LIVING WILLS AND THE RIGHT TO DIE WITH DIGNITY

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[*A competent patient can generally refuse medical treatment even if that treatment is necessary to save the patient's life. The question whether similar decisions can be made on behalf of incompetent patients is more problematic. Patients while competent may wish to dictate or influence decisions whether to reject medical treatment in the event of supervening incompetence. One way they can do so is to make a living will. This article examines the living will technique adopted by statute in South Australia and the Northern Territory and suggests a broadening of the scope of the legislation.*]

1. *INTRODUCTION*

'Living Will' statutes go some way towards resolving the conflict, discussed in an earlier article in this series,[1] between the sane adult's right to refuse medical treatment and society's interest in preserving life, in favour of the individual's right to self-determination. The living will solution, adopted in South Australia by the Natural Death Act 1983, in the Northern Territory by the Natural Death Act 1988, and in four-fifths of the United States jurisdictions,[2] generally recognizes a competent patient's directive or living will, which authorizes a medical practitioner to withdraw or withhold life-sustaining treatment if the patient becomes terminally ill, and frees medical practitioners and hospitals complying with a valid directive from liability. This article examines the advantages, disadvantages and scope of living wills legislation, using as its focus the Natural Death Act 1983 (S.A.) and drawing from United States legislation where appropriate.

2. *LEGISLATIVE BACKGROUND AND CURRENT AUSTRALIAN POSITION*

The living will was proposed in 1969 in the United States by Dr Luis Kutner.[3] Moves towards giving legislative form to the idea were prompted by a number of 'right to die' cases going before the courts, beginning with the Karen Ann Quinlan case in 1975.[4] The California Health and Safety Code, effective from 1 January 1977, was the first living wills legislation to be enacted.[5] Although

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1 Lanham, D., 'The Right to Choose to Die with Dignity' (1990) 14 *Criminal Law Journal* 401.

2 Francis, L. P., 'The Evanescence of Living Wills' (1989) 24 *Real Property, Probate and Trust Journal* 141, 145; Nanovic, S. J., 'The Living Will: Preservation of Right to Die Demands Clarity and Consistency' (1990) 95 *Dickinson Law Review* 209, 213.

3 Kutner, L., 'Due Process of Euthanasia: The Living Will, A Proposal' (1969) 44 *Indiana Law Journal* 539.

4 *In the Matter of Karen Quinlan* 355 A.2d 647 (1976).

5 California Health and Safety Code paras 7185-7195. American legislation is cited in this article for comparative purposes and not as a definitive statement of the position in those jurisdictions at the date of publication.

statutes subsequently enacted in other American states vary as to their specific provisions, their overall purpose is the same: to permit competent adults to prepare in advance a legally recognized document that gives directions for terminal care, compliance with which will protect medical practitioners from liability.

South Australia and the Northern Territory are the only Australian jurisdictions to have enacted legislation giving legal recognition to living wills. The Natural Death Act 1983 (S.A.) and the Natural Death Act 1988 (N.T.) provide that a person of sound mind, of or above the age of 18 years, who does not desire to be subjected to extraordinary measures in the event of terminal illness, may make a direction to this effect in the prescribed form, witnessed by two persons. As the Natural Death Act 1988 (N.T.) was modelled closely on the Natural Death Act 1983 (S.A.), attention will not be drawn specifically to the Northern Territory Act in subsequent discussion, except where differences arise.

In Victoria similar legislation, the Refusal of Medical Treatment Bill, was introduced in 1980 as a Private Member's Bill by the Hon. Roderick Mackenzie, but after the second reading stage it was put aside and never dealt with.[6] The living will alternative was given some consideration but was not adopted by the Victorian Social Development Committee's report on the *Inquiry into Options for Dying with Dignity* 1987.[7]

At present in Victoria, the Medical Treatment Act 1988 provides a procedure enabling a patient to register by certificate a refusal to accept medical treatment. The Medical Treatment (Enduring Power of Attorney) Act 1990 (Vic.) allows individuals to appoint a person to make decisions about their medical treatment should they become unable to do so. In some U.S. states these options are available in addition to living wills. A consideration prompting this article is whether living wills legislation fulfils a function not provided for by the current Victorian provisions.

Such considerations are particularly relevant at the present time, when a number of Australian states are examining various approaches regarding the right to refuse medical treatment and dying with dignity issues. A Select Committee of the South Australian House of Assembly was set up in December 1990 to enquire into the law and practice relating to death and dying, including the extent to which both the health services and the present law provide adequate options for dying with dignity. The Committee's terms of reference include a detailed consideration of the Natural Death Act 1983 (S.A.). At the time of writing, the Committee was taking submissions.

The Law Reform Commission of Western Australia released a *Report on Medical Treatment for the Dying* in February 1991, which did not recommend the introduction of legislation to provide for living wills. The report instead

[6] The Hon. Roderick Alexander Mackenzie, President, Legislative Council, Parliament of Victoria, Minutes of Evidence of Inquiry into Options for Dying with Dignity Inquiry, Parliament of Victoria Social Development Committee, 2 July 1986, 439.

[7] Parliament of Victoria Social Development Committee, *Inquiry into Options for Dying with Dignity*, Second and Final Report, 1987, 69-70.

recommended the enactment of legislation closely following that now found in the Medical Treatment Act 1988 (Vic.).[8]

In New South Wales, the Legal Services Branch of the New South Wales Department of Health in November 1990 released a discussion paper, *Proposed Legislation to Give Legal Effect to Directions Against Artifical Prolongation of the Dying Porcess*. Although it was said in the discussion paper that 'New South Wales is considering adopting the South Australian model as draft legislation',[9] it is understood that the Department's position has altered significantly since the discussion paper was released and that the South Australian model is no longer to be adopted, primarily, it is understood, because of opposition by doctors who did not believe that it provided sufficient protection.

In Tasmania, Dr Bob Brown has been attempting to introduce a private member's bill based on the South Australian legislation since 1986. The bill was originally called the Natural Death Bill but in 1990 was changed to the Medical Treatment and Natural Death Bill and was based on the Victorian Model. The legislation was passed by the House of Assembly in December 1990, but in July 1991 it was rejected by the Legislative Council.

There are apparently no current plans to consider or introduce legislation regarding these issues in the Australian Capital Territory or Queensland.

3. *ADVANTAGES OF LIVING WILLS LEGISLATION*

It is generally agreed that, without legislation, the status of living wills is uncertain. They may be legally binding in some circumstances. In others they may represent a non-legally binding indication of the wishes of the patient, which may or may not have a morally persuasive effect on the patient's family and the medical practitioner responsible for the patient's medical treatment. Without legislation, it is more likely that expensive judicial proceedings will result, in which the court will decide the issue on the facts of each case, with the result being difficult to predict. Moreover, if such legislation is not consistently adopted throughout Australia, principles of statutory interpretation, as well as the United States caselaw (in the absence of any relevant Australian cases) suggests that a living will executed in a state having living will legislation has no binding force outside that jurisdiction but can only present 'clear and convincing evidence' of the individual's wishes. This was held to be the situation in *Saunders v. State of New York*,[10] when a declarant of a living will petitioned the New York Supreme Court to determine whether a living will executed in Pennsylvania would be valid in New York if application of the living will became necessary.

