

Essentials
of **Law** for
HEALTH
PROFESSIONALS

4e

Kim Forrester
Debra Griffiths

MOSBY



ELSEVIER

Essentials of Law for HEALTH PROFESSIONALS

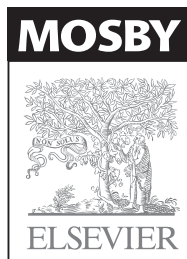
4e

Kim Forrester

RN, BA, LLB, LLM (Advanced), PhD,
Barrister at Law
Associate Professor, Faculty of Health Science and Medicine
Bond University, Australia

Debra Griffiths

RN, BA, LLB, LLM, PhD, Legal Practitioner
Head of Campus, School of Nursing and Midwifery,
Peninsula Campus
Faculty of Medicine, Nursing & Health Sciences
Monash University, Australia



Sydney Edinburgh London New York Philadelphia St Louis Toronto

Contents

Foreword	vi
Preface	viii
Reviewers	x
SECTION 1 INTRODUCTION TO LAW FOR HEALTH PROFESSIONALS	
1 Introduction to the Australian Legal System	3
2 The Australian Constitution and System of Government	25
3 Working with Legal Representatives	35
SECTION 2 LEGAL CONCEPTS FOR HEALTH PROFESSIONALS	
4 Management of Patient and Client information	65
5 Negligence	101
6 Intentional Torts	145
SECTION 3 LIFE AND DEATH ISSUES	
7 Refusal and Withdrawal of Treatment	177
8 Manipulation of Life	209
9 Criminal Law issues and the Coroner	233
SECTION 4 WORKING WITHIN THE LAW	
10 Contractual and Industrial Elements of Professional Practice	265
11 Statutes Controlling Health Service Delivery	301
12 Registration and Regulation of Health Professionals	329
APPENDICES	
Table of Cases	365
Table of Statutes	369
Abbreviations	381
Index	383

Foreword

There is no doubt that the complexity of health service delivery requires a clear understanding of the legal principles and the regulatory environment in which practitioners (of all professions and disciplines) operate. To succeed, the task of navigating this difficult legal and regulatory landscape requires clear and up-to-date guidance that is grounded in a practical understanding of the day-to-day challenges faced by health service providers. The authors of this excellent introductory work provide that clear, practical guidance.

The structure of this book lends itself to a natural progression from an understanding of the fundamentals of our legal system, through the key legal concepts to the more difficult day-to-day issues where the law and health service provision often collide, and ending with a practical understanding of how various legal and regulatory regimes impact on the working lives of health professionals. The authors take us on an important journey and ensure we can keep up with them along the way.

As chapters build on chapters, and understanding grows and builds, the reader is able to see the practical application and impact of the legal concepts and frameworks. And the authors are unafraid to quote from case law to illustrate the points they are making; indeed, one of the valuable elements of this introductory work is the citation of relevant cases and the elucidation of the changes and development of the law over time.

While many may be tempted to skip over the first three chapters (in the mistaken belief that fundamental legal concepts are either already well-understood or irrelevant to their day-to-day work), the introductory section is neither a dry dissertation on a well-travelled country nor the exploration of a legal backwater of interest only to constitutional lawyers. The authors are at pains to ensure that health professionals are able to see the relevance of these fundamental concepts and they provide clear examples of the impact these concepts and principles have on the working lives of all health service providers.

The second section provides clear guidance on the requirements placed on all of us to maintain accurate records, as well as leading the reader through the legal, ethical and professional obligations that attach to the need to maintain confidentiality of patient information and the need to understand the circumstances in which confidentiality can and should be breached. The authors explore the practical implications of the law around medical negligence and the disclosure of risk, and provide a clear pathway through the often vexing issue of consent.

The third section deals with extraordinarily difficult issues and does it with sensitivity and in language that is straightforward and easy to understand. The law in relation to refusal and withdrawal of treatment varies between jurisdictions, and the authors carefully assist the reader to understand the important aspects of the law in each jurisdiction. Issues of competency and guardianship are dealt with comprehensively, as is the difficult issue of futile treatment. And the final chapter in this section (on the manipulation of life) deals with (at times) controversial and confronting issues with a no-nonsense practicality that is sensitive to the ethical issues involved. I particularly commend the authors on this third section; it is of particular importance for health professionals as it provides valuable assistance in understanding areas of the law where a professional's individual ethical position may be challenged and where great care is needed to ensure that personal beliefs are not substituted for lawful decisions.

The final section deals with issues dear to the heart of those involved in the management of health complaints. Important concepts and principles in contract and industrial law are explored, statutory obligations and responsibilities in relation to medicines, mental health issues and child and elder abuse are detailed, and the key legislation and frameworks surrounding the registration and regulation of health professionals are comprehensively explained. As with the preceding chapters, legislation and regulatory frameworks are explained clearly on a jurisdictional basis and by reference to case law or practical examples wherever necessary. While no health professional ever wishes to be involved in disciplinary hearings, the authors provide a valuable tool for navigating the disciplinary regimes in place as well as relevant examples from case law to illuminate the principles involved.

While the authors have provided an excellent guide to the law, moving clearly and purposefully from legal principles to practical application, they have also provided a useful reference tool for health professionals to dip into, and out of, as needs be. This is an up-to-date and comprehensive introduction, and I am very honoured to have been asked to provide the foreword to the fourth edition of *Essentials of Law for Health Professionals*, particularly as I follow in the pioneering footsteps of Beth Wilson, former Health Services Commissioner in Victoria.

I commend this work to health service professionals and to those who are involved in the governance of health service delivery systems; it continues to be an excellent introduction to fundamental legal principles and issues that have the potential to bedevil us all if we are not alert to them.

*Leon Atkinson-MacEwen
Health Ombudsman, Queensland
July 2014*

Preface

This book was written with the intention of providing students undertaking studies in health sciences with an introduction to the legal issues relevant to the provision of health care services in Australia. Over preceding decades, courses in nursing, medicine, physiotherapy, pharmacy and other allied health fields have recognised the significance of including legal content in the curriculum and have incorporated health law as a discrete unit within a suite of compulsory subjects. This occurred as a response to the need recognised by health professionals to have knowledge of the legal principles and legislative provisions that are pertinent to their area of clinical practice and the delivery of high quality patient and client care.

As registered nurses, both authors bring decades of clinical experience in a wide range of clinical areas, including critical care, midwifery, medical and surgical nursing and coronary care, to the content of the text. They have sought, based on their own clinical experience and legal backgrounds, to address the law and legal processes in a manner that has application to the multidisciplinary nature of healthcare and in a context that emphasises the practical relevance of the information to clinical practice.

Both authors teach students studying a variety of health disciplines. It is from this experience that the authors appreciate students' desire for concise legal answers that may translate into meaningful practice guidelines. While it is recognised that the law is often imprecise, the authors have attempted to, first, state the law as it currently exists in many Australian jurisdictions and, secondly, to highlight and comment on those areas of the law that lack clarity. This book is not intended to provide legal advice in the strict sense, but rather to be a starting point to allow practitioners to identify relevant sources and principles of law, develop a knowledge base and then embrace further legal research.

Ultimately, this book aims to provide undergraduate students from a wide range of healthcare disciplines with the information and knowledge necessary to make well-informed and considered decisions about their legal rights and obligations, and the legal rights and obligations of the patients and clients under their care. Such knowledge should significantly contribute to sound, independent clinical judgments in relation to daily practice.

