According to the MTA,

> 'Medical treatment' means the carrying out of —
> (a) an operation; or
> (b) the administration of a drug or other like substance; or
> (c) any other medical procedure[178]

However, neither the patient nor the agent can refuse 'palliative care'[179] which under the MTA includes:

> (a) the provision of reasonable medical procedures for relief of pain, suffering and discomfort; or
> (b) the reasonable provision of food and water.[180]

Palliative care has been defined as treatment which increases the well-being of the patient by relieving symptoms of disease or illness without effecting cure.[181] Traditionally, palliative care has focused upon alleviating pain and suffering associated with diseases which can no longer be cured or ameliorated.[182] However, at the present time palliative care has wider application than the traditional care for the dying.

Medical practitioners have recognised that severe, chronic pain can induce feelings of helplessness and hopelessness leading the sufferer to believe that suicide is the only way out.[183] Therefore, relief of pain is seen as an important part of medical treatment at the stage when the disease can still be cured or, if that is not possible, when its severity can be ameliorated.

The definition of palliative care in the MTA is inclusive, and thus wide enough

appointed under the enduring power of attorney (medical treatment) instrument who hold very strong religious views that the time of death should be fixed solely on the basis of cardiorespiratory criteria. However, in all Australian States, except for Western Australia, death is defined by statute as 'the irreversible cessation of all brain function; irreversible cessation of blood circulation.': Human Tissue Act 1983 (N.S.W.) s.33; Human Tissue Act 1982 (Vic.) s.41; Human Tissue Act 1985 (Tas.) s.27A; Human Tissue Transplant Act 1979 (N.T.) s.23; Transplantation and Anatomy Act 1979 (Qld) s.45(1); Death Definition Act 1983 (S.A.) s.2; Transplantation and Anatomy Act 1978 (A.C.T.) s.45. See also Olick, R.S., 'Brain death, religious freedom, and public policy' (1990) 1 *Kennedy Institute of Ethics Journal* 275, 289-92.

177 Medical Treatment Act 1988 (Vic.): see Schedule 1, Schedule 3 for the relevant certificates.

178 Medical Treatment Act 1988 (Vic.) s.3.

179 Medical Treatment Act 1988 (Vic.) s.3.

180 *Ibid.*

181 Maddocks, I., 'Changing concepts in palliative care' (1990) 152 *The Medical Journal of Australia* 535.

182 Saunders, C., 'What's in a name?' (1987) 1 *Palliative Medicine* 57.

183 Angarola R.T. and Joranson D.E., 'Pain and Euthanasia: The Need for Alternatives' (1992) 2 *Bulletin of the American Pain Society* 10.

to include palliation through pharmacotherapy, as well as through more intrusive medical procedures such as intrathecal chemotherapy, which is carried out to control pain and weakness caused by spinal spread of lymphoma, or treatment through the use of endobronchial laser to relieve tumour obstruction of a major bronchus.[184]

In Australia, medical practitioners can use opioid analgesics for optimal control of intractable pain, providing they comply with the relevant regulations.[185] However, although palliative therapy through pharmacotherapy, neurosurgery and anaesthesia is increasingly successful in the relief of pain and physical discomfort, the emotional distress stemming from the dependency and invalidity experienced by persons suffering from serious disorders is more difficult to redress. Many terminally-ill patients experience deep spiritual distress which should be addressed by religious and spiritual, rather than medical, counselling.[186]

Since the MTA is exclusively concerned with medical treatment, the term 'suffering' in the context of the Act must refer to suffering due to physical discomfort and psychological pain. Therefore, a medical practitioner should not be precluded from administering anti-depressant medications to a patient who has signed the general certificate, where it is evident that the patient is suffering from depression.