Although there is nothing to prevent a person from exercising his or her

[8] Law Reform Commission of Western Australia, *Report on Medical Treatment for the Dying*, Project No. 84, 1991, paras 1.23, 2.12.

[9] Legal Services Branch, New South Wales Department of Health, Discussion Paper: *Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process*, 1990, 8.

[10] 492 N.Y.S.2d 510 (Sup. 1985).

existing common law rights to make a direction refusing medical treatment, the extent to which the courts will at common law give effect to directions made in advance of the need for treatment is uncertain, so that doctors and medical practitioners who comply with such a direction may face civil or criminal liability when termination or withdrawal of treatment leads to a patient's death. Yet non-compliance may also result in liability at common law, for battery.

The resulting uncertain status of living wills in the medical context where no legislation exists was well illustrated by the responses of three Victorian public hospitals in 1984, to inquiries made by the President of the Voluntary Euthanasia Society of Victoria regarding the action which would be taken if a patient was admitted carrying a card to the effect that the patient had made a living will.[11] The policy of one hospital was to respect the wishes of the patient, if these wishes were established and supported by the views of the appropriate next of kin — however, decisions would be made within the overall duty of medical practitioners to ensure that every effort is made to preserve the life of the individual. At two other hospitals there was said to be no general instruction for the medical staff concerning patients with living wills. One hospital's representative stated that the matter would be for the doctor concerned to decide, while the representative of another hospital wrote that the attitude of medical staff would be 'conservative'.[12]

A number of United States cases indicate that, where the issue goes before the courts, the response is likely to be more positive. The decision of the New York Court of Appeals in *Eichner v. Dillon*[13] did not directly concern living wills, but was the first case in New York (where no living wills legislation has been enacted), to enforce a person's directions, made prior to the diagnosis of a terminal illness, not to have extraordinary treatment applied if the person suffered terminal illness and became incompetent. This was done on the basis that 'clear and convincing evidence' of the patient's wishes was present. More directly on point is the case of *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*,[14] which arose in Florida before living wills legislation was enacted. A doctor and hospital filed an action seeking declaratory relief regarding the legal status of a living will executed by a patient who had since become terminally ill while hospitalised. In the course of delivering its judgment, to the effect that mandatory court approval was not required to exercise the right of terminally ill patients to avoid extraordinary medical treatment when on the threshold of death, the Florida Supreme Court held that if, as in this case, a patient executed a living will while competent, that declaration would provide persuasive evidence of the patient's intent and should be given 'great weight' by persons utilizing substituted judgment on the patient's behalf.[15] The *Bludworth*

[11] Written submission of Robert Young, President of the Voluntary Euthanasia Society of Victoria, to the Parliament of Victoria 'Dying with Dignity' Inquiry, 1986, *op. cit.* n. 7. Submissions to the committee are currently kept by the Social Development Committee at Nauru House, Melbourne.

[12] *Ibid.*

[13] N.Y., 420 N.E.2d 64; Ct.App., 438 N.Y.S.2d 266 (1981).

[14] 452 So.2d 921 (1984).

[15] *Ibid.* 926.

case suggests that, at least in the U.S., without legislation the living will is not a mandate, but will be persuasive evidence.

In other United States cases, the 'clear and convincing evidence' standard has been applied, but not always consistently or unambiguously. In *Saunders v. State*,[16] the New York Supreme Court held that a living will satisfied the clear and convincing evidence standard established in *Eichner*[17] by the New York Court of Appeals. In the case of *A.B. v. C.*,[18] the New York Supreme Court suggested a higher standard, stating that if a patient became incompetent, the living will and a live videotape of the petitioner would be sufficient for a guardian to seek judicial approval that no medical care or nourishment be given, in accordance with the petitioner's wishes.[19] The enforceability of living wills in the absence of living wills legislation is therefore possible, but this outcome is by no means guaranteed.

In addition, the judicial forum may be an inappropriate place in which to determine refusal of life saving treatment issues. Court actions are expensive in terms of monetary and emotional costs and are time-consuming. Courts in the United States have often voiced reluctance to decide upon such issues. In *Satz v. Perlmutter*,[20] for example, the Florida Supreme Court held that such issues, involving complex legal, medical and social values, were best addressed in a legislative forum where fact-finding is less confined, and the interests of all parties may be considered.[21]

Besides offering the advantages of greater predictability and uniformity of outcome, living wills legislation has the important advantage of providing a framework that recognizes individual control and autonomy regarding certain medical treatment. Although living will statutes are generally limited in their application to the use of extraordinary measures in the event of terminal illness,[22] in cases where such statutes apply, they offer the individual significant control over her or his death. In contrast with a right to refuse medical treatment, as provided under the Medical Treatment Act 1988 (Vic.), living wills may generally be executed by a competent adult at *any* time, including the period *before* a medical problem is diagnosed. While enduring powers of attorney, as provided by the Medical Treatment (Enduring Power of Attorney) Act 1990 (Vic.), may cover a broader range of circumstances than living will statutes, there may be a risk that the appointed agent will have a conflict of interest (for example, not wanting the patient to die) and so allow the continuation of life-prolonging measures beyond the stage that the patient would have desired. Carefully drafted living wills legislation relieves the family and the medical practitioner of the responsibility of deciding whether treatment should or should

16 492 N.Y.S.2d 510 (Sup. 1985). On this issue generally, see Vile, S. E., 'Living Wills in New York: Are They Valid?' (1987) 38 *Syracuse Law Review* 1369.
17 N.Y., 420 N.E.2d 64; Ct.App., 438 N.Y.S.2d 266 (1981).
18 477 N.Y.S.2d 281 (Sup. 1984).
19 *Ibid.* 284.
20 Fla., 379 So.2d 359 (1980).
21 *Ibid.* 360-1. A similar view was expressed by the Missouri Supreme Court in *Cruzan v. Harmon* 760 S.W.2d 408 (Mo.banc 1988), 426.
22 These limitations are discussed *infra*.

not be applied. As a result, undue family suffering may be avoided, medical practitioners' and hospitals' fears of civil and criminal liability may be allayed and a patient can assert his or her right to self-determination, avoiding artificial prolongation of life which may result in loss of patient dignity and produce unnecessary pain and suffering.

Well-publicized living will legislation may also have the advantage of encouraging public discussion of the reality of death and result in considered decisions by patients about the time at which life-prolonging measures should cease to be administered. Unfortunately, no statistical information is available regarding the extent to which the Natural Death Act 1983 (S.A.) is being utilized. Although the July 1985 issue of *Choice* magazine reported that more than 5,500 Notices of Direction, as provided by the Natural Death Act, had been distributed, no current record of the number of notices printed or distributed, let alone executed, has been kept. Further afield, the statistics are disappointing. Surveys in the United States have indicated that an overwhelming majority of Americans have not executed living wills.[23] Figures of 9 *per cent* and 15 *per cent* have been put forward.[24] In the recent decision of the U.S. Supreme Court of *Cruzan v. Director Missouri Department of Health*,[25] Justice Brennan, in a dissenting judgment, suggested reasons for these low statistics, including a perceived lack of urgency by members of the public, an unwillingness to dwell upon issues of mortality, lack of awareness of statutory provisions and the necessity of seeking legal assistance to execute a valid advance directive.[26] Living wills legislation providing for the straight-forward execution of an advance directive, accompanied by a publicity programme to encourage public awareness, could go some way towards solving these problems.