The book has been divided into four sections. Section 1, 'Introduction to Law for Health Professionals', deals with an overview of the Australian legal system, including some practical information when working with legal representatives. Section 2, 'Legal Concepts for Health Professionals', includes chapters that examine current practice concerns including the law of negligence, consent and patient information. Section 3, 'Life and Death Issues', adopts a broad approach to a number of common concerns such as the patient's right to refuse treatment and substituted decision making, the law of abortion and criminal aspects of health practice. Finally, Section 4, 'Working Within the Law', addresses industrial and employment issues, professional regulation and significant areas of the law that impact daily practice such as drugs and poisons regulation and mental health legislation. The task of writing this book, as with the three previous editions, has been both inspirational and challenging and we therefore wish to acknowledge and thank those who have provided assistance. The authors wish to thank Vaughn Curtis, Publishing Director, Elsevier APAC for his unfailing support, and Vicky Spichopoulos, Libby

Houston and Jon Forsyth for their coordination and editing skills. We also thank George Conrad for his very valuable comments and contribution in researching and checking resource materials. The book is dedicated to George Conrad, Julian Pearce, Alexander, Victoria, Megan and Caroline. The legislation and commentary in this text is as current as possible at the time of going to press; however, no statement of the law should be relied on without verification.

*Kim Forrester
Debra Griffiths
2014*

Reviewers

Pierre Baume RN, RPN, BAppSc, DCH, MHP, LLM, JD
Barrister, Victorian Bar

Bronwyn Betts ASM, BAppSc (Nursing), LLB, LLM, RN
Senior Educator, Queensland Ambulance Service
Sessional Academic, Queensland University of Technology

Lyn Francis BN, MHM, LLB, LLM, Grad.Cert.TT, PHD Candidate
School of Nursing and Midwifery, University of Newcastle

Christian Pedrosa BA Nursing, MA Health Administration
Member of the Public Health Association of Australia
Member of the National Tertiary Education Union
Member of the NSW Nurses and Midwives' Association

Refusal and Withdrawal of Treatment

LEARNING OBJECTIVES

Upon completion of this chapter you should be able to:

- ▲ identify the statutory requirements and mechanisms that allow patients to refuse treatment in all Australian jurisdictions;
- ▲ describe the terms 'advance care planning' and 'advance care directives';
- ▲ discuss the circumstances highlighted in the case law that enable treatment to be withdrawn from incompetent patients and defective neonates;
- ▲ describe the requirements of a medical power of attorney;
- ▲ discuss the role of guardianship in relation to patient decisions for treatment and financial considerations; and
- ▲ explain the legal significance of a not-for-resuscitation order.

INTRODUCTION

The common law maintains that a legally competent person may either consent to treatment or refuse treatment. In recent decades medical technology has developed to support very ill patients, in prolonging and maintaining life. However at what point can treatment be withdrawn or might a patient indicate they do not wish to continue therapy? What is the duty of the health professional to the patient, particularly if the patient's refusal of treatment means they will certainly die? How might an incompetent person indicate a preference to limit treatment in certain circumstances? There is often confusion associated with a patient's right to refuse treatment or establish treatment parameters and the role of the health professional following such a refusal. The source of this confusion often relates to the context in which the refusal occurs, the health professional's understanding of the law of consent, and knowledge of the relevant legal framework. For example, do patients need to be terminally ill before they can refuse treatment, must they be adult, can someone else make the decision when the patient is no longer able to communicate, what type of treatment may be refused, and is it always the decision of the health professionals? The purpose of this chapter is to clarify the acceptable legal practice in these situations, remembering that the health professional has a professional and ethical responsibility as well as a legal responsibility to ensure that any refusal or withdrawal of treatment reflects what is in the patient's best interests, including the patient's informed wishes or request.

While there is legislation in several states and territories, the scope and breadth in each jurisdiction vary considerably. Some jurisdictions allow an agent to decide for patients when they are unable to make decisions; others provide mechanisms by which patients are able to identify and record, in advance, what treatment options they refuse or accept. Some legislative frameworks require the patient to be terminally ill before identified forms of treatment can be refused. All jurisdictions allow for the appointment of a guardian when the patient is intellectually incompetent and, in some cases, physically disabled. The importance of health professionals understanding the relevant legislative frameworks cannot be overstressed, as the health professional's criminal and civil liability is protected if they act in good faith and comply with the relevant legislation.

In addition to the legislation, there are common law decisions relevant to circumstances where life-sustaining treatment is to be withdrawn from patients. The case law encompasses specific decisions relating to the withdrawal and discontinuation of treatment, including the removal of feeding tubes or artificial ventilation from patients. More recently, there has been a challenge to the precise extent to which a patient may refuse treatment. As patients assert control and establish boundaries of acceptable treatment, the legislation will be tested and presumably clarified.

REFUSAL OF TREATMENT

The most helpful manner of approaching this issue is to be aware of the common law and the relevant legislation in the state or territory in which the health professional is practising. There are differences between the various Australian state and territory jurisdictions. Not all jurisdictions have enacted legislation, for example New South Wales and Tasmania. Where this is the situation, the common law prevails. For example, in New South Wales, the Ministry of Health has formulated guidelines to assist patients and health professionals, particularly when patients are dying. These guidelines should be read in conjunction with the common law.¹

Health professionals require some understanding of the common law and existing statutory frameworks. This also requires knowledge of power of attorney mechanisms

and guardianship orders. These are discussed below. It is important to remember that this area of law is an extension of the law of consent, which fundamentally recognises the autonomy of the individual. However, it is interesting to note that not every decision emphasises the paramount significance of the individual patient's right to decide. Furthermore, research demonstrates that health professionals working in acute care settings are not expecting patients to refuse therapy and are often ill equipped to deal with the resultant dilemmas.²

ADVANCE CARE PLANNING AND DIRECTIVES

Advance care planning for end-of-life care allows patients to express their preferences for treatment should at some future point in time illness or disease renders them mentally incompetent. In recent years there is growing community support for people to be encouraged to discuss, plan and record their future therapy wishes. The underlying rationale is to ensure the autonomy and dignity of the person is maintained, allowing some control over future care should they be unable to participate in decisions. The process involves health professionals discussing with their patients what therapy, including boundaries or parameters of care, would be personally acceptable, including the limits on life-sustaining treatment. Advance care directives (sometimes referred to as living wills) are documents that allow a person to record their life goals, personal views and preferred outcomes of care. This process is encouraged to be undertaken with appropriate health professionals and family.

The focus has previously been for patients diagnosed with a chronic illness or life-limiting condition to be informed of the illness trajectory. Thus, allowing patients to know the course and nature of their condition and enabling them to record decisions around preferred care, should they become incompetent. However, in recent years advance care planning is being encouraged for healthy Australians who are anticipating a future period when they may be unable to make their own decisions. Their advance care directives are therefore written for a yet undiagnosed condition, making directions difficult to predict.