The refusal of treatment certificate does not apply to 'the reasonable provision of food and water.'[187] This section permits at least two interpretations. A narrow construction would allow the patient to refuse all medical procedures, except for ordinary feeding by mouth, which may be carried out either by the patient or by non-medical personnel. Such a narrow construction, though in accordance with the plain meaning of the words, would exclude nutrition or hydration administered intravenously or by gastric tube. It would thus effectively condone death by starvation and dehydration of any person, be it a terminally-ill patient, a person with a treatable disease, a physically-fit though mentally-ill person contemplating suicide, or a political protester on a hunger strike.[188]

However, the adjective 'reasonable' which precedes the phrase 'provision of food and water', renders this section amenable to a much wider application, including intubation for the purposes of nutrition and hydration. Artificial feedings can be administered either through a tube inserted to the functioning gastro-intestinal tract for the purpose of improving hydration and electrolyte balance, or through an intravenous feeding line inserted into one of the major veins of the chest for the purpose of intravenous alimentation. The intravenous infusion, which may require restraint of the patient, can only be applied while the patient is in the hospital, and it increases the risk of infection.

The issue raised by refusal of consent for an insertion or continuance of

184 Maddocks, I., *op. cit.* n.181, 536.

185 Mendelson, G. and Mendelson, D., 'Legal aspects of management of chronic pain' *op. cit.* n.53; Mendelson, G. and Mendelson, D., 'The Requirements for Prescribing Opiates' *op. cit.* n.60.

186 Medical practitioners should not confuse their role with that of the clergy (of all denominations). Unless they happen to be ministers of religion with a medical degree, doctors are neither qualified nor required to minister to patients' spiritual needs.

187 Medical Treatment Act 1988 (Vic.) s.3.

188 Lord Mustill, in *Airedale N.H.S. Trust v. Bland* [1993] 2 W.L.R 316, 392, noted that in 20 of the 39 American States which have legislated in favour of living wills, the legislation specifically excludes termination of life by the withdrawal of nourishment and hydration.

temporary nasogastric tubes is more complex. Nasogastric tubes are portable and the patient need not be hospitalized in order to use them. However, even nasogastric tubes, though they tend to be relatively well tolerated, may require arm restraints to prevent dislodging of the tube, and they do present an increased risk of pneumonia.[189] Thus, the administration of artificial feeding and hydration has to be seen in context of the reasons for the refusal by each patient before the decision is made as to whether the palliative benefits of this kind of medical care outweigh its burdensome effects.[190]

The statutory offence of medical trespass

Failure to comply with a refusal of treatment certificate or a validly empowered agent's direction under the MTA, is a criminal offence of medical trespass punishable by a maximum penalty of five penalty units (imprisonment not being specified as an alternative). An offence punishable by five penalty units amounts to a summary offence for which a maximum fine of $500 may be imposed,[191] and it must be heard and determined before the Magistrates Court.[192] The location of the penalty at the foot of the provisions indicates that the Magistrates Court has a discretion to decide upon such alternatives to the penalty as an adjournment, a dismissal of the charge without penalty, an imposition of a lesser number of penalty units, or an imposition of a fine without recording the conviction.[193]

Under the Sentencing Act 1991 (Vic.) there are 14 levels of punishment, and five penalty units is the second lowest of those levels. The deliberate choice to place the penalty for the offence of medical trespass at the second lowest level of gravity indicates that the State of Victoria regards a doctor's failure to comply with the refusal of treatment certificate as one of the least serious wrongdoings to merit criminal punishment. The level of penalty suggests that this offence is regarded as being on a par with fortune telling and pretending to exercise witchcraft,[194] tattooing of juveniles,[195] teaching another to drive without appropriate licence,[196] being in possession of an unregistered dog,[197] or falsely registering a dog.[198]

As well as invoking statutory sanctions for medical trespass, the patient whose refusal of treatment has been disregarded has the right to sue the medical practitioner for damages for the civil tort of trespass,[199] and to lodge a complaint with the Medical Board of Victoria.[200] The Medical Board may require any legally

189 Pence, G.E., *Classic Cases in Medical Ethics* (1990) 61.

190 For a detailed discussion of a person's right to die through refusal of food and water, see: Lanham, D., 'The right to choose to die with dignity' *op. cit.* n.16.

191 Sentencing Act 1991 (Vic.) s.110.

192 Interpretation of Legislation Act 1984 (Vic.) s.52. The statutory offence of medical trespass appears to be one of strict liability, since the MTA does not provide for any defences.

193 Sentencing Act 1991 (Vic.) s.111.

194 Vagrancy Act 1966 (Vic.) s.13.

195 Summary Offences Act 1966 (Vic.) s.42(1).

196 Road Safety Act 1986 (Vic.) s.33(12).

197 Dog Act 1970 (Vic.) s.4(2).

198 Dog Act 1970 (Vic.) s.6(2).

199 Substantial aggravated or exemplary (punitive) damages may be awarded for the injury to the plaintiff's honour and dignity that is a result of trespass to person: Luntz, H., *Assessment of Damages For Personal Injury and Death* (3rd ed. 1990) 62-4.

200 Under the Health Services (Conciliation and Review) Act 1987 (Vic.), the aggrieved patient can also lodge a complaint with the Victorian Health Commissioner's Office.

qualified practitioner to appear before it to enable an inquiry to be held into any matter concerning the activities of the practitioner, which may include non-consensual medical treatment.[201]

The offence of medical trespass under the MTA is a summary offence. As such, it does not require the Medical Board to refuse to register a medical practitioner convicted under the MTA,[202] or to institute disciplinary proceedings either for infamous conduct in a professional respect, or for professional misconduct.[203] Infamous conduct in a professional respect has not been statutorily defined, but it has been judicially defined by Lord Justice Scratton in *Rex v. General Medical Council* as a

> serious misconduct judged according to the rules written and unwritten governing the profession.[204]

Where the Medical Board finds that the practitioner has been guilty of infamous conduct in a professional respect, it must remove the person's name from the Register.[205] Professional misconduct applies to conduct which does not necessarily warrant non-discretionary removal from the Register, but for which a less drastic penalty is appropriate.[206] Statutory medical trespass as a summary offence is, technically, outside the purview of the Medical Board's disciplinary powers of investigation for professional misconduct.[207] However, that does not preclude the Board from taking a very serious view of a doctor who has committed medical trespass by negligently or recklessly disregarding a refusal of treatment by a truly competent patient.[208]

The attitude of the Medical Board, or of a judge and jury, is less predictable in cases where the doctor saves the life of a patient in disregard of the patient's refusal of treatment certificate. There may be differing responses towards the medical practitioner's defence that, according to his or her professional judgment, the patient, although of sound mind in the sense of cognitive competence, was suffering at the time from a severe affective or psychotic disorder.

In view of the low classification of the offence of medical trespass on the scale

201 Medical Practitioners Act 1970 (Vic.) s.16.

202 Medical Practitioners Act 1970 (Vic.) s.8 mandates the Medical Board of Victoria to maintain a Medical Register of legally qualified medical practitioners registered to practice in Victoria. Under s.9(1)(a), the Medical Board may refuse to register the name of any person who is otherwise entitled to be registered, on the grounds that the person has been convicted of an indictable offence in Victoria.

203 Medical Practitioners Act 1970 (Vic.) s.17.

204 *Rex v. The General Council of Medical Education and Registration of the United Kingdom* [1930] 1 K.B. 562, 569, *per* Lord Justice Scrutton. The conduct of a medical practitioner need not be criminal or even strictly illegal to come within the purview of the Medical Board. Although sex between consenting adults is perfectly legal, the medical profession takes a very serious view of sexual relations between medical practitioners and their adult patients (particularly psychiatrists): *Childs v. Walton*, the N.S.W. Court of Appeal, 13 November 1990 (unreported).

205 Medical Practitioners Act 1970 (Vic.) s.17(4A).

206 Medical Practitioners Act 1970 (Vic.) s.17: when the Medical Board finds that a medical practitioner is guilty of a professional misconduct, it can do one or more of the following: issue a reprimand; impose a condition, limitation or restriction on the practice of the person concerned; suspend the registration of the person; remove the name of the person from the Register; impose a fine of up to 100 penalty units.

207 Medical Practitioners Act 1970 (Vic.) s.17.

208 Mental Health Act 1986 (Vic.) s.84(2) provides that a medical practitioner who performs a non-psychiatric treatment on any (presumably involuntary patient) patient without obtaining 'informed consent', or who fails to obtain a consent of a 'plenary guardian', or a 'limited guardian', or the 'authorised psychiatrist', 'is guilty of a professional misconduct unless the medical practitioner satisfies the Medical Board of Victoria that there were valid reasons for not obtaining that consent.'

of criminal punishments, a question arises as to the wisdom of the statutory transfer of the therapeutic relationship between a doctor and a patient, based upon a covenant from the realm of private law, into the criminal context with its public law normative standards.

By creating the criminal offence of medical trespass and incorporating it into the MTA, the Victorian legislature has ensured that the statute will need to be interpreted with reference to principles of criminal law. Thus, the MTA grants immunity to doctors complying with the refusal of treatment certificate, stating that a medical practitioner who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or continue medical treatment will not be:

(a) [guilty of] a misconduct or infamous misconduct in a professional respect; or
(b) . . . guilty of an offence; or
(c) . . . liable in any civil proceedings.[209]

This protective provision for complying doctors must be read as a separate enactment, and not as an indication that a doctor who undertakes to treat, or continues to treat, a person who has created a refusal of treatment certificate will automatically contravene paragraphs 9(1)(a), (b) or (c) of the MTA.

The MTA and the suicidal patient

Under provisions of the MTA, a patient may validly create a refusal of treatment certificate on the grounds that the proposed treatment is unacceptable to him or her for religious reasons, or because it is too burdensome in the circumstances. The certificate will not be invalidated because the patient had full knowledge that medical compliance with the instrument will effectively lead to his or her death. Thus, the provisions of the MTA imply that the right to die should be regarded as an absolute right. However, the question arises whether there exist other countervailing medical, ethical, and legal considerations which should qualify or even nullify the implied right to die.[210] This issue is especially pertinent in cases where the patient's refusal of treatment is accompanied by an express suicide wish. There are a number of diverse reasons why patients direct that life-saving treatment be withdrawn or not undertaken; some of these reasons may, in effect, amount to a request for a medically-assisted suicide.

Whereas the law today generally protects the right of any adult person of sound mind to refuse medical treatment, even where the refusal is likely to result in death,[211] the law does not grant the patient an additional right to compel medical personnel to assist in any way in the furtherance of the refusing person's wish to die.[212] On the contrary, as Justice Fullagar pointed out, the courts tend to lean 'to the preservation of the subject-matter, so to speak, rather than to its destruction.'[213]

[209] Medical Treatment Act 1988 (Vic.) s.9(1).

[210] It should be noted that the 'right to die' legislation in Australia mirrors in many aspects the U.S.A. enactments in respect of the 'patients' right to self-determination'. However, in the U.S.A., where the litigation in respect of patient self-determination was initiated in the 1970's, the courts tend to look at this issue from the perspective of Constitutional law.

[211] In Victoria the rule of law whereby it was a crime for a person to commit, or to attempt to commit, suicide has been abrogated by s.6A of the Crimes Act 1958 (Vic.). Therefore, the patient who attempts or succeeds in committing suicide through refusal of medical treatment will attract no criminal liability under the law.

[212] *Airedale N.H.S. Trust v. Bland* [1993] 2 W.L.R. 316, 393-4.

[213] *In Re Graham Michael Kinney*, Supreme Court of Victoria, 23 December 1988 (unreported) 5.

The principle that the law will not condone an assisted death may also be inferred from Justice McHugh's statement that 'a person cannot consent to the infliction of grievous bodily harm without a "good reason" '.[214]

Traditionally, suicide has been defined as 'the act of killing oneself intentionally'.[215] 'Killing oneself' includes initiating the cause or causes which produce death. Whether or not a patient who decides to forgo medical treatment should be considered to be suicidal will depend on a number of factors. These factors will include the person's actual wishes — does he or she want to die, or does he or she merely not wish to undergo the particular treatment? A typical example would be a committed Jehovah's Witness who does not want to die, but whose religion compels him or her to refuse a life-saving blood transfusion.

The nature of the treatment and the patient's condition will also help to ascertain whether or not the refusal of medical treatment amounts to an attempt at self-destruction. If a terminally-ill person refuses life-sustaining treatment it may be said that the resulting death is caused by the illness and thus is not self-inflicted, given that the patient would have died of the illness in a relatively short time regardless of what medical measures were undertaken. As the Supreme Court of New Jersey pointed out in the *Conroy* case:

> declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.[216]

The refusal of a life-saving treatment in favour of treatment which is not as effective, by a patient who fervently wants to live, will not necessarily constitute suicide. Conversely, when a clinically-depressed person, with the specific intent of bringing about death, refuses a life-saving, curative procedure, the elements of suicide or attempted suicide may well be present.

Despite the statutory immunities granted to complying doctors, the MTA specifically states that its provisions do not limit the operation of sub-section 6B(2) and section 463B of the Victorian Crimes Act. Under sub-section 6B(2) the Crimes Act, any person who

> (a) incites any other person to commit suicide and that other person commits or attempts to commit suicide in consequence thereof; or
> (b) aids or abets any other person in the commission of suicide or in an attempt to commit suicide shall be guilty of an indictable offence and liable to level 7 imprisonment.[217]

This means that the offence of inciting or aiding and abetting suicide is punishable by a term of imprisonment not exceeding 60 months.[218] A doctor complying with a refusal of treatment certificate who has provided medicine-related methods of committing suicide to a patient who then used these means to bring about his or her death, may be found guilty of inciting another to commit suicide. Similarly, a medical practitioner who, when faced with both a refusal of treatment certificate and a suicide note (or any express death-wish, like the document signed by Mr

214 *Secretary, Department of Health & Community Services (N.T.) v. J.W.B. and S.M.B.* (1992) 175 C.L.R. 218, 309.
215 *A Concise Dictionary of Law*, Oxford University Press (1983) 353.
216 *In the Matter of Claire C. Conroy* 486 A.2d 1209 (1905), 1224, *per* Schreiber J.
217 Crimes Act 1958 (Vic.) ss 6B(2)(a) and 6B(2)(b).
218 Sentencing Act 1991 (Vic.) s.109.

McEwan), withdraws life-saving treatment, may subsequently be deemed to have thus assisted the patient to complete his or her suicide. It is also possible that a doctor who has complied with the patient's wish not to be treated for a condition which they both know will result in death unless treated (such as diabetes or pneumonia) may come within the definition of aiding and abetting suicide under sub-section 6B(2) the Crimes Act.

Moreover, the MTA does not grant any immunity from civil, criminal, or professional liability to the witnessing medical practitioner. In cases where the refusing patient dies[219] or suffers damage as a result of another doctor's compliance with the certificate, the witnessing doctor may be liable in negligence if it can be shown that on the balance of probabilities the witnessing doctor knew, or ought to have known, that at the time of signing the certificate the patient was clinically depressed or was suffering an episode of cognitive failure. The doctor may also be found guilty of professional misconduct or infamous conduct in a professional respect.

The importance which the criminal law places on the discouragement and prevention of suicide is emphasised by the fact that the penal provisions contained in section 6B are reinforced by section 463B of the Crimes Act, which states that:

> Every person is justified in using such force as may be reasonably necessary to prevent the commission of suicide, or of any act which he believes on reasonable grounds would, if committed, amount to suicide.

The object of section 463B is to grant immunity from prosecution for criminal assault to persons who use such force as may be reasonably necessary to prevent the commission of suicide. The words 'or of any act', which refer to the attempting of suicide, are general enough to include a refusal of life-saving treatment by a suicidal patient through a refusal of treatment certificate.

It is true that section 463B only refers to the use of force. However, it would be difficult to exclude non-violent means of preventing suicide from the ambit of this protective provision. Therefore, a non-complying doctor can use section 463B of the Crimes Act as a defence to the charge of medical trespass if he or she can show that there were reasonable grounds to believe that the refusal of treatment certificate was, in effect, a means of committing suicide.[220]

The judicial attitude towards the legal and ethical consequences of doctors acquiescing in refusal of treatment by suicidal patients was expressed by Justice Fullagar of the Victorian Supreme Court in the case of *In Re Kinney*.[221] His Honour was asked to consider an urgent oral application by the patient's wife for an injunction restraining St Vincent's Hospital and its doctors from carrying out on the patient any operative or invasive procedures whatsoever.

The patient, Mr Kinney, who was on bail for the alleged murder of his mother-

[219] In the case of the patient's death, the psychiatric autopsy may reveal the psychiatric condition of the patient at the time of signing the certificate. Mendelson, G., *Psychiatric Aspects of Personal Injury Claims* (1988).

[220] Purpose 4(3)(b) of the Medical Treatment Act 1988 (Vic.) states that the Act does not limit the operation of any other law. Therefore, a doctor who in compliance with the refusal of treatment certificate discontinues or does not undertakes a medical treatment in order that his patient's death should be hastened or brought about, if in fact this happens, may also be liable on the charge of manslaughter.

[221] *In Re Graham Michael Kinney*, Supreme Court of Victoria, 23 December 1988 (unreported).

in-law, deliberately took an overdose of drugs on 20 December 1988. Two days later he was taken by an ambulance to St Vincent's Hospital where he was intubated. This treatment caused a haemorrhage; since the patient suffered leukaemia, the doctors thought it desirable to undertake a minor exploratory procedure under general anaesthetic to locate the source of the haemorrhage. At the time of taking the overdose Mr Kinney left a suicide note but did not create a refusal of treatment certificate.

In the course of his judgment, Mr Justice Fullagar declared that very powerful considerations would be needed to persuade the Court to grant an injunction 'to prevent doctors from saving life of a person'.[222] His Honour then pointed out that in the light of the Medical Treatment Act

> even more powerful considerations would be required to persuade the Court to grant an injunction when the preventing of the medical or surgical treatment amounts to carrying into execution the attempted suicide of the person concerned.[223]

Mr Justice Fullagar concluded that to grant the injunction which Mr Kinney's wife sought on his behalf 'would be to assist the person to complete his suicide'.[224]

Finally, the MTA protects the doctor who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or discontinues medical treatment from 'being guilty of an offence',[225] without specifying what criminal immunity is conferred on doctors. At no stage does the legislation explicitly confer upon the compliant doctor any immunity from criminal prosecution for murder, attempted murder, or manslaughter, if the patient's death is caused by the lack or cessation of medical treatment.

In its Preamble the MTA accords recognition to 'the difficult circumstances that face medical practitioners in advising patients and providing guidance in relation to treatment options'.[226] The legal position of medical practitioners in Victoria, and the aims of the MTA which relate to relief of pain and suffering for terminally-ill patients, would be considerably enhanced by clarification of the criminal law regarding causation along the lines of section 6 of the NDA which provides that

> the non-application of extraordinary measures to, or withdrawal of extraordinary measures from, a person suffering from a terminal illness does not constitute a cause of death.[227]

Conclusion

The therapeutic doctor-patient relationship involves complex psychological dynamics between the two parties; it is an interplay between the patient's respect for and trust in the scientific expertise of the doctor, and the doctor's respect for the experiences, feelings and wishes of the patient. The relationship is based on

222 *Ibid.* transcript at 4.
223 *Ibid.*
224 *Ibid.*
225 Medical Treatment Act 1988 (Vic.) s.9(1)(b).
226 Medical Treatment Act 1988 (Vic.) Preamble (c).
227 Natural Death Act 1983 (S.A.) s.6(1). It should be noted that, while absolving the medical practitioner who either does not apply or who discontinues extraordinary measures of prolonging life from legal responsibility for the death of the terminally-ill patient, the NDA does not permit medical conduct leading to 'accelerated death' through euthanasia or doctor assisted suicide: 'Nothing in this Act authorizes an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course.': s.7(2).

such values as the autonomy of the patient's choices, and the ethical integrity of medicine and medical-professional judgment. Since Hippocrates, physicians have observed that the degree of trust which the patient reposes in the expertise of the treating doctor is of vital importance in the efficacy of treatment.[228] In the eighteenth century Jerome Gaub wrote that it is the patients' faith in the medical art and the hope of recovery which enable physicians 'to breathe new life into them by words alone' and to increase 'the power of their remedies'.[229]

Traditionally, society has delegated the responsibility for making clinical treatment decisions to the physician in the belief that his or her clinical training, a degree of emotional detachment, and the ethical ideals expressed in the Hippocratic oath,[230] would make the doctor the best qualified person to take full account of the patient's medical condition and his or her best interests in the circumstances.

This is because the clinician is trained to utilise the science of medicine and the art of healing in arriving at an accurate diagnosis and at the treatment options which are in the best interests of the particular patient.[231] Consequently, clinical decision-making involves consideration of ther patient's psychological and physical needs, as well as technical and moral aspects which, at times, may be difficult to reconcile.

A request by the patient that life-saving treatment be withheld or withdrawn may involve the physician in having to resolve a conflict between two ethical obligations. The doctor's first ethical obligation is to further the physical well-being of patients. This may require an attempt by the medical practitioner to protect the patient from the harmful consequences of his or her choice when that choice appears to be due to abnormal illness behaviour. The second obligation of a medical practitioner is to respect the right of patients to make decisions about their own bodies and lives, and to ensure that the medical treatment accords with the patient's wishes. When a competent patient appears to make a choice about the treatment which is patently contrary to his or her well-being, these two obligations will come into conflict.[232]

Whenever a physician determines that the patient's choice is adversely affected by irrational considerations, whether conscious or unconscious, he or she will attempt to persuade the patient to change or modify that choice. At the same time, medical practitioners should be made aware that, in cases where there exists a conflict between the patient and the treating physician in respect of the preferred treatment options, the latter must be conscious of his or her own psychological responses to a difficult situation. Doctors should be careful not to designate the patient's refusal of treatment as abnormal simply because that refusal is at odds with the doctor's views on the issue.[233]

228 According to the Hippocratic aphorism, 'Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician.' Nuland, S.B., *Doctors: the Biography of Medicine* (1989) 17. Nuland describes a case of a hopelessly ill patient who gave as a reason for his inexplicable recovery his desire not to disappoint his doctor.

229 Brown, T.M., 'Cartesian Dualism and Psychosomatics'(1989) 30 *Psychosomatics* 322, 324.

230 'I will come for the benefit of the sick, remaining free of all intentional injustice.' Hippocratic Oath, translated by Edelstein, L., *Ancient Medicine* (1967) 6.

231 Laor, N. and Agassi, J., *Diagnosis: Philisophical and Medical Perspectives* in *Episteme* (1990) Volume 15.

232 Brock, D.W. and Wartman, S.A., *op. cit.* n.97, 1596.

233 Pilowsky, I., *op. cit.* n.93, 392.

In cases where the choice to die is made by a patient who is of sound mind in the cognitive sense, but who suffers from a psychiatric illness, respect for the patient's autonomy should generally give way to the professional judgment of the treating physician. It is regrettable that the MTA attempts to prevent the treating medical practitioner who is presented with a refusal of treatment certificate from exercising his or her professional discretion and requires the practitioner to acquiesce in the patient's wishes, no matter how harmful the consequences may be.

The MTA shifts the balance of power in the patient-doctor relationship in favour of the patient by prohibiting, within the statutorily-defined circumstances, the exercise of the professional judgment and obligations of the doctor. A medical practitioner with sufficiently-refined oratorical skills may be able to modify the wishes of a conscious patient who refuses beneficial medical treatment.[234] But where that is impossible, a humane physician, just like a lay rescuer, may still have to proceed with life-saving or curative treatment even at the risk of incurring criminal penalty.

[234] Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death. (1990) 336 *The Lancet* 610, 612.