Finally, the existence of living will legislation and the fact that it carries with it at least some core of certainty may, and should, lead to greater discussion between patients and medical helpers on what treatment should and what treatment should not be given once incompetence supervenes. It is all too easy to view living wills legislation as an attempt to protect patients from over-zealous doctors. Occasionally it may be needed for that purpose. But the more benign and, it is to be hoped, the more frequently encountered object is to provide a sound legal basis for decisions which both patients and doctors see as appropriate but which doctors might fear would, without the legislation, lead to civil, criminal or professional liability. The second object is more likely to be present and fulfilled if prospective patients discuss their intention to execute a living will with their doctor beforehand. The utility of such discussions will vary immensely with the circumstances, including the state of health of the prospective patient at the time the living will is to be made and the kind of treatment which he or she

23 *Cruzan v. Director, Missouri Department of Health* 111 L Ed 2d 224 (1990), 249.

24 *Ibid.* 270. Justice Brennan cites Emmanuel and Emmanuel, 'The Medical Directive: A New Comprehensive Advance Care Document' (1989) 261 *Journal of the American Medical Association* 3288 (9%), and *American Medical Association Surveys of Physician and Public Opinion on Health Care Issues* (1988) 29-30 (15%).

25 111 L Ed 2d 224 (1990), 249.

26 *Ibid.* 270.

wishes to avoid. Even where there is no room to pick and choose as in the case of the South Australian legislation, where a standard form is prescribed,[27] such basic questions as whether the doctor is in principle sympathetic to living wills or whether she or he agrees that a persistent vegetative state is a terminal condition can be sorted out calmly and deliberately in advance rather than in highly charged emergency conditions.[28]

4. *DISADVANTAGES OF LIVING WILLS LEGISLATION*

The major criticism generally made of living wills is that such directives appear to involve an uninformed refusal of treatment in a wide range of unforeseeable circumstances.[29] At the time of making a direction, a person cannot be expected to take into account all of the factors, including personal circumstances and changes in medical technology, which may be relevant at some future time. An individual's perceptions of life and what he or she values may change over time and, in the event of illness, individuals might experience a will to live and strength which they doubted they had.[30] In contrast with this opinion is the view that patients' 'points of view beforehand are very much tailored with their point of view after diagnosis and treatment ... the sort of people who have made those decisions have examined the situation quite clearly and have a firm view on where they stand.'[31]

Some submissions to the Victorian Social Development Committee *Inquiry into Options for Dying with Dignity* interpreted living wills as a form of suicide in the face of serious illness, using a blanket refusal of appropriate treatment as the instrument.[32] Such criticisms fail to consider the fact that suicide requires a specific intent to die rather than a desire to be freed of unwanted medical treatment. This distinction has been made and acted on many times in numerous American cases, a point noted by the Supreme Court of New Jersey in *Re Farrell*.[33] A similar view was taken by the Social Development Committee in its *Inquiry into Options for Dying with Dignity* (1987).[34] The distinction is easier to state than to analyse, but it appears at least in part to involve a desire to die for reasons unrelated to the treatment which is being refused. So if a patient on a respirator wished to die because of fear of nuclear war, a request to be disconnected from the respirator would be suicidal. But if the patient would prefer life to death, but only if free of the respirator, a request for the removal of the respirator would not involve suicide.[35] The first patient would want to die

27 See discussion *infra*.

28 For a persuasive plea for a co-operative approach see Johnson, S. H., 'Sequential Domination, Autonomy and Living Wills' (1987) 9 *Western New England Law Review* 113.

29 *Supra* n. 7, 50, and n. 8, para. 2.5.

30 Written submission of the Alfred Hospital Social Work Department, Victorian Social Development Committee, *Inquiry into Options for Dying with Dignity* 1987.

31 Mrs G. J. Sleeman, Social Worker, Minutes of Evidence, 23 July 1986, Victorian Social Development Committee, *Inquiry into Options for Dying with Dignity* 590-1.

32 *Supra* n. 7, 50.

33 529 A.2d 404 (1987), 411.

34 *Supra* n. 7, para. 3.4.6.

35 This point is more fully developed in Lanham, D., 'The Right to Choose to Die with Dignity' (1990) 14 *Criminal Law Journal* 401. See also Skegg, P. D. G., *Law, Ethics and Medicine* (1988) 110-14.

even if the respirator was unnecessary to his or her survival. The second would be delighted to live without the respirator even if he or she realises that the chance of life without it are remote or even non-existent. It may be that the intent required for suicide is even narrower and involves not only a willingness to die, but contempt or disdain for one's own life. One who is prepared to sacrifice his or her life for what to that person is a higher cause cannot properly be regarded as suicidal. In *R v. Blaue*[36] the English Court of Appeal gave the examples of Eleazar, who preferred to die rather than eat the flesh of swine, and Sir Thomas More, who preferred death to accepting Henry VIII as head of the Church of England. This kind of reasoning would exempt from the taint of suicide those who are willing to accept an earlier death to avoid imposing anguish or financial hardship upon their family.

A further general criticism is that living wills legislation may open the way to psychological, social, family or other pressure upon individuals, particularly the sick and elderly, to make declarations that they would not spontaneously have made. This concern raises the issue of who should be permitted to act as witnesses to such declarations, which is raised as a specific criticism of the Natural Death Act 1983 (S.A.) later in this article.

Another general criticism of living wills legislation is that the law already gives the right to consent or refuse treatment, and that what is required is further education of medical students, doctors and the public, so that informed decisions can be made.[37] The above discussion has revealed the problems inherent in enforcing living wills in the absence of legislation.

The most persuasive general criticism of living wills legislation, however, is the argument that such legislation is unworkable, because it attempts the impossible task of medical 'life and death' decision making. It is this criticism which lies at the base of many of the more specific criticisms that can be made of the South Australian, Northern Territory and United States statutory provisions. It is this criticism which also appears to lie at the base of the various difficulties with the living wills concept identified by the Law Reform Commission of Western Australia in its recent *Report on Medical Treatment for the Dying*.[38] The difficulties identified by the Commission provide a good example of the criticisms often made. They included 'the fundamental difficulty that it prescribes a form of medical treatment without knowing a precise circumstances which would exist when the will is required to be activated,'[39] the difficulty in determining the appropriate 'triggering event' for the activation of the living will (incompetence alone, incompetence with a particular conditional disability, or incompetence with terminal illness), determining the meaning of 'terminal illness', determining what the doctor involved should do (or should not do) once

[36] [1975] 1 W.L.R. 1411, 1415. Professor G. Williams would exclude altruistic acts of self-destruction from the definition of suicide: *The Sanctity of Life and the Criminal Law* (1958) 241-4, noting a variety of opinions on the point.

[37] Andrews, K., 'The Refusal of Medical Treatment Bill and Living Will Legislation' (1984) 2(9) *Lawyer* 12, 13. See also *supra* n. 8, para. 2.11.

[38] *Supra* n. 8, ch. 2.

[39] *Ibid.* para. 2.5.

the 'triggering event' is identified, the practical difficulties of bringing the living will to a doctor's attention and the loss of flexibility to the patient when a standard form living will is prescribed, as under the South Australian Natural Death Act. As a result, the major objection, in the view of the Western Australian Law Reform Commission, was that a living will is likely to be either too specific, too general or too discretionary.

In the light of the various advantages and disadvantages identified above, and what appears to be a legislative trend away from the living wills concept, this article re-examines the issue, in the context of a critical evaluation of the South Australian Natural Death Act 1983.

5. *THE NATURAL DEATH ACT 1983 (S.A.): A CRITICAL EVALUATION*

(a) *Stated Purpose of the Act*

The stated purpose of the Natural Death Act 1983 (S.A.) is to provide for, and give legal effect to, directions against artificial prolongation of the dying process. Two aspects of the Act, and of living wills statutes generally, are particularly important in limiting this stated purpose. First, the Natural Death Act 1983 (S.A.) can only be raised to refuse 'extraordinary measures'.[40] Second, a declaration made in accordance with the Act is effective to refuse such care only after a patient has become terminally ill,[41] and does not operate as a directive through which treatment can be refused more generally. As a result, not all people who execute directives will ultimately fall within the stated scope of the statute. In its effect, therefore, the Natural Death Act 1983 (S.A.) is closer to the stated purpose of the Californian legislation: to recognize the right of an adult person to make a written directive instructing his or her physician to withdraw or withhold life-sustaining procedures in the event of terminal condition.[42] Thus, from its outset, the Natural Death Act 1983 (S.A.) encourages the suggestion that living wills may create new problems in the course of solving old ones.

(b) *Power to Make Directions*

Under section 4(1) of the Natural Death Act 1983 (S.A.), a person of sound mind of or above the age of 18 years may make a direction. The Act is therefore specifically restricted in its application to competent adults and does not confront the situation of incompetent persons or minors. This provision is similar to those existing in several states of the United States,[43] a situation recently criticised by Rebecca Dresser, who argues that by honouring living wills 'the law reveals a moral preference for the interests of the competent individual'.[44] However some American states have made wider provision. Louisiana's Natural Death Act,[45]

[40] S. 4(1), discussed *infra*.
[41] *Ibid*.
[42] California Health and Safety Code para. 7186.
[43] *E.g.*, California Health and Safety Code para. 7188.
[44] Dresser, R., 'Relitigating Life and Death' (1990) 51 *Ohio State Law Journal* 425, 434, criticizing the view of Rhoden, N. K., 'Litigating Life and Death' (1988) 102 *Harvard Law Review* 375.
[45] Louisiana Revised Statutes Annotated paras 40:1299.58.1-58.10.

following the North Carolina approach,[46] applies to all persons, and not merely to competent adults, to the extent that a declaration can be made on behalf of an incompetent patient after the patient is declared a 'qualified patient', defined as a patient diagnosed by two physicians as having a terminal and irreversible condition.[47] Such a declaration may be made by a wide range of persons, including a judicial appointee, and the patient's immediate relatives, before at least two witnesses, but in cases involving relatives the decision must apparently be unanimous.[48] Originally under the Louisiana legislation, a minor could not prepare a declaration, but a declaration could be executed on behalf of a terminally and irreversibly ill minor. However, since amendments to the legislation, the parents or spouse of a minor are no longer required to execute a declaration in order to terminate life-sustaining procedures.[49] The problem with the wider provisions of the Louisiana statute is that they detract from the notion of a living will as an advance directive prepared by the individual so that she or he can maintain control over her or his own dying process. Such provisions also raise concerns regarding the motives of persons who may be able to execute a declaration on behalf of an incompetent patient, and who also have an interest, for example, in the patient's estate.

(c) *When May a Direction be Made?*

The National Death Act 1983 (S.A.) does not state explicitly when a person may make a direction. Although the wording of section 4(1) suggests that a direction must be made before the diagnosis of a terminal condition, the opinion of the then Minister of Health in South Australia, the Hon. F. T. Blevins, in 1985, was that a person may make a direction under the Act at any time.[50] This situation differs from the Californian Health and Safety Code, which provides that a living will is binding upon those responsible for treatment of the patient only if the living will has been executed or re-executed at least 14 days after a patient has been diagnosed as terminally ill.[51] A directive which fails to comply is of merely persuasive value in a physician's decision whether or not to withdraw treatment.[52] The Californian approach therefore presents problems when a patient is diagnosed as being terminally ill and becomes incompetent before the expiration of the 14 day period, after which a binding directive can be made.

The approach taken in South Australia, and also in several American states, is preferable but should be more clearly indicated in the wording of the Natural

46 North Carolina General Statutes paras 90-320 -323, enacted 1977. Other states following this approach are Florida, New Mexico, Oregon and Virginia.

47 Louisiana Revised Statutes Annotated para. 40: 1299.58.5.

48 *Ibid.* para. 1299.58.6.

49 Vitiello, M., 'Louisiana's Natural Death Act and Dilemmas in Medical Ethics' (1985) 46 *Louisiana Law Review* 259, 267-8.

50 Correspondence of 9 May 1985 to the Voluntary Euthanasia Society of South Australia, written submission of the Voluntary Euthanasia Society of South Australia, Victorian Social Development Committee, *Inquiry into Options for Dying with Dignity* 1987.

51 California Health and Safety Code para. 7188.

52 *Ibid.* para. 7191(c).

Death Act 1983 (S.A.). The Virginia legislation,[53] for example, provides that '[a]ny competent adult may at any time execute a living will'[54] and that the date of execution does not diminish the effectiveness of the document.

(d) *Formalities and Safeguards*

The Natural Death Act 1983 (S.A.) provides that a direction may be executed in the 'prescribed form'.[55] Pursuant to section 4(5) of the Act, the Governor by regulation has prescribed a form by which individuals may make a signed direction to the effect set out in section 4(1).[56] Section 4(2) provides that a direction must be witnessed by two witnesses.

These provisions raise the question of whether a direction not made in compliance with the prescribed form will be valid under the Act. In the United States, where some states, for example California,[57] have legislation making similar provision, the use of a standard form has been the issue of some debate.[58] A major concern is that if a person inadvertently does not exactly follow the statutory procedure set out for signing a living will, the living will may be totally invalid. As a result, some American state legislatures have moved away from requiring compliance with a standard form. In Nevada, for example, the prescribed form may but need not be followed.[60] In Louisiana, the form is not mandatory and oral declarations are also permitted. Such declarations must be made in the presence of two witnesses, witnessed by the attending physician, and are not binding unless they are made after the diagnosis of a terminal condition. Their content and the reasons why a written declaration was not made, must be made part of the patient's medical record.[60]

Another problem with standard forms of the type adopted in South Australia is their 'all or nothing' quality. The Western Australian Law Reform Commission was critical of the fact that 'only one standard form is prescribed'.[61] A prospective patient may object to some but not all kinds of extraordinary treatment,[62] yet the South Australian standard form does not allow the patient to pick and choose. The Northern Territory form does allow this flexibility and so more closely reflects the right to self-determination inherent in the spirit of the living wills legislation. It may also lead patients to give more careful consideration to the implications of making the living will,[63] though it could lead to doubts whether a particular instruction was within the scope of the legislation and so to

53 Virginia Natural Death Act, Virginia Code Annotated Title 54.1 ch. 29.
54 *Ibid.* Art. 8.
55 S. 4(1).
56 Natural Death Act Regulations 1984 (S.A.)
57 California Health and Safety Code para. 7188.
58 See Gelfand, G., 'Living Will Statutes: The First Decade' [1987] *Wisconsin Law Review* 737, 755.
59 Nevada Revised Statutes Annotated para. 449.613.
60 Louisiana Revised Statutes Annotated para. 1299.58.3(A).
61 *Supra* n. 8, para. 2.11.
62 Vitiello, *op. cit.* n. 49, 272.
63 Marsh, L. A., 'Living Will Legislation in Colorado: An Analysis of the Colorado Medical Treatment Decision Act in Relation to Similar Developments in Other Jurisdictions' (1987) 64 *Denver University Law Review* 5, 10.

recourse to undesirable litigation.[64] But that is also true of non-statutory living wills which a patient might adopt if the statutory form is too limiting.

A third issue arises in relation to the witnessing of declarations. The Natural Death Act 1983 (S.A.) and Regulations impose no requirements regarding who may act as a witness. In contrast, in the Northern Territory, the Natural Death Act 1988 (N.T.) provides that the two witnesses must have attained the age of 18 years and that neither must be a medical practitioner responsible for the treatment of the person.[65] The requirements regarding witnesses are even more stringent in some American states. For example, in Texas and Oregon, the two witnesses must not be related to the declarant, or be entitled to anything from the declarant's estate, or be in the employment of the medical practitioners responsible for the treatment of the declarant.[66] Given the criticism of living wills raised above, to the effect that patients may be pressured by those around them into executing directives, it seems advisable to impose such requirements, particularly since the South Australian Act imposes no penalties for destruction, concealment, forgery or falsification of directives or revocations of directives. In contrast, the Louisiana legislation, for example, imposes civil liability for anyone who damages a written declaration or falsifies a revocation and criminal penalties for anyone who forges a declaration or conceals a revocation.[67]

Unlike a number of American statutes,[68] the South Australian legislation does not require the witnesses to certify their belief in the competence of the prospective patient. Instead, the South Australian Act appears to rely on the presumption of sanity which obtains elsewhere in the law.[69] The possibility, however, of a person's executing a living will in the presence of two witnesses while incapable of understanding the issues involved seems fairly remote.

A further safeguard not required by the Natural Death Act 1983 (S.A.) but required by a number of United States acts is that the declarant's physician must be notified of the directive and that the directive must be placed on the declarant's medical record. The Louisiana statute places responsibility on the declarant to notify his or her attending physician that he or she has made a declaration. If the declarant is unable to do so, any other person may notify the physician. The physician must then make the declaration part of the declarant's medical record.[70]

Given that the medical practitioner's duty to follow a directive only arises under the Natural Death Act 1983 (S.A.) when the medical practitioner has notice of the directive,[71] such requirements regarding the giving of notice are critical yet are absent from the Act. In 1989, the issue arose in the South Australian House of Assembly. It was suggested that a Central Register for living

64 *Ibid.* 11.
65 Natural Death Act 1988 (N.T.) s. 4(2).
66 Texas Revised Civil Statutes Annotated Art. 4590 h; Oregon Revised Statutes para. 127.610(1). See Carey, R. L., 'Choosing How To Die: The Need For Reform Of Oregon's Living Will Legislation' (1987) 23 *Williamette Law Review* 69, 87.
67 Louisiana Revised Statutes Annotated paras 1299.58.9.
68 See, *e.g.*, the Oregon form discussed by Carey, *op. cit.* n. 66.
69 *E.g.*, in criminal law under the McNaghten Rules.
70 *Supra* n. 67, para. 1299.58.3B.
71 S. 4(3).

wills should be established, due to concerns that many of the statutory declarations executed pursuant to the 1983 Act 'may never be found at the appropriate time'.[72] In response, the opinion of the Hon. F. T. Blevins, the then Minister of Health, was that such a Register would have the disadvantage of taking the onus from the patient to ensure that her or his wishes were known right to the last moment and that as the Act allows verbal revocation of the declaration at any time, a conflict may arise between what was said in the Register and later statements by the declarant.[73] While it is clearly necessary that declarations should be revocable, this point should not detract from the issue that for declarations made under the Act to be effective the notice requirement must be satisfied and that therefore some formal registration procedure is advisable.

(e) *Renewal and Revocation*

In South Australia, a living will made under the Natural Death Act 1983 is effective indefinitely, unless revoked. In contrast, the now defunct Victorian Refusal of Medical Treatment Bill 1980 provided that living wills were automatically revoked if they were not re-executed every 10 years,[74] thus meeting the concern that the wishes of declarants might change over time. In the United States, the California Health and Safety Code, which provides that a valid directive initiated in the prescribed form is valid for five years,[75] was in 1989 the only statute requiring declarants to re-execute their directives.[76] Originally, Wisconsin, Idaho and Georgia had similar provisions[77] but these have been deleted by 1986 amendments.[78] The trend away from re-execution provisions[79] seems logical. While re-execution requires an individual to re-consider and, if necessary, revise his or her position periodically, all living will statutes allow revocation of directives at any time and so a compulsory re-execution requirement errs on the side of caution and may also result in some unnecessary inconvenience for declarants.

Section 4(3)(a) of the Natural Death Act 1983 (S.A.) acknowledges that revocation may occur, providing that a medical practitioner has a duty to act in accordance with the direction unless there is reasonable ground to believe that the patient has revoked, or intended to revoke, the direction. A medical practitioner acting without negligence in accordance with such a belief incurs no liability.[80] It is of some concern, however, that the Act provides no procedure for revocation. In 1989, the view of the then Minister of Health, the Hon. F. T. Blevins, was that the legislation allows declarations to be revoked at any moment, verbally.[81]

72 The Hon. D. Ferguson, South Australia, *Parliamentary Debates*, House of Assembly, 23 February 1989, 2142.
73 *Ibid.*
74 *Supra* n. 6.
75 California Health and Safety Code para. 7189.5.
76 See Gelfand, *op. cit.* n. 58, 765.
77 *Ibid.* Idaho: 5 years; Wisconsin: 5 years; Georgia: 7 years.
78 *Ibid.* 765: 1986 Idaho Sess. Laws 196, ch. 71, para. 4; 1985 Wisconsin Laws 199, para. 2 (effective 22 April 1986); 1986 Georgia Laws 445, para. 1.
79 *Ibid.* 766.
80 S. 5(3)(b).
81 South Australia, *Parliamentary Debates*, House of Assembly, 23 February 1989, 2142.

This approach reflects society's interest in preserving life and the view that no one should be taken to have refused treatment who really desires it, but raises the problem of determining if, and when, a revocation has in fact occurred. When a patient who can barely comminicate says tearfully that she does not want to die, will this be an effective revocation?[82] Almost certainly so, on the basis of the above opinion of the Minister of Health. And what of non-verbal indications? Under the Natural Death Act 1983 (S.A.), such actions would also be likely to constitute revocation. While the pro-life basis of this approach is powerful, informal, verbal and non-verbal revocations raise real problems for medical practitioners who have to decide whether the patient consents to the proposed medical procedure or not. While section 5(3)(b) ensures that a medical practitioner acting without negligence in the belief that a revocation has or has not occurred will not incur liability, the Act does not resolve the problem that as a result, a declarant may be subjected to treatment in contravention of a directive which has *not* in fact been revoked, or that the opposite situation may occur.

In some American states, more formal revocation procedures have been enacted. Most commonly, revocation is permitted only by written statement, oral statement, or destroying or defacing the original document.[83] In California, oral expression of intention to revoke the directive is effective only when communicated to the attending physician.[84] Some states provide that revocations do not become effective until they are communicated to the attending physician by the patient, or someone acting at the patient's direction[85] and several states require oral revocations to be witnessed.[86] Such provisions decrease the risk that casual comments will be taken as revocation.

The situation appears to be that all living wills statutes in Australia and the United States respect revocations no matter what the mental state is of the declarant at the time of the revocation, following the general principle that living wills bow to a patient's current desires.[87]

(f) *When Does a Living Will Take Effect?*

The Natural Death Act 1983 (S.A.) provides that a directive becomes effective in the event of the declarant suffering from a 'terminal illness', when 'extraordinary measures' of medical treatment would otherwise be applied.[88] 'Terminal illness' is defined as meaning any illness, injury or degeneration of mental or physical faculties such that death would, if extraordinary measures were not undertaken, be imminent, and from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.[89] 'Recovery', in relation to a terminal illness, includes a remission of

82 See Francis, *op. cit.* n. 2, 152.
83 *E.g.*, California Health and Safety Code para. 7189(a).
84 *Ibid.*
85 Francis, *op. cit.* n. 2, 153.
86 *Ibid.*
87 *Ibid.* 154. For practical difficulties see Herlan, E. C., 'Maine's Living Will Act and the Termination of Life Sustaining Medical Procedures' (1987) 39 *Maine Law Review* 83, 91-2.
88 S. 4(1).
89 S. 3.

symptoms or effects of the illness.[90] 'Extraordinary measures' means 'medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of the bodily functions that are temporarily or permanently incapable of independent operation'.

In looking at whether the 'triggering event' for living wills should be incompetence alone, incompetence with some other condition or disability, or incompetence with terminal illness, the Law Reform Commission of Western Australia took a wide view of the potential operation of living wills,[91] for it is generally true of living wills statutes that they apply only in the event of terminal illness, in relation to extraordinary medical treatment. This limited application and the related difficulty in defining terms such as 'terminal illness' and 'extraordinary measures' are probably the most problematic aspects of living wills legislation.

The meaning of ordinary and extraordinary medical treatment varies as between patients and doctors and changes as medical science progresses.[92] Economics also play a significant role in determining what constitutes extraordinary treatment.[93] While the Northern Territory Regulations to the Natural Death Act 1989 (N.T.) allow a declarant to direct that he or she not be subject to particular kinds of extraordinary treatment, *or* to make a general directive in relation to such treatment,[94] the Natural Death Act 1983 (S.A.) allows only for general directives thus largely leaving to medical judgment 'the distinction between life-prolonging care, comfort and cure'.[95]

While artificial respiration and circulation, and cardio-pulmonary resuscitation are typically deemed to prolong dying and fall within the measures to be withheld, painkillers are generally regarded as comfort care and may be administered as 'therapeutic measures' under section 5(2) of the Natural Death Act 1983 (S.A.). Administration of antibiotics, nutrition and hydration are particularly problematic areas. The living wills of several American states[96] specifically exclude artificial nutrition and hydration from the category of life-sustaining treatment, but the Natural Death Act 1983 (S.A.) does not specifically deal with this issue.[97]

The limitation of living wills legislation to patients suffering from 'terminal illness' poses similar definitional problems. Section 3 of the Natural Death Act 1983 (S.A.) provides that death must, if extraordinary measures were not applied, be imminent. Similarly, in all American states except Arkansas,[98] a diagnosis of terminal illness is required prior to life-support withdrawal. In some American states, for example California,[99] a further safeguard is provided by the stipulation

90 *Ibid.*
91 *Supra* n. 8, para. 2.6.
92 Havens, S. L., 'In re Living Will' (1981) 5 *Nova Law Journal* 445, 452-4.
93 Stephenson, S. A., 'The Right to Die: A Proposal for Natural Death Legislation' (1980) 49 *University of Cincinnati Law Review* 228, 230.
94 Schedule of Natural Death Regulations 1989 (N.T.).
95 Francis, *op. cit.* n. 2, 146.
96 *Ibid.* 147-8.
97 This question is considered in the context of palliative care in section (g) *infra*.
98 Arkansas Statutes Annotated para. 20.17.202.
99 California Health and Safety Code para. 7187(e).

that certification of terminal condition must be made by two physicians. While the definition of 'terminal illness' in the Natural Death Act 1983 (S.A.) extends beyond illness to injury or degeneration of mental or physical faculties, thus widening the potential application of the Act, the meaning of 'imminent' raises difficulties. In 1985, the then Minister of Health, the Hon. F. T. Blevins, in a letter corresponding to concerns expressed by the Voluntary Euthanasia Society of South Australia, stated that 'imminent' means 'soon to happen',[100] and that 'interpretation must be relative to the patient's condition,'[101] a statement which, with respect, does little to resolve the existing uncertainty.

Living wills executed pursuant to legislation that is limited to extraordinary measures in the event of terminal illness will not give legal effect to the decisions of patients suffering from chronic or slowly deteriorating conditions such as multiple sclerosis or Alzheimer's disease, nor of patients with stable disabilities, such as brain damage resulting from stroke or accident, or patients who wish to refuse treatment such as blood transfusions on religious or other grounds.[102] However, the recent decision of the United States Supreme Court in *Cruzan v. Director Missouri Department of Health*[103] suggests that in such circumstances, directives, although not legally enforceable under the legislation, will constitute clear and convincing evidence of the patient's wishes, which may lead the court to order discontinuation of medical treatment. By a majority of five to four, the Court upheld the decision of the Supreme Court of Missouri and refused to allow the family of a comatose patient to withdraw artificial feeding tubes, maintaining that in the absence of the formalities required by the Missouri living will statute,[104] Cruzan's statements to her housemate did not constitute clear and convincing evidence of her wishes.[105] However the Court in so holding *implied* that if Nancy Cruzan had executed a living will, although the directive would probably not have been enforceable under the Missouri legislation (which requires that for a living will to take effect, a patient's condition must be 'terminal'),[106] the Court would still be prepared to give consideration to such a document in the wider treatment context of the non-terminal, comatose patient, as clear and convincing evidence of her wishes.

[100] This is similar to the 'short time' formula adopted in some American legislation. One commentator has suggested that this could be anything from a few days to a few years: Murphy, R. E., 'A New Form of Medical Malpractice?: Missouri's Living Will statute' (1986) 42 *Journal of the Missouri Bar* 11, 16. On the meaning of 'imminent', a California Survey showed that 80% of doctors considered death imminent if it will occur within a week: Redleaf, D. L., Schmitt, S. B. and Thompson, W. C., 'The California Natural Death Act: An Empirical Study of Physicians' Practices' (1979) 31 *Stanford Law Review* 913, 933.

[101] Letter dated 9 April 1985 attached to the written submission of the Voluntary Euthanasia Society of South Australia, Victorian Social Development Committee, *Inquiry into Options for Dying with Dignity* 1987.

[102] Beraldo, C., 'Give Me Liberty and Give Me Death: The Right to Die and the California Natural Death Act' (1980) 20 *Santa Clara Law Review* 971, 989; Dufraine, C. J., 'Living Wills — A Need For Statewide Legislation or a Federally Recognized Right?' (1983) 3 *Detroit College of Law Review* 781, 788-94.

[103] 111 L Ed 2d 224 (1990), 249.

[104] Missouri Uniform Rights of the Terminally Ill Act, Missouri Annotated Statutes paras 459.010-.005.

[105] *Supra* n. 103.

[106] Under the Missouri legislation, the condition is 'terminal' only if it is incurable or irreversible and will result in death 'within a short time regardless of the application of medical procedures': Missouri Annotated Statutes para. 459.010(6).

The limitations in relation to extraordinary treatment and terminal illness are copied from American legislation. American law regards the right to self-determination as a qualified right which must give way to state interests in the preservation of life, the prevention of suicide, the maintenance of the integrity of the medical profession and the protection of innocent third parties. The extraordinary treatment/terminal illness limitations appear to be a rough and ready way of balancing the patient's right to self determination against the interests of the state.[107] The protection of third parties does not seem to be adequately reflected in the two statutory limitations. Some American legislation goes further towards meeting this state interest by providing that a living will cannot be applied during the course of a woman's pregnancy.[108] Even if the state's interest in preserving life is in part to be reflected in some general limitation, the distinction between ordinary and extraordinary treatment is ill-adapted to serve this purpose. In America, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research[109] criticized as confused the distinction between ordinary and extraordinary treatment and recommended its replacement by the notion of proportionality. This change of approach was adopted by the California Court of Appeal in *Barber v. Superior Court.*[110] While an improvement on the distinction between ordinary and extraordinary treatment, the requirement of proportionality still injects too great an element of paternalism into the law or at least gives too much weight to state interests over the right to self-determination. In the first article in this series,[111] it was suggested that the only state interest which should be allowed to outweigh a competent adult's right to self-determination is the right to prevent suicide. This would represent a more workable solution and one more in line with the Australian approach to these problems.[112]

(g) *Palliative Care*

The limitation to extraordinary treatment as defined by section 3 of the Natural Death Act 1983 (S.A.) means that the prospective patient cannot exclude palliative care by executing a living will. Keeping the patient warm, bathing the patient or turning her or him in bed to prevent bedsores is not intended to prolong

107 Cocotas, V. and Storm, F., 'The Florida Living Will: Alive and Well?' (1989) 19 *Stetson Law Review* 175, 179-80; Kutner, L., 'The Living Will: Coping with the Historical Event of Death' (1976) 27 *Baylor Law Review* 39, esp. at 48.

108 Florida Statute para. 765.08: see Cocotas and Storm, *ibid* 187; California Health and Safety Code para. 7188: see Clementino, B. J., 'A Proposed Amendment to the California Natural Death Act to Assure the Statutory Right to Control Life Sustaining Treatment Decisions' (1983) 17 *University of San Francisco Law Review* 579, 594; for a discussion of the constitutional validity of such provisions, see Dufraine, *op. cit.* n. 102, 803-4, and Gelfand, *op. cit.* n. 58, 778-780. S. 6(c) of the model Uniform Act, adopted by the National Conference of Commissioners on Uniform State Laws in 1985, permits pregnant women to decline treatment by express declaration. For a discussion see Mooney, C. A., 'Indiana's Living Wills and Life-Prolonging Procedures Act: A Reform Proposal' (1984) 20 *Indiana Law Review* 539, 556.

109 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Deciding to Forego Life Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions* (1983) 88-9.

110 195 Cal.Rptr. 484 (Cal.App.2Dist. 1983). See Capron, A. M., 'Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment' [1984] *Arizona State Law Journal* 647, 654-5.

111 *Supra* n. 1.

112 And with Dr Kutner's original proposals for living wills: Kutner, *op. cit.* n. 3, 551.

life by supplanting or maintaining bodily functions, but is intended to relieve the patient from pain or discomfort.[113]

The provision of food and water may be palliative in some circumstances, but will not always be so. Where they are given to remove the pain and discomfort of hunger and thirst, food and water will be palliative, but where the patient is unable to experience pain or discomfort, for example because he or she is in a persistent vegetative state, the provision of food or water merely prolongs life and so falls within the definition of extraordinary treatment.[114]

(h) *Responsibility of a Medical Practitioner to Comply*

The Natural Death Act 1983 (S.A.) provides that when a person who is suffering from a terminal illness has made a direction under the Act and the medical practitioner responsible for that person's treatment has notice of the direction, it is the duty of the medical practitioner to act in accordance with the direction unless there are reasonable grounds to believe that the patient has revoked, or intended to revoke the direction, or that the patient was not at the time of giving the direction capable of understanding the nature and consequences of the direction.[115] The power to make a direction does not derogate from the duty of a medical practitioner to inform a conscious and competent patient of treatment alternatives.[116] While the Act protects decisions made by medical practitioners in good faith and without negligence as to whether the patient is suffering from a terminal illness, whether the living will has been revoked and whether the patient was capable of giving and understanding a direction made under the Act,[117] the Act does not relieve a medical practitioner from the consequences of a negligent decision as to whether or not a patient is suffering from a terminal illness.[118]

Of some concern is the fact that while the legislation imposes a duty on medical practitioners to comply with directives that come to their notice, no legislative sanctions are imposed under the Act in the event that a medical practitioner ignores a clearly valid directive. The response of the South Australian Minister of Health in 1985 was that sanctions would 'not be within the spirit of the act' and that 'should the situation arise, the patient or his family and the medical practitioner should discuss the matter and if necessary could refer the patient to another medical practitioner'.[119] It does seem desirable, however, to at least include a 'conscience clause' as enacted in several American states, requiring a medical practitioner who objects to the living will of a patient to make reasonable efforts to transfer responsibility for the patient to a medical practitioner who will follow the directive.[120] The California Health and Safety Code

113 Herlan, *op. cit.* n. 87, 100.

114 For an argument that living wills legislation should not permit the refusal of food and water (at least in the United States) see *ibid.* 134-47.

115 S. 4(3).

116 S. 4(4).

117 S. 5(3).

118 S. 6(2).

119 *Supra* n. 50.

120 *E.g.*, in Louisiana, Louisiana Revised Statutes para. 40: 1299.58.7B. The transfer defence may be available even if it is not expressly mentioned: see Morgan, S., 'Selecting Medical Treatment: Does Arizona's Living Will Statute Help Enforce Decisions?' [1986] *Arizona State Law Journal* 275, 295.

goes further, providing that to ignore a binding directive constitutes 'unprofessional conduct',[121] yet violates no other criminal or civil duties. In the interests of both patients executing living wills and non-complying doctors fearing that liability at common law may be established,[122] it is advisable that the issue of sanctions should be clarified under the Natural Death Act 1983 (S.A.).

(i) *Saving Provisions*

The Natural Death Act 1983 (S.A.) contains a number of saving provisions designed to protect the interests of non-declarants, including unborn infants and the future recipients of organ transplants. First, the Act does not affect the right of any person to refuse medical or surgical treatment.[123] This provision was incorporated as a result of fears expressed before the South Australian Select Committee on the Natural Death Bill 1980,[124] that such legislation might affect the zeal with which non-declarants would be treated.

In the *Cruzan* case,[125] discussed above, this fear may have in fact been realized. Although the Missouri living will statute contains an explicit statement that no presumption concerning the intention of an individual who has not executed a declaration shall be made,[126] the decision of the majority suggests that in a 'living will' jurisdiction, in the absence of a duly executed directive, it may be difficult to establish 'clear and convincing evidence' of the patient's wishes. The majority of the U.S. Supreme Court appeared to endorse the opinion of the Missouri Supreme Court, that the Missouri living will statute embodied a state policy strongly favouring the preservation of life, and that no person can assume the choice of an incompetent patient in the absence of the formalities required by the living will statute or clear and convincing evidence of the patient's wishes.[127] While the case was decided largely on constitutional issues, the importance of taking up the living will alternative in jurisdictions where it is provided is made manifest.

The Natural Death Act 1983 (S.A.) also provides that the Act does not prevent the artificial maintenance of the circulation or respiration of a dead person for the purposes of organ transplantation or, where the dead person is a pregnant woman, for the purpose of preserving the life of the foetus.[128] In addition, nothing in the Act authorises an act that causes or accelerates death as distinct from an act that permits death to take its natural course.[129] Thus the Act only

121 California Health and Safety Code para. 7191(b). Even transfer may be objectionable to some doctors who take a strong pro-life stand — see Murphy, J. G., 'The Virginia Natural Death Act — A Critical Analysis' (1983) 17 *University of Richmond Law Review* 863, 872-3. But the issue is a societal not a medical one.

122 *E.g.*, the initiation or continuation of treatment involving bodily contact in defiance of a living will would in most cases amount to the crime and tort of battery. For a brief account of a $1.26 million suit for battery for refusing to withdraw a patient from a respirator see Marsh, *op. cit.* n. 63, 20-1.

123 S. 5(1). See also s. 5(2)(b).

124 *Report of the Select Committee of the Legislative Council on the Natural Death Bill, 1980* (S.A.), para. 20.

125 111 L Ed 2d 224 (1990).

126 Missouri Revised Statutes para. 459.055(3).

127 *Supra* n. 125.

128 S. 7(1).

129 S. 7(2).

permits voluntary, passive euthanasia, an important point often overlooked by opponents of such legislation.

(j) *Causation and Withdrawing or Withholding Treatment*

Section 6 of the Natural Death Act 1983 (S.A.) provides that the non-application of extraordinary measures to or the withdrawal of extraordinary measures from a person suffering from a terminal illness does not constitute a cause of death. In its *Discussion Paper on Medical Treatment of the Dying*,[130] the Western Australian Law Reform Commission commented that the purpose of this section was not clear. The Commission suggested that it might have been intended to protect those who complied with a written directive, but pointed out that the section was not confined to such cases. A second possibility suggested was that the section was intended to prevent an assailant in a murder or manslaughter case from contending that death was caused not by the defendant's act but by the doctors who withdrew or withheld extraordinary treatment.

The nearest equivalent Northern Territory provision, section 6(1) of the Natural Death Act 1988 (N.T.), does limit the causation rule to cases where a living will has been made and this seemed to fit in well with the general approach of the legislation which favours patient autonomy. The second solution suggested in the Western Australian Law Reform Commission discussion paper involves no fundamental departure from the overall purpose of the Act, but, as with the first solution, the wording of the South Australian section contains no express limitation to third party injury cases. In its most natural interpretation, the section appears to be conferring an immunity on the person who withholds or withdraws the extraordinary treatment from a terminally ill patient.

It is this interpretation which in some cases could do violence to the patient autonomy approach which otherwise largely permeates the Natural Death Act 1983 (S.A.). It would do so, for instance, where a patient is prepared to face a painful and lingering death and requests the application of all available treatment ordinary or extraordinary. To allow a doctor to withhold or withdraw treatment in these circumstances, even if the patient is willing to pay for the treatment and no one else is in need of it, is the very negation of patient autonomy.

It is perfectly possible for Parliament to make provision for the withdrawal or withholding of treatment where the patient has given no direction. This was done by the North Carolina legislature in paragraph 90.322 of its Living Will Legislation,[131] the terms of which are fairly similar to s. 6 of the South Australian statute. But paragraph 90.322 of the North Carolina legislation appears under a separate heading of the statute, which makes it clear that it is dealing with cases where no direction has been given, and the power to withhold or withdraw is made subject to certain procedural safeguards. One would expect no less of the South Australian Parliament were it intending to introduce so wide-ranging a reform.

There are ways in which the more objectionable consequences of a literal

130 *Project No. 84* (1988), 27.
131 North Carolina General Statutes para. 90.322.

interpretation of s. 6 can be avoided. It could, for instance, be argued that where treatment is available and within the resources of the patient (or whoever is paying for the patient's treatment) and was requested by the patient when competent, such treatment is not extraordinary. It could also be argued that s. 6 does not confer full immunity, but deals only with causation. This would mean that a doctor who withdrew extraordinary treatment from a patient who desired to have the treatment could not be found guilty of murder or manslaughter, because of the causation rule in s. 6, but could be found guilty of some other crime or tort, like battery. Though these solutions would avert the worst consequences of the literal interpretation of s. 6, they appear contrived and haphazard.

Probably, the best way to bring s. 6 into conformity with the spirit of the legislation is to regard it as merely declaratory of the common law. No doubt there are cases in which it is appropriate to withhold or withdraw extraordinary treatment from a terminally ill patient even where the patient has requested the treatment, for example, where there are limited resources and other patients in need. The denial of treatment in such cases would be permitted at common law. The common law would limit its reach to appropriate cases. If the section is limited in the same way, it will do no mischief.

6. *CONCLUSION*

A critical examination of the Natural Death Act 1983 (S.A.) indicates that problems lie not so much with the concept of living wills legislation, but with formulating a workable statute which will enforce the wishes of the declarants and protect from liability medical practitioners who act responsibly and in good faith. The Natural Death Act 1983 (S.A.) satisfies the latter of these requirements more satisfactorily than it satisfies the former. While living wills legislation is to be recommended because of its potential to give the individual a significant degree of control over her or his death, such legislation should be extended to include non-terminally ill patients, such as comatose persons. Formalities for making declarations should include a requirement that witnesses have no emotional, professional or pecuniary interest in the death of the declarant, and revocation procedures should be clearly set out. Living wills should be made binding upon the medical practitioners responsible for the treatment of the declarant, with some sanctions being provided for deliberate non-compliance, and provision should be made for a register of living wills so that medical practitioners will readily be able to establish the existence of a living will. Resolution of the difficulties inherent in terms such as 'extraordinary treatment', 'terminal illness' and the 'imminence' of death is more difficult and should be achieved by replacing these limitations with a requirement that a living will must not be used as a means of committing suicide. It could be made clear by express provision that suicide requires a specific intent to die. Finally, living wills legislation should be widely publicized and members of the public should be actively encouraged (for example by their solicitors, when an ordinary will is executed) to consider making a living will. Only then will the advantages of such legislation be fully realized.