Advance directives record patient decisions in relation to a range of treatment preferences — for example, the wish not to be maintained on a life-support machine in certain situations or not to be given a blood transfusion. Advance care planning can be achieved by appointing a substitute decision maker and/or completing an advance care directive. Despite advance care planning and directives being utilised in Australia, every state and territory identifies them with different names and whilst they are considered to be recognised under the common law, there are differing statutory schemes in each state and territory, which only serves to confuse.³ In an attempt to clarify the varying language and necessary considerations, in 2011 the Australian Health Ministers Advisory Council published a comprehensive set of guidelines to assist planning, titled 'A National Framework for Advance Care Directives'.⁴ Nevertheless, those jurisdictions with a statutory scheme usually require the individual's advance directions to be in a prescribed format, requiring specific criteria, such as the presence of witnesses. Should the statutory requirements not be adhered to, the directive or appointment may be considered invalid at law, therefore it is important for health professionals to familiarise themselves with their specific state or territory statutory scheme. Refer to the legislative framework of each jurisdiction, below.

At common law there is no specified document or form, and the advance care directive can be given verbally or in writing. However, for clarity and evidence it is advisable that the advance care directive be written. The key requirements to be fulfilled at common law are threefold. First, the patient must be competent at the time the advance care directive was made (see Chapter 6). Secondly, the advance care directive must have

been intended to apply in the circumstances that have arisen. Broad statements or vague instructions may not provide sufficient guidance for health professionals. Thirdly, there must not be evidence that the patient was coerced or unduly influenced at the time the advance directive was made. The directive must reflect the patient's decision and wishes regarding care. Patients can revoke an advance care directive at any time, while they are competent. The very nature of the directive is to continue when the patient loses competence and for this reason it is imperative that the patient's instructions are clear and considered. Moreover, the advance care plan and directive need to be readily accessible, should the person be admitted to a hospital for care unexpectedly. Family members should be aware of who has been appointed as a substituted decision maker and where to locate the advance care plan. Despite the introduction of various programs to assist with advance care planning, there remain many settings where discussion and responses to patient and families' wishes are limited or impeded.⁵ Health professionals are therefore encouraged to discuss with patients their wishes and expectations regarding care and utilise the existing state and territory legislative requirements.

STATES AND TERRITORIES WITH LEGISLATIVE FRAMEWORKS

Victoria

The title 'Options for Dying with Dignity' was the name given to a Victorian parliamentary committee in the mid-1980s, formed to consider the rights a patient had in relation to refusing medical treatment. The result was the enactment of the Medical Treatment Act 1988. This Victorian legislation established two mechanisms that allow patients to refuse treatment. The first mechanism — in Schedule 1 of the Act — allows a person to refuse treatment using a refusal of treatment certificate. The features of this instrument require the person to identify the 'specific' area of treatment (such as antibiotics) they intend to refuse or, more broadly, treatment in 'general' may be refused. The patient's refusal of treatment should relate to treatment of a 'current condition' that must be identified by a medical practitioner. For example, a fractured femur may be a current condition, and the certificate would relate to treatment for that condition. Effectively, the patient returning for treatment with a different 'current condition' would need to have their wishes regarding treatment ascertained anew.

The common law principles of consent have been incorporated into the certificate. Therefore, the patient's decision to refuse treatment must be made voluntarily. The patient must be competent — that is, of sound mind, and at least 18 years of age. The certificate requires the signature of two witnesses. One must be that of a medical practitioner and both witnesses must be satisfied that the aforementioned criteria have been met. The Act is intended to allow individuals to clarify their wishes in relation to treatment and includes a section making it an offence for medical practitioners to continue to provide treatment once the certificate is signed. The sanction under the Act for non-compliance amounts to a fine. This penalty has never been invoked, and where a doctor is acting in good faith, without the knowledge of the certificate, the conduct will not be subject to the fine. It appears that a health professional, other than a doctor, who provides treatment against the patient's wishes would not be subject to the fine. However, there has been no judicial interpretation to date. In any event, such conduct may constitute an action in trespass should any other health professional provide treatment without the patient's consent.

The second mechanism established by the Victorian legislation allows a competent adult (the donor) to appoint an agent to make decisions on their behalf. This document

takes the form of an enduring power of attorney and when used in the context of refusal of treatment is called an ‘Enduring Power of Attorney (Medical Treatment)’ (Schedule 2 of the Act). This instrument generally does not come into effect until the donor loses their legal competency. At that stage, the agent may produce the Enduring Power of Attorney (Medical Treatment) and make decisions in relation to the medical treatment of the donor. The legislation defines ‘medical treatment’ as an operation, the administration of a drug or other like substance, or any other medical procedure. It is unclear how broadly this definition would be construed by a court. For example, would the action of a nurse or physiotherapist amount to a medical procedure if it was carried out at the express direction of the doctor? The definition fails to provide clarity in response to precisely what treatment amounts to medical treatment. In practice, the boundaries of treatment provided by a range of health professionals are often seamless. For this reason, it is considered prudent to include in the definition all care provided by health professionals as well as medical practitioners.

In order to execute an Enduring Power of Attorney (Medical Treatment), the donor must be legally competent and must choose the agent who will make decisions on the donor’s behalf. When choosing an agent, it is important that the donor trusts the agent to carry out the donor’s wishes and that the agent respects the beliefs of the donor. To assist the agent in understanding the donor’s views about possible medical treatment, the Office of the Public Advocate suggests that donors write this information down and give it to the appointed agent. The agent’s power extends to providing consent to treatment and refusing or withdrawing consent to medical treatment (Schedule 3 of the Act allows an agent or guardian to refuse treatment on behalf of the incompetent patient). The agent can only refuse treatment if the treatment would cause the donor patient unreasonable distress or the agent believes, on reasonable grounds, that the donor would not want the treatment to continue. A competent donor can cancel a medical enduring power of attorney at any time. If there is reason to believe that the agent is not making decisions as the donor intended or is abusing their power, the Guardianship and Administration Board may revoke or suspend the power of attorney.

The legislation does not permit a person to refuse palliative care, which is defined widely to include ‘the provision of medical procedures for the relief of pain, suffering and discomfort or the reasonable provision of food and water’. Clark⁶ argues that this is unworkable as it remains unclear what ‘reasonable’ may include. For example, does it include the insertion of an intravenous infusion or a nasogastric or gastroscopy tube to provide fluid to a patient? It could be argued that this definition does not necessarily create problems for the health professional as the basic philosophy of palliative care is to respect the wishes of the individual patient. Thus, a patient may specify that there will be no invasive procedures such as a nasogastric tube once they can no longer take fluid orally.

Is it ‘medical treatment’ or ‘palliative care’?

A case in Victoria provides some clarity regarding the meaning of specific terms used in the Medical Treatment Act 1988 (Vic). Ultimately, this should assist patients and their agents or guardians when making decisions relating to certain forms of treatment. In *BWV*,⁷ a woman suffering from Pick’s disease (a rare and progressive dementia) had a percutaneous endoscopic gastrostomy (PEG) tube inserted, to provide her with food and hydration. The PEG had been inserted for some 5 to 7 years, but by 2002 she had deteriorated to the extent that she was unable to communicate, move or take any food or fluid orally. She had no cognitive capacity and medical opinion agreed that there was no prospect for improvement or recovery. Her husband made an application to the

Victorian Civil and Administrative Tribunal (VCAT) to be appointed as her guardian, as she had not appointed an agent or enduring guardian when she was still competent. He wanted the authority to complete a refusal of treatment certificate to have the PEG tube removed, which would result in her eventual death. VCAT appointed the Public Advocate as guardian, given the significance of the decision. The Public Advocate, realising the legal consequences of such a decision, applied to the Supreme Court of Victoria seeking a declaration (an authoritative pronouncement by a superior court) that: (1) the provision of nutrition and hydration via the PEG constitutes ‘medical treatment’ within the meaning of the Act; and (2) the refusal of nutrition and hydration to BWV via the PEG constitutes a refusal of ‘medical treatment’ rather than ‘palliative care’, within the meaning of the Act.

Mr Justice Morris indicated that it was the court’s role to interpret the Act as parliament had intended. In so doing the aims of the Act and the underlying objects of the Act would be preferred, and these could be gained from reports of parliamentary proceedings and any relevant parliamentary committees. The Act defines ‘medical treatment’ and ‘palliative care’ in s 3 as follows:

‘Medical treatment’ means the carrying out of:

- (a) an operation; or
- (b) the administration of a drug or other like substance; or
- (c) any other medical procedure — but does not include palliative care.

‘Palliative care’ is defined as:

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

There is some overlap between these definitions and it was unclear whether the provision of nutrition and hydration via a PEG tube constituted ‘medical treatment’ or ‘palliative care’. According to the Act the former (medical treatment) can be refused while the latter (palliative care) cannot be refused.

The court decided that the use of a PEG, or any form of artificial feeding, constituted a medical procedure. His Honour reasoned that this was the case because ‘artificial nutrition and hydration involves protocols, skills and care which draw from, and depend upon medical knowledge’ and must be subject to regular medical and nursing supervision.⁸ His Honour also noted that the Osmolite, the nutritional substance administered via the PEG, was ‘intended to provide complete and balanced nutrition, without the need for any food whatsoever’.⁹ The court then considered whether the provision of artificial feeding in this manner also amounted to palliative care. Morris J considered that the definition of palliative care, within the context of the Act, was to mean ‘care, not to treat or cure a patient, but to alleviate pain or suffering when a patient is dying’.¹⁰ His Honour reasoned that the administration of hydration and nutrition via a PEG could not amount to palliative care as this is a procedure ‘to sustain life, it is not a procedure to manage the dying process, so that it [death] results in as little pain and suffering as possible’.¹¹

The court concluded that:

the intention of Parliament, in excluding the provision of food and water from the concept of medical treatment, was to ensure that a dying person would have food and water available for oral consumption, if the person wished to consume such food or water. It can hardly have been the Parliament’s intention that dying patients would be forced to consume food and water.¹²

The reference to the provision of food and water was intended to apply to the ordinary, non-medical provision of food and water.¹³

Morris J also noted that there was a greater need to protect in those situations where the decision to refuse medical treatment was being made by an agent or guardian. He noted that the Act provided several safeguards including the formal process to appoint an agent (Schedule 2), the requirement that the agent be sufficiently informed about the patient's current medical condition, the need for formal execution of a refusal of treatment certificate by the agent or guardian (Schedule 3) and the fact that the VCAT has the power to review such decisions. Moreover, s 5B(2) of the Act allows the agent or guardian to complete the refusal of treatment certificate only if the medical treatment would cause unreasonable distress to the patient or there were reasonable grounds for believing that the patient, if competent and fully informed of their current medical condition, would consider the treatment unwarranted. This decision relies on some evidence of the previously expressed wishes of the patient. This is a welcome decision for the practice of many health professionals as it provides much-needed clarity regarding interpretation of the existing legislation. This decision should facilitate the provision of clearer policies and guidelines available to health professionals in all healthcare facilities throughout Victoria.

Refusal of a blood transfusion — when the legislative framework is not strictly followed

The case of *Qumsieh*¹⁴ highlights the limitations to upholding a clearly expressed wish of a patient not to receive specific life-saving treatment when that patient becomes incompetent. The case also emphasises the need to adhere to the legislative requirements of the particular jurisdiction when refusing treatment. Mrs Qumsieh was a 20-year-old Jehovah's Witness who was admitted to hospital for the delivery of her first child. On admission, she signed the hospital's consent to 'operative treatment and anaesthetic' form, which she later amended to read that she specifically did not consent to having a blood transfusion or being transfused with other blood products. The staff treating the patient were aware of her wishes.

After delivery of her baby, Mrs Qumsieh haemorrhaged and her condition deteriorated. A radical hysterectomy was performed and she was transferred to the intensive care unit of another hospital. When the patient's condition began to decline, her husband produced to medical staff a document called an 'Advance Medical Directive'. This document had been signed by Mrs Qumsieh some 5 weeks earlier. The document directed that 'no blood transfusions ... be given to me under any circumstances'. Four days after the delivery of the baby, Mr Qumsieh sought legal advice, informing his solicitor that although he and his wife were Jehovah's Witnesses he wanted her to be treated. Mrs Qumsieh had not completed a refusal of treatment certificate or an enduring power of attorney pursuant to the Medical Treatment Act 1988.

An urgent hearing was arranged before the Guardianship and Administration Board, which was informed of the patient's refusal of blood products. The board accepted evidence that the patient was unconscious and artificially ventilated, and there was only an hour or so before irreparable brain damage would occur. The board was satisfied that the patient did have a 'disability' within the meaning of s 3 of the Guardianship and Administration Act 1986, in that she was unable to make reasonable judgments in relation to matters concerning her. The board was also satisfied that there was an urgent need for a blood transfusion, which was a decision for the Public Advocate or a delegated guardian. The board was not informed as to why the patient refused the blood transfusion nor was the advance directive produced.

The board noted that there was no evidence before it that Mrs Qumsieh did not want a guardian appointed to make healthcare decisions outside her wishes, which she had expressed in the consent to 'operative treatment' form. The board observed the consent form was limited to procedures performed while under an anaesthetic and made an order pursuant to s 32 of the Guardianship and Administration Act 1986, which enables a person to apply for a temporary order to appoint a guardian. The Public Advocate was appointed. Mr Qumsieh successfully requested that he be appointed as the delegated guardian of the Public Advocate. The instructions of the temporary guardianship were conveyed to the hospital and the transfusions were given. Mrs Qumsieh responded to treatment and was discharged about 1 week later.

Mrs Qumsieh applied to the Supreme Court of Victoria for a review of the board's temporary guardianship order, which had lapsed or been revoked. Beach J declined to review the guardianship order. Mrs Qumsieh then appealed to the Victorian Court of Appeal, arguing that in light of the evidence of her refusal to consent to the transfusion of blood products, made when she was legally competent, the Guardianship Board did not have jurisdiction to make an order based on her disability at the time the application was made. The court held that the board was only required to ensure that the relevant section, s 32 of the Act, applied and that the earlier direction of Mrs Qumsieh did not influence the board's decision.

Additional argument was made that the board should have inquired further into the specific circumstances of her refusal of treatment. The court held that the urgency of the matter dictated that it was not appropriate for the board to make such inquiries, given the change in circumstances from the time she had signed the advance directive and the time the board was asked to make an order. Moreover, the court accepted the fact that the board had not authorised the transfusions, but had merely appointed a guardian to make whatever decision the guardian considered appropriate. Mrs Qumsieh then sought special leave to appeal to the High Court. However, her application for special leave to appeal was rejected in February 2000. The only manifest outcome from this case for individuals who want to make decisions regarding treatment is the absolute necessity to adhere to the specific legislative requirements. It has been suggested that the Guardianship and Administration Board may have erred in making the order which was upheld by the Court of Appeal. Effectively, the reasoning in *Qumsieh* allows for a competent person's wishes to be overridden as soon as they lapse into unconsciousness because they are suffering from a disability (in this case, an intellectual impairment) and a guardian may then be appointed to make a treatment decision.¹⁵

The *Qumsieh* case raises a number of issues. The patient may have thought that she had made her wishes clear. However, the lack of compliance with the Victorian Medical Treatment Act 1988, in that she had not successfully appointed an agent or completed a refusal of treatment certificate, appears to have thwarted her intention. The use of a document labelled 'Advance Medical Directive' was not discussed by the board and its legitimacy therefore remains unclear. Although specific legislative requirements exist in most jurisdictions, it is understandable that a court or tribunal may err in favour of the statutory requirements rather than place reliance on an unauthenticated document. Another issue to consider is the situation had Mrs Qumsieh appointed her husband as an agent. What would occur if he had made a decision that was inconsistent with his wife's directions? Would he be removed as the agent? Probably not, because her unequivocal wishes could only be verified after she regained consciousness, a fact which only highlights the difficulty of the predicament. Despite the

fact that the patient had attempted to make her wishes clear — she amended the consent form, in addition to writing her wishes in the ‘Advance Medical Directive’ — the courts were reluctant to use the opportunity to provide clarification of the law that espouses a patient’s right to refuse treatment. From a health professional’s perspective, this is most confusing and serves to remind professionals of the importance of understanding the specific legal and policy requirements applicable in the state or territory in which they practice.

Northern Territory

The Natural Death Act 1988 in the Northern Territory allows legally competent adults who have a terminal illness to refuse ‘extraordinary’ measures. ‘Extraordinary’ treatment or procedures include medical or surgical measures that prolong life by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation. The regulations set out the prescribed form required to document an individual’s wishes. The individual may refuse ‘extraordinary’ treatment and procedures generally or specify the particular ‘extraordinary’ treatment and procedures they wish to refuse. Two witnesses must sign the certificate; neither may be the medical practitioner responsible for the treatment of that person. The Act specifies that the withdrawal of, or the non-application of, the ‘extraordinary’ measures to a person with a terminal illness does not constitute a cause of death when made in accordance with a direction of the patient.

South Australia

The newly introduced Advance Care Directives Act 2013 (at the time of writing the Act was not fully in force) provides the broadest scope of decision making capacity for competent adults. This legislation is the first enacted since the Health Ministers’ National Framework for Advance Care Directives (2011) attempted to identify the use of consistent language and make advance care planning available to everyone, not just people planning end-of-life care. The new South Australian Act allows adults to give directions and express their wishes in relation to their future healthcare, residential and accommodation arrangements, and personal affairs, as well as the ability to appoint substitute decision makers. The Act applies to decisions not just at the end of life or when suffering from a terminal illness, which was the case in previous South Australian legislation, but at any time. Furthermore, there are guiding principles which must be taken into account in connection with the enforcement and administration of the Act (s 10). For example, a person wishing to make an advance care directive can indicate specific or general wishes in relation to future care but also express what constitutes ‘a quality of life’ for him or her. This allows for specific variation in an attempt to consider decisions from the individual’s perspective. The advance care directive cannot provide directions for any unlawful act (see s 12), such as voluntary euthanasia.

In a bid to reduce the legal ease and involvement of lawyers, the Act allows for the appointment of one or more substitute decision makers (this is not a power of attorney) who can make decisions, or assisted decisions at an appointed date, or when the adult becomes incompetent (see ss 21–24). In addition, anyone who might be considered to have a conflict of interest cannot be appointed; for example, an individual who is a paid carer, or a health practitioner who has sole care of the person giving the advance care directive (see s 21). A limit is set in relation to some decisions, for example, a substitute decision maker cannot refuse the provision of food and fluid by mouth or medication to relieve pain (see s 23(4)).

Interestingly, the Act places obligations on health practitioners to recognise and give effect to the advance care directive or substitute decision maker and this does not just apply to medical staff, but anyone who is recognised under the national registration laws, such as nurses and psychologists (see Chapter 12 for a comprehensive discussion of registered health practitioners).

There will be a prescribed advance care directive form¹⁶ and particular certification requirements of witnesses who must be satisfied the person making the directive understands what they are doing, what is contained in the directives and there is no coercion or fraud. Witnesses must certify that they believe that the person giving the advance directive understood the information and explanation, and that person was not acting under any duress or coercion. There is also a section which addresses the facilitation of any disputes relating to advance care directives or decisions. The Public Advocate may mediate a matter or the matter may be referred to the Guardianship Board or the Supreme Court (see ss 45–52).

Australian Capital Territory

In the Australian Capital Territory, the Medical Treatment Act 1994 permits competent adults to refuse medical treatment. The refusal may be communicated orally, in writing or in any other way the person is able to communicate. When the refusal of treatment is not in writing, a direction must be witnessed by two adults with one signatory being a medical practitioner. Provision is made in the Act for a person to provide a written direction. This must be in the format (Form 1) prescribed in the Schedule. The requirements are similar to those in the Victorian certificate in that the fundamental principles of consent are highlighted and the signatures of two witnesses are required. The direction to refuse treatment does not have to relate to a current condition, as is the requirement in Victoria.

The Act defines palliative care in a similar manner to the Victorian legislation. However, instead of restricting an individual's right to refuse palliative care, it specifically excludes palliative care. The Act does not affect any right, power or duty to provide palliative care. Thus the provision of palliative care remains the responsibility of the health professional. Effectively, this would not allow a person to refuse the reasonable provision of medical and nursing procedures for the relief of pain and suffering or the reasonable provision of food and fluid.

The Act places the onus on the health professional to take reasonable steps to ensure that the person has been informed about the nature of the illness, alternative forms of treatment and the consequences of treatment or of a failure to treat. The Act specifies that the health professional should not follow a person's direction to refuse or withdraw treatment unless the health professional believes the person has understood the information regarding the illness and has weighed the options. A health professional is defined to include both medical practitioners and registered nurses. The legislative framework places greater onus on the health professionals to be certain that, before responding to the person's wishes to refuse treatment, all relevant information is discussed. Moreover, the health professional is not to proceed if the professional believes the direction to withdraw or refuse treatment does not comply with the Act or the person has changed their mind. The Act allows for the granting of a medical power of attorney, as provided in Form 2. The requirements are similar to other medical powers of attorney.

Queensland

A mechanism to allow for advance directives and the appointment of a statutory health attorney or an enduring power of attorney (personal and/or financial) was formalised in

the Powers of Attorney Act 1998. The Act allows a competent adult to give an advance directive regarding 'health care' and 'special health care'. The advance directive allows the principal (donor) to give directions and information relating to healthcare and also allows the principal to appoint one or more people to exercise powers to consent to future health treatment or, in specified circumstances, to withhold or withdraw life-sustaining treatment. The adult must understand the nature and effect of each directive and the directive operates only while the person is incompetent. 'Health care' is defined broadly to include treatment and procedures to diagnose and treat the person's condition and excludes first-aid treatment, the administering of non-prescription drugs and non-intrusive diagnostic examinations. 'Health care' includes care, treatment and procedures to maintain or treat the principal's (donor's) physical or mental condition and also includes the withholding or withdrawal of life-sustaining measures. 'Special health care' is defined to include more precise situations such as removal of organs for donation, sterilisation, termination of pregnancy and participation in research and experimental healthcare.

The directive to withhold or withdraw life-sustaining measures is dependent upon the application of specific conditions and criteria. An advance directive can only operate when the person:

- 1 has an illness that is incurable or irreversible and is likely to die within 12 months; or
- 2 is suffering a persistent vegetative state; or
- 3 is permanently unconscious; or
- 4 suffers an illness of such extreme severity that there is no chance of recovery.

In addition, the directive to withhold or withdraw life support must be considered good medical practice in the circumstances and the person to whom it applies must have no reasonable prospect of regaining capacity. 'Good medical practice' is defined to include regard to recognised medical practices and ethical standards of the medical profession in Australia.

The Act provides for an adult of sound mind to appoint an enduring power of attorney (personal) to make decisions in relation to healthcare. The Act provides for the appointment of one or more attorneys who may act jointly or severally. As with other medical powers of attorney, the document comes into effect when the donor loses their legal capacity. The Queensland Act also recognises lawful medical powers of attorney made in other jurisdictions.

The attorney may make decisions, as in other jurisdictions, including the power to exercise an advance directive for healthcare in the event that the patient's directions are inadequate. However, the Act specifically excludes an attorney making decisions in the event that the patient's advance directive is unclear and relates to 'special health care'. Instead the Act provides some guidance as to who may make decisions on behalf of an incompetent adult. If, in an advance directive for 'special health care' and 'health care', an adult has provided a clear explanation of the desired treatment they expect, then it is lawful. The directive is taken as if the patient had given it at that time. If an agent has been appointed under an enduring power of attorney (personal) and there is no advance directive, then the agent may provide the consent, except for 'special health care' as mentioned above.

In the absence of an advance directive or the appointment of an enduring power of attorney (personal), the right to consent to the treatment of the incompetent adult is deemed to vest in the non-paid primary carer. This person is referred to as the 'statutory health attorney'. The Act refers to a spouse, an adult who has the care of the patient, a close relative or the adult guardian, as people who may be eligible statutory health

attorneys. Moreover, in the absence of a lawful agent or advance directive, a health professional is given authority without a consent to provide care that is minor and uncontroversial, provided it is necessary to promote the adult's health and wellbeing and the health professional is unaware of any objection to the contrary. Minor and uncontroversial treatment is not defined in the Act.

Western Australia

Legislation was introduced in 2008. The Acts Amendment (Consent to Medical Treatment) Act (WA) amends the existing Guardianship and Administration Act 1990 (WA). Individuals can now appoint an enduring guardian (enduring power of guardianship) using a prescribed form. Witnesses must sign the form at the time of the appointment. More than one individual can be appointed and they are called 'substitute enduring guardians'. Decisions can be made to consent to or refuse consent to medical or surgical treatment, including life-sustaining measures. The patient may record directions about how the enduring guardian is to perform any of their functions. As with other jurisdictions the Administrative Tribunal has the power to intervene, consider decisions and revoke the enduring guardian's power should decisions not be in the patient's best interests.

The legislation makes provision for advance health directives, again in a prescribed form, and the patient is advised to seek medical or legal advice. A treatment decision in an advance directive operates only in the circumstances specified in the directive. The legislation expressly indicates the matters to be considered in relation to the directive before it is acted on. These include the person's age at the time the advance directive was made and the period of time that has since elapsed. Other people may be consulted regarding the directive, presumably to confirm the person's wishes, from an enduring guardian, to the person's spouse or de facto, the primary carer or child, parent or sibling, in that order.

New South Wales and Tasmania

New South Wales and Tasmania rely on guidelines and the common law. The New South Wales Ministry of Health has published guidelines for end-of-life care and decision making.¹⁷ The guidelines address a range of issues including the importance of collaboration between the patient and the treating healthcare team. When the patient is incompetent, the guidelines recommend that the treating team and family draw on existing knowledge of the patient's personal values and medical condition for shared decision making. Palliative care should be continued and this includes controlling pain and providing emotional and psychological support. The guidelines also highlight that, regarding the reasonableness of the therapy plan, accountability for decisions rests with the senior clinician. The guidelines deal with assessment, disclosure, discussion and consensus regarding treatment decisions and care plan. There is also specific mention of artificial hydration and nutrition and 'not for resuscitation' decisions, allowing artificial hydration and nutrition to be withheld. Children between the ages of 14 and 18 years should not solely make decisions limiting treatment; the guidelines state that this should be in conjunction with family and health professionals. The New South Wales Ministry of Health recommends that health facilities develop policies in keeping with the guidelines.

In addition, NSW has released guidelines to direct health professionals in the use of advance care directives.¹⁸ The guidelines recommend that before an advance directive has sufficient authority it must satisfy at least three criteria. The directive must be *specific*;

it must be clear the direction applies to the clinical circumstances that arise and provide adequate guidance as to care. The advance directive must be *current*, in so far as it must reflect the current wishes of the patient. The guidelines state that the directive should be reviewed periodically, particularly after an illness or change in health status. The person must be *competent* to make the directive; this includes appearing to comprehend, retain and weigh the relevant information. The guidelines suggest that it is not essential the document be witnessed, but recommend that this be undertaken. There is no precise format for written advance directives, although the guidelines provide information about organisations where they can be obtained.

Tasmania does not have a separate legislative framework in relation to refusal of treatment decisions and advance directives; hence the common law applies. The guardianship legislation (discussed below) does, however, allow for the appointment of an enduring guardian who can make decisions regarding treatment when the patient is unable to by reason of disability.

Revocation and limits of a decision regarding treatment

It is important to note that, regardless of the legislative or policy frameworks within Australia, an individual patient can withdraw their refusal to treatment or change their mind at any time. In addition, none of the mechanisms allow for care that is unlawful to be provided. For example, a patient could not provide an advance directive, or delegate power to an agent, that provided for the suffocation of that patient as soon as they became incompetent, as this would amount to unlawful homicide. Patients and agents must operate within the boundaries of what is considered in the particular circumstances ‘reasonable care’ and in the patient’s ‘best interests’ although this may well include the withdrawal of life support.

Suicide

The common law recognises that there are sometimes circumstances where it is legitimate to override a competent patient’s decision to refuse treatment or self-harm. Despite the fact that suicide and attempted suicide are no longer crimes, five jurisdictions have made provision in their crimes legislation relating to this area. The legislation provides that it is not an assault or battery to restrain or attempt to prevent a person from committing suicide.¹⁹ The expected practice for health professionals in Australia is to provide emergency treatment to preserve life.

Where a patient is mentally ill, the mental health legislation in some states allows for certain classes of individuals to intervene and detain a person who is suicidal. A recent High Court case¹⁷ examined the extent of that responsibility. The Victorian mental health legislation provides police officers with the statutory power to apprehend a mentally ill person if they reasonably believe that the person has recently attempted suicide or is likely to attempt suicide.²⁰ The case involved two police officers who found a man, Mr Veenstra, in his car at a beachside car park with a hose leading from the exhaust pipe to the interior of his vehicle. The car engine was turned off and Mr Veenstra was sitting in the car with the window down. The officers spoke with him for some 15 minutes and offered him assistance, which he declined. Mr Veenstra stated that he had been contemplating ‘doing something stupid’, but had changed his mind and informed the officers that he would return home and talk to his wife. Later that same day at his home, Mr Veenstra committed suicide.

The court was required to consider whether the police officers were in breach of their duty and should have apprehended him at that time. The High Court observed

that the mental health legislation required two conditions to be satisfied. First, the person must ‘appear to be mentally ill’ — the definition of mental illness is characterised as a ‘significant disturbance of thought, mood, perception or memory’. The statutory power required the police officers to make an assessment in the circumstances, but they were not required to exercise clinical judgment. The court found that the officers’ observation and interactions were sufficient for them to determine that Mr Veenstra was not mentally ill. The court also highlighted that there is no proposition at common law that attempted suicide or suicide gives rise to a presumption of mental illness. The second condition necessary before the power to apprehend would be satisfied focuses on the officers’ belief that Mr Veenstra was likely to attempt suicide. The court noted that Mr Veenstra’s responses to the officers was rational and cooperative, and this supported their belief that he was not likely to attempt suicide in the near future. The court held that neither of the two conditions were satisfied and the officers were not obliged to exercise the statutory power provided. The case highlights the court’s reluctance to impose a duty on the police officers. It remains unclear, however, how those experienced in mental health would be assessed.

No statutory scheme, or relevant documentation — common law application for competent patients

There are Australian cases which support the right of a competent person to refuse treatment. Where no legislative framework exists or the person has not completed the relevant documentation, then the common law of consent applies. In *Re PVM*,²¹ a 39-year-old man who suffered severe brain and spinal injuries, requested cessation of his artificial ventilation. Concerns were raised regarding his competence. However, the Queensland Guardianship and Administrative Tribunal found that he was competent. Upon establishing his competence his request to remove the ventilator was respected.

In *Brightwater Care Group v Rossiter*,²² a competent male quadriplegic requested that his hydration and nutrition feeding via his endoscopic percutaneous gastrostomy tube (PEG) be removed. He repeatedly instructed his carers to remove the PEG tube stating that it was keeping him alive and that he did not want it, indeed he wanted to die. The Supreme Court of Western Australia recognised that the common law grants a right to self determination which includes a right to refuse feeding. The court held that provided a medical practitioner provided an explanation of the consequences of ceasing such care, he could refuse the treatment. The court focussed on establishing if Mr Rossiter was mentally competent to arrive at his decision. This was confirmed by several medical experts. The court also highlighted that the healthcare facility would not be criminally responsible for any consequences. The tube was removed and Mr Rossiter later died of a chest infection.

If the patient is incompetent, then a guardian could be appointed by a guardianship board to make decisions on their behalf. Why then are statutory schemes enacted in most states and territories? Establishing mechanisms to specify treatment wishes, or provide for the appointment of an agent/medical attorney, allows the competent person to choose who will make decisions and what type of treatment decisions will be made on their behalf should they be incapacitated. When a guardianship board appoints a guardian to make decisions, the now incompetent patient is frequently not in a position to request a specific individual, nor are their wishes often known. There is the added advantage that when a competent person has utilised the existing statutory schemes and appointed a medical attorney or made their wishes clear regarding treatment, there has been, in all likelihood, a discussion whereby personal beliefs,

values and limits of treatment have been considered and communicated. An incompetent individual who has not addressed such issues frequently has no influence on their subsequent care.

POWER OF ATTORNEY

A power of attorney is a legal document that enables an individual (the donor/principal) to give authority to another individual (the agent/attorney) to make decisions or take control of business affairs on the donor's behalf.²³ This is sometimes referred to as substitute or proxy decision making, where decisions regarding the patient are made by another person. There are different types of power of attorney and a donor must have legal capacity — that is, have attained 18 years of age and be of sound mind. Generally, a power of attorney allows the donor to appoint an agent to make business decisions on their behalf. This includes matters such as banking and signing contracts on behalf of the donor. The power of attorney lapses if the donor loses legal capacity. In most states, an enduring power of attorney is similar to a power of attorney in that it pertains to the business affairs of the donor. In Victoria, for example, recent changes to the legislation enable the donor to limit or place conditions on the power the attorney may exercise. The legislation also requires the attorney to keep accurate records and accounts of all dealings and transactions made under the power.²⁴ An enduring power of attorney is suitable for an individual who has a medical condition where deterioration is foreseeable. The agent/attorney is able to take responsibility for handling the business affairs of the donor. Because of the significance of the agent/attorney's power, the donor must choose the attorney carefully.

Enduring power of attorney medical treatment/medical power of attorney

The enduring power of attorney mechanism was adopted to allow for decisions to be made in the healthcare environment. A medical treatment enduring power of attorney allows an individual (the donor) to appoint someone (the agent or attorney) to make decisions related to medical treatment when the donor is unable to do so. This type of enduring power of attorney is specific to medical treatment and does not include decisions regarding business affairs. In some jurisdictions, this enduring power of attorney is called a 'Medical Power of Attorney'. This type of power of attorney document is like the enduring power of attorney medical treatment, referred to above, and must be completed by the donor who appoints an agent or attorney. The agent will make decisions regarding medical treatment on behalf of the incapacitated donor. This type of power of attorney usually applies only to medical treatment and does not include the authority to handle the business affairs of the donor. As with all powers of attorney, the donor can revoke the power at any time, provided they are legally competent. The requirement for witnesses applies to all powers of attorney. In most situations, one witness must be eligible to sign a statutory declaration and the witnesses must not be the appointed agent. Should the agent be considered not to be acting in the best interests of the patient then the courts or guardianship boards may remove the agent or attorney. It is important that health professionals are aware of the different types of powers of attorney in the state or territory in which they practise. For example, in Victoria a person may complete an enduring power of attorney and an enduring power of attorney medical treatment. These documents confer on the agent/attorney very different powers and it is not uncommon for patients and their families to be less than clear as to the breadth and depth of these powers.

The parents of a Down syndrome infant, suffering intestinal obstruction, refused to consent to life-saving surgery. A civil action was brought by the local authority to dispense with the parents' objections to surgery. The case was decided based on an examination of what was in the 'best interests' of the child. The court overrode the parents' wishes. It was held that following the operation the infant would live the normal life span of a Down syndrome infant, and it was thus in the infant's 'best interests' to be treated. However, Lord Justice Templeman did refer to the possibility of allowing an infant to die when he said:

At the end of the day it devolves on this Court ... to decide whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die. There may be cases, I know not, of severe proved damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court may be driven to a different conclusion.⁵²

In *Re C (a Minor)*,⁵³ it was argued that a defective infant would die within weeks or months even if it did receive treatment. The court pointed out that it was better to provide intravenous fluids for dehydration, or antibiotics for pneumonia, in addition to nursing care, rather than let the infant suffer. The case is notable because the court acknowledged the practice of managing some defective neonates towards their deaths. The court highlighted that treatment should be provided to make them comfortable, yet it recognised the futility of continuing to treat at all costs.

In *Re J (a Minor)*,⁵⁴ a premature infant, born not breathing, was placed on a ventilator which he intermittently required for some months. He suffered frequent convulsions and apnoeic attacks. Ultrasound scans showed a large area of fluid-filled cavities where brain tissue should have existed. His life expectancy was considered to be severely reduced, at most into his teens. The Official Solicitor acting as J's guardian *ad litem* sought an order that the relevant health authority continue to treat the infant with the object of sustaining and preserving his life. The court had to decide whether it was in the best interests of the infant to artificially ventilate him if at some time in the future he was unable to breathe spontaneously. The treating doctors recommended against this, stating such continued care would cause the infant distress and may risk further brain damage. The Court of Appeal held that in view of the infant's condition further efforts at resuscitation should not be attempted. The court's decision recognised that continued medical intervention was not warranted in all cases.

The Australian position

There are few Australian cases that provide guidance. In the case of *Re F; F v F*,⁵⁵ the grandfather of an infant born with spina bifida sought a court order to force the hospital to continue to provide nursing care. It was alleged that the infant's life was jeopardised as he was sedated and sustenance had been withdrawn for the purpose of permitting death. It was also alleged that the infant required prompt surgery to the spinal lesion as his life was at risk. Vincent J noted that in the absence of supporting medical evidence he could not order the surgery. However, Vincent J did order the hospital to follow proper medical practice and take all necessary steps to preserve the infant's life. This, he considered, included the provision of basic hydration and nourishment. His Honour added that a deliberate course of treatment that pursued an outcome of death may well result in criminal charges of the most serious kind.

The views expressed in *Re C* and *Re J* find some support in the Victorian case of *Re Baby M*.⁵⁶ A coronial inquiry was held into the death of an infant born with spina bifida and severe mental and physical defects. During the 12 days she lived, various medical

specialists assessed the infant and a decision was reached not to undertake corrective surgery on the basis that her condition was irreversible and that immediate surgery would not affect her current state. She was provided nourishment on demand only, and was ordered analgesic and anticonvulsant medication.

The coroner distinguished this case from *Re F*, noting that Vincent J made an interim order that the infant be given sustenance and that no medical evidence was actually heard. The coroner pointed out that his Honour was concerned to impress upon the hospital the meaning of the law, in limited circumstances, regarding the feeding of a spina bifida infant. Conversely in *Baby M's* case, the issues were multiform, concerning her medical condition, treatment and prognosis.

The coroner stated that the accepted Australian standard is to leave decisions relating to the management of infants born with gross congenital malformations to the parents and physicians together. Furthermore, the coroner's findings in relation to the drug regime were that, rather than bringing about her death, it was appropriate and achieved the goal of easing the baby's suffering, albeit with a degree of sedation. It could be argued that this view tends to ignore the fact that the sedated infant's natural instinct to feed on demand is somewhat reduced, arguably hastening death.

The coroner was requested to provide guidelines in relation to the non-treatment of defective neonates. She refrained from doing so, noting the following issues:

- 1 historically governments have been reluctant to intervene in private decision making between parents and doctors, and a mature community should have confidence in and support this process; and
- 2 if guidelines were created, they may inhibit rather than enhance good decision making in a particular case, and may be subject to a challenge in the courts.⁵⁷

The cases demonstrate that courts recognise there is a duty of health professionals generally to provide treatment and that parental rights may be overridden in such circumstances. It is unclear precisely what type of treatment is expected. However, there is some support for the view that basic sustenance should be provided, and a drug regime that alleviates pain and suffering is acceptable. The courts have difficulty in providing clear guidelines of acceptable medical and nursing practice and are hesitant to do so, possibly because individual cases, including treatment, can differ widely. Nevertheless, there is a clear lack of judicial authority in this area, as the cases, particularly in Australia, are few in number and, with the exception of *Re F*, have not been heard in superior courts. Thus, the law as it currently stands may render a health professional guilty of homicide (see Chapter 9 on criminal law issues). Successful prosecutions appear to be negligible. However, this does not address the problem of certainty and consistency when managing defective neonates for the health professionals, the parents or the infant.

'NOT FOR RESUSCITATION' OR 'DO NOT RESUSCITATE' ORDERS

For health professionals working in many varied settings resuscitation orders are commonplace. The issue for health professionals is to ensure the order fits with the existing law and relevant policies, and as this chapter has demonstrated, this can be somewhat convoluted.

Firstly, the orders most frequently apply in situations where a patient suffers collapse requiring cardiopulmonary resuscitation and the 'not for resuscitation' (NFR) order signifies that resuscitation will not be commenced by the healthcare team. Death will ensue

in all likelihood. ‘Not for resuscitation’ and ‘do not resuscitate’ (DNR) orders usually become relevant in situations in which a patient’s condition is unlikely to improve or is considered to be hopeless. The practice of NFR should be openly discussed as it could be argued that there are times when a lack of clarity and communication has rendered the practice legally questionable. For example, there may be times when the treating doctor has not conveyed the order to other members in the healthcare team who are placed in a difficult position when the patient subsequently collapses. Conversely, there is confusion when the patient specifies that there be ‘no heroics’ should collapse occur, and the health professionals have no clear NFR order, or indeed are uncertain whether the patient can give the direction.

A number of issues need to be addressed in order to avoid legal problems. The precise criteria and philosophy that underpin a NFR decision should be openly discussed and known to those health professionals involved. Many hospitals and agencies have criteria clearly listed and incorporated into policies. The method of documenting the order should be clear and concise. The order should be written in the patient’s notes unambiguously. Covert practices such as abbreviations and symbols used to denote the order can create confusion. The problem with the use of symbols is that the author is anonymous. For example, using self-adhesive coloured dots on the patient’s file is an unacceptable method of signifying an NFR order.

‘Not for resuscitation’ can be viewed as a patient decision to refuse treatment, or a medical decision not to provide treatment because in all likelihood the resuscitation will not succeed due to the patient’s illness. Therefore, there are two situations where the law would support such an order. When considering who is involved in making the decision, it follows that this should comply with the law of consent and the state or territory statutory schemes where relevant. Thus the patient, or the patient’s representative (medical power of attorney or guardian), should be involved in making the decision rather than the decision being solely a medical one. However, where the medical team believe that any further treatment, including resuscitation, is futile the order can be made. It is though always considered to be good practice to discuss this such that the patient or representative are aware. It has been suggested that the determination that cardiopulmonary resuscitation would be futile is not an objective analysis but rather relativistic, based on probability and influenced by the doctor’s values and assumptions and hence the doctor’s opinion should not be the sole determining factor for an order not to resuscitate.⁵⁸ Nonetheless, the case law highlights the courts’ reliance on medical opinion being a major influence, in cases where treatment is deemed futile.

There will be situations when in all probability there is an extremely low chance of survival and it is relevant to discuss the usefulness of resuscitation. Moreover, there may be cases where the burden of resuscitation for the patient outweighs the benefits to the patient. It is desirable that a NFR order be based on a shared perception and understanding of what amounts to a benefit worth pursuing.⁵⁹

Australian jurisdictions that have enacted legislative frameworks in relation to patients’ rights to refuse treatment may provide some assistance to patients. Several jurisdictions provide for the patient to express their wishes regarding treatment or allow for the appointment of an attorney or agent who may make decisions on the patient’s behalf. It is generally considered that a NFR order is appropriate where it conforms to the patient or agent’s wishes. In the criminal context, a failure to initiate resuscitation has given rise to a number of queries. For example, is the decision not to resuscitate and subsequent omission to provