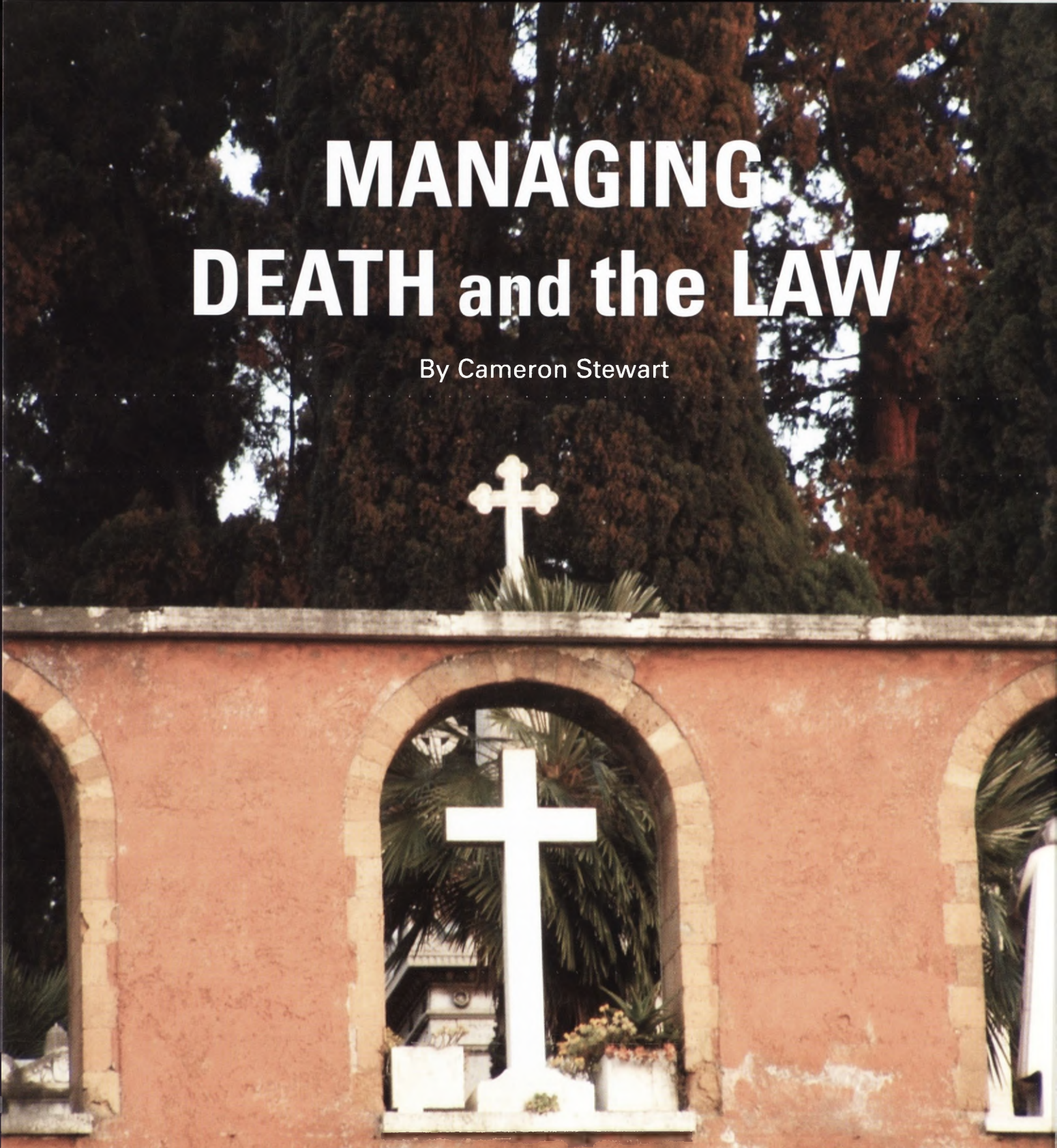
# MANAGING DEATH and the LAW

By Cameron Stewart



In the last 30 years, the process of dying has changed. Dramatic improvements in healthcare have meant not only that we live longer, but that we die differently. Dying now occurs more commonly in health institutions, like intensive care units and nursing homes. When death occurs in an institutional setting, it is invariably a managed process where families and carers work together to give the dying person the most comfortable and dignified passing they can.

Australian healthcare workers have an excellent reputation in providing such care, but invariably disputes do arise and, in such cases, it is important for the law to provide a clear process for dispute resolution where each party understands their rights and obligations. Unfortunately, not all Australian jurisdictions have provided such a framework, as the law in this area differs widely across jurisdictions. This article reviews the basic principles of end-of-life decision-making in Australia. It begins with an analysis of the right of patients to make a decision about their end-of-life care, and then examines the various other substitute decision-makers and their role in the management of dying.

## THE RIGHT TO REFUSE TREATMENT AND MAKE AN ADVANCE DIRECTIVE

Currently, Australian common law recognises the right of competent patients to refuse life-sustaining treatments. This right is based in trespass and can be found around the common law world. Lord Donaldson put the right thus:

> 'This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent...'[1]

A patient has the right to refuse even minor or minimally invasive treatments, even when they will sustain life. For example, in *B v an NHS Trust*,[2] a quadriplegic and ventilator-dependent patient, B, requested that she be sedated and her ventilation be withdrawn, having created an advance directive to that effect. Part of the treatment team argued that B was depressed and hence incompetent, with the result that her wishes could be ignored and treatment continued. The judge rejected this argument, found B to be competent and completely free to request the withdrawal of treatment, and upheld her decision. Only nominal damages were ordered for the unauthorised treatment, and B died following the treatment withdrawal.

Similar cases can be found in Australia. In *Re PVM*,[3] a 39-year-old man with severe brain and spinal injuries requested the removal of artificial ventilation, but there were concerns about his competence. The Queensland Guardianship and Administrative Tribunal found the man to be competent and to have the right to refuse treatment. Treatment was withdrawn.

The right to refuse treatment extends to making a decision about treatment in the future. 'Advance directives' or 'living wills' are decisions made by patients about what medical treatments they would like in the future if, at some point, they cannot make decisions for themselves. Advance directives ordinarily record decisions about refusing life-sustaining treatments, but they can also contain the patient's preferences and desires about a whole range of treatment matters.

In Australia, the right to make an advance directive is sourced in common law, and has been legislated in the ACT, NT, SA, Queensland and Victoria.[4] In these jurisdictions (with the possible exceptions of Queensland SA) the common law has been preserved, so that it is still possible to make an advance directive at common law, as well as under statute.

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At present, advance directives have a low take-up rate, but they may prove useful, particularly when patients have a long history of chronic illness and are knowledgeable about the progression of their disease, or where they have a religious conviction or strongly held belief against particular types of treatment. When written with the help of healthcare professionals, advance directives can provide a level of reassurance to patients and their families. Of course, the opposite is also true. When they are written loosely and employ vague terms and preferences, advance directives >>

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have little utility and may cause confusion among both the family and health-carers. To avoid these problems, it is best to employ advance care directives as part of a wider process of advance care planning, which involves a continuing process of consultation with the patient about their wishes and desires for treatment.

## APPOINTING SUBSTITUTE DECISION-MAKERS: ENDURING HEALTH ATTORNEYS

Perhaps one of the reasons for the low take-up rate of advance directives in Australia is that culturally, Australian patients are more comfortable with their family members making such decisions when the time eventually comes. One of the ways that patients can ensure that family members have appropriate authority to take health-related decisions is to appoint them as health attorneys. All jurisdictions, barring NT and WA, allow for the appointment of such a decision-maker, and in some states (like SA and Victoria) such health attorneys can be appointed in two different ways.

In all jurisdictions that recognise enduring powers of attorney (barring NSW), an attorney may consent to withholding and withdrawing life-sustaining treatments. Unfortunately, the NSW position has been complicated by *WK v Public Guardian*[5] (see below). In Victoria, a medical agent appointed under the *Medical Treatment Act* 1988 (Vic) may also create a refusal of treatment certificate (a kind of advance directive) on behalf of the patient, on the condition that:

(a) the medical treatment would cause unreasonable distress to the patient; or
(b) there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider the medical treatment to be unwarranted.[6]

In the ACT, under the *Powers of Attorney Act* 2006, s86, enduring attorneys must have regard to the patient's right to receive relief from pain, suffering and discomfort to the maximum extent that is reasonable in the circumstances. Moreover, the patient has a right to the reasonable provision of food and water. In providing relief from pain, suffering and discomfort to the patient, the health professional must give adequate consideration to the patient's account of his or her level of pain, suffering and discomfort. Importantly, the appointment of an enduring guardian will revoke any previous advance medical directive given by the patient.[7]

## THE ROLE OF FAMILY MEMBERS WITHOUT POWERS OF ATTORNEY IN MAKING END-OF-LIFE DECISIONS

At common law, family members have no rights to consent to treatment on behalf of their incompetent adult relatives. To fill this hole, some jurisdictions (NSW, Queensland, SA, Tasmania, Victoria and WA) have created statutory powers for relatives to give consent (known as 'persons responsible powers'). 'Persons responsible' are alternative substitute decision-makers, and include guardians, enduring health attorneys, relatives, friends and carers, who can all be called upon to give consent in the absence of other consent mechanisms. The ACT and NT do not currently have persons responsible legislation.

In NSW, there is currently conflicting authority as to whether persons responsible have the power to consent to the withdrawal of life-sustaining treatments (see below). In Queensland, the 'statutory health attorney' (a form of person responsible) has the power to consent to the withholding and withdrawing of life-sustaining measures. This is granted on the condition that the patient's health-provider reasonably considers starting or continuing the measure for the adult to be inconsistent with good medical practice.[8] In SA, no express mention is made of a power to refuse consent to life-sustaining treatment but, arguably, if a person is given the power to consent, one could say that it includes a power to refuse consent. However, in the absence of judicial consideration this is conjectural.

Similar problems exist with the wording of the *Guardianship and Administration Act* 1995 (Tas). However, s43 of the Act expressly authorises the person responsible to consider the best interests of the patient. As persons responsible can consent only when treatment is in the patient's best interests, the Act seems to acknowledge that there may be occasions when life-sustaining treatments are not in the patient's best interests and should be withheld or withdrawn.

In Victoria, the person responsible must consider the patient's best interests before consenting to treatment. Again, it could be said that the *Guardianship and Administration Act* 1986 seems to acknowledge that there may be occasions when life-sustaining treatments are not in the patient's best interests and should be withheld or withdrawn. In s42L, express mention is made of a person responsible refusing consent to treatment. The section allows a medical practitioner to provide treatment despite the person responsible's objections, when the practitioner believes, on reasonable grounds, that the proposed treatment is in the best interests of the patient. The practitioner must inform the person responsible in writing of their decision, and the avenue for appealing the decision to the Victorian Civil and Administrative Tribunal (VCAT).

In WA, s119 of the *Guardianship and Administration Act* 1990 states that a number of alternative decision-makers can consent to medical treatment. Consent to medical treatment

has been considered by the WA Guardianship Board (which has now been subsumed by the State Administrative Tribunal) to include decisions to withhold and withdraw life-sustaining treatments.

This occurred in *BTO*,[9] where a comatose man had suffered a severe stroke. Questions were raised as to whether s119 could be applied to the withdrawal of artificial nutrition and hydration (ANH), when such withdrawal would be in the patient's best interests. The WA Guardianship Board found that the concept of treatment adopted by the Act included not only consent to medical or surgical procedures but also decisions to withdraw life-sustaining measures. A guardian was appointed, with the power to withdraw ANH.

## THE POWER OF GUARDIANSHIP TRIBUNALS AND TRIBUNAL-APPOINTED GUARDIANS TO MAKE END-OF-LIFE DECISIONS

As the jurisdiction of guardianship authorities grows exponentially, they are being increasingly involved in disputes about end-of-life decisions.

In Queensland, the Guardianship and Administration Tribunal (QGAAT) has made numerous decisions regarding the withdrawal of treatment. Treatment can be withheld or withdrawn on the order of the Tribunal, but only when the patient's health-provider considers the commencement or continuation of the treatment to be inconsistent with good medical practice. In *Re RWG*,[10] the wife of a 73-year-old man with an acquired brain injury applied for a no-CPR order and for the power to refuse antibiotics. The QGAAT agreed to the no-CPR order, but would not consent to the refusal of antibiotics, given that the patient was not suffering from an infection at the time of hearing and, as such, it would be premature to examine the issue. In *Re MC*,[11] permission was sought to withdraw ANH from an 80-year-old woman in a persistent vegetative state. The QGAAT found that the treatment was of no benefit to her and should be ceased. Finally, in *Re HG*,[12] a 58-year-old man with Wernicke's encephalopathy and Korsakoff's psychosis had a brain stem stroke that left him in a 'locked-in state'. The QGAAT was asked to determine whether ANH should be continued. The QGAAT found that, on the basis of medical evidence, it would be inconsistent with good medical practice to continue ANH, and ordered such treatments to cease. A finding about good medical practice did not require the practice to have the unanimous support of all medical experts.

VCAT has also been involved in a number of high-profile cases. In *Re BWV*,[13] the Supreme Court of Victoria, when reviewing a decision by VCAT, ordered a guardian to be appointed to refuse ANH to a 68-year-old woman with advanced Pick's disease. The Court found that ANH was medical treatment and not the reasonable provision of food and water, under the legislation. Given that the ANH was medical treatment, it could be refused under the *Medical* >>

The legal position on end-of-life decision-making is complicated by the existence of eight different guardianship regimes.

*Treatment Act* 1988 (Vic). In *RCS*,[14] the wife and brother of a patient with severe brain damage were appointed as limited guardians for the purpose of refusing medical treatment, namely antibiotics.

In the case of *Korp*,[15] VCAT appointed the Public Guardian to make a decision regarding the withdrawal of ANH from a woman with severe anoxic brain injury. The woman had been injured after an attempt was made on her life, and she had fallen into a persistent vegetative state. An application was made to appoint the Public Guardian to make decisions regarding her medical treatment including, among other things, a decision about whether to issue a refusal of treatment certificate refusing ANH. Her husband (who at the time had been charged with her attempted murder) argued that, as a devout Catholic, the patient would not have refused ANH. Morris J decided that the appointment of the Public Guardian was in her best interests. The fact that the patient was Catholic did not necessarily mean that she would have wanted ANH to be continued. It was said that the hypothetical question posed by s5B(2)(b) of the *Medical Treatment Act* is not one 'that is automatically answered in a particular way because a person holds a particular religious faith' (at 36).

## END-OF-LIFE DECISIONS IN NSW

Unlike Queensland and Victoria, where the roles of the tribunals and substitute decision-makers is clear, there have been disputes in NSW about whether decision-makers under Part 5 of the Act (included enduring guardians and persons responsible) must make decisions that would 'promote and maintain health and well-being', and therefore exclude end-of-life considerations. The NSW Administrative Decisions Tribunal (NSWADT) has stated that this phrase prevents it (and other decision-makers) from making orders to withhold or withdraw treatment.

This occurred in *WK v Public Guardian (No. 2)*,[16] which concerned Mr X, a 73-year-old man with end-stage kidney disease, advanced heart disease, dementia and bowel cancer. Mr X was receiving haemodialysis. A decision was made by his treating physician, Mr X's sister in law and other relatives and friends, to stop the dialysis. However, a friend of Mr X's, WK, objected to the decision to withdraw treatment, and the decision was referred to the NSW Guardianship Tribunal. The Tribunal appointed the Public Guardian as Mr X's guardian. The Public Guardian, among other things, consented to the withdrawal of treatment, a no-CPR order and palliative care.

WK appealed the decision of the Public Guardian to the NSWADT. The Deputy President of the NSWADT issued a stay on the decision to withdraw treatment, and ordered that further evidence be presented.[17] On the return of the application, the NSWADT decided that the decision to withdraw dialysis and to refuse 'aggressive' treatment was beyond the power of the Public Guardian.

On the Deputy President's reading of the Act, a decision to withdraw treatment did not promote health and well-being. As such, all substitute decision-makers who draw power from the NSW *Guardianship Act* have no power to consent to the withdrawal of life-sustaining treatments.

It should be noted that the authority of *WK (No. 2)* is questionable on a number of fronts, and recently the Guardianship Tribunal disputed a number of its key findings. *Re AG*[18] concerned a 56-year-old woman with mild intellectual disability. She had been born in Malta but raised in Australia. Both her parents had died and she lived alone in her own home, receiving support services on a daily basis from a specialist care-provider. AG had been diagnosed with a renal tumour with lymphadenopathy in the abdomen and pelvis. There was also the possibility that she had secondary brain tumours, and her prognosis was consequently very poor. She had a history of refusing medical treatment, including fear of needles. She also refused to acknowledge the existence of the kidney tumour, although she had accepted that she had cancer.

The Public Guardian had previously been appointed to manage AG's care but was now faced with a decision concerning a palliative care plan, which included decisions to forego CPR and dialysis. The Public Guardian approached the Guardianship Tribunal for directions on the care plan, given that the *WK (No. 2)* decision seemed to conclude that it was not possible for the Public Guardian to consent to such a plan.

The Tribunal decided that, generally, consent could be given or refused for medical treatment, which included palliative care. Palliative care, in turn, could include treatment limitations, such as the non-provision of treatment, on the proviso that the palliative care promoted and maintained health and well-being, as required by the Act. The Tribunal stated that the weight of authority supported the notion that treatment limitation can promote and maintain a person's health and wellbeing, if it prevents futile treatment and allows the person to die with comfort and dignity.

The Tribunal also found that guardians with healthcare functions could be given the power to be involved in advance care planning. It recognised that advance care planning did

not require the appointment of a guardian with a healthcare function.

Applying these findings to AG's situation, the Tribunal felt that it was necessary for a specific order to be made giving the Public Guardian the power to consent to the proposed palliative care plan, which could be done only after further medical investigations were completed.

## THE POWER OF SUPERIOR COURTS TO CONTROL LIFE-SUSTAINING TREATMENTS

Supreme Courts in each jurisdiction also enjoy the *parens patriae* power, which can be used to determine what treatments are in the patient's best interests, even those treatment options that involve the withholding or withdrawal of life-sustaining measures.

This was discussed by the NSW Supreme Court in *Messiha (by his tutor) v South East Health.*[19] In this case, the family of a patient sought a court order to continue life-sustaining treatments. The patient had suffered a cardiac arrest and severe brain damage as a result. He had a history of heart disease and severe lung disease, and medical opinion was unanimous that his best interests would be served by the managed withdrawal of treatment. However, his family did not agree and argued that treatment was not futile if it continued to support his life.

Howie J decided that the managed withdrawal of treatment was in the patient's best interests. He was swayed by the unanimous medical opinion as to the patient's prognosis, and held that the treatment was burdensome and futile.

Most recently, the NT Supreme Court made a similar finding in *Melo v Superintendent of Royal Darwin Hospital.*[20] The Court refused to order the continuation of ventilation for a brain-damaged man, Paulo Melo, who had been severely injured in a motor vehicle accident. He was found unconscious at the scene with no pupil responses and no responses to painful stimulation. His 'Glasgow coma score' was three and he had a very low blood pressure, which compromised the flow to his brain. It was later determined that his spinal cord had been severely damaged. The hospital treatment team and four experts agreed that further treatment was futile. On that basis, the judge could find no reason to order the continuance of treatment.

## SOME CONCLUSIONS

There is now a growing jurisprudence of Australian law on end-of-life decisions. The legal position is complicated by the fact that there are eight different guardianship regimes, which all differ in their approach as to how decisions should be made. While there is a degree to which these regimes attempt to mutually recognise each other, overall it is hard to argue that there is any real benefit in having eight different regimes for a highly mobile population of 22 million people, whose families are often spread across jurisdictional boundaries. Recently, the Senate Standing Committee on Legal and Constitutional Affairs made a number of recommendations in its report on elder care, which supported nationally consistent legislation on guardianship and administration. In the absence of such reforms, practitioners should be awake to the wide jurisdictional differences relating to the management of end-of-life care. ■

**Notes:** **1** *Re T (An Adult) (Consent to Medical Treatment)* [1992] 2 Fam 458, 460 (Lord Donaldson MR). In the same case, Butler-Sloss LJ stated: 'A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered' (at 474). **2** [2002] EWHC 429 (Fam). **3** [2000] QGAAT 1. **4** *Medical Treatment (Health Directions) Act* 2006 (ACT); *Natural Death Act* 1988 (NT); *Powers of Attorney Act* 1998 (Qld); *Consent to Medical Treatment and Palliative Care Act* 1995 (SA); *Medical Treatment Act* 1988 (Vic). See, also, *Acts Amendment (Consent to Medical Treatment) Bill* 2006 (WA). **5** (No. 2) [2006] NSWADT 121. **6** *Medical Treatment Act* 1988, s5B(2). **7** *Medical Treatment (Health Directions) Act* 2006, s19. **8** *Guardianship and Administration Act* 2000, s66A. **9** [2004] WAGAB 2. **10** [2000] QGAAT 2. **11** [2003] QGAAT 13. **12** [2006] QGAAT 26. **13** [2003] VSC 173. **14** [2004] VCAT 1880. **15** [2005] VCAT 779. **16** [2006] NSWADT 121. **17** *WK v Public Guardian* [2006] NSWADT 93. **18** [2007] NSWGT. **19** [2004] NSWSC 1061. **20** [2007] NTSC 71.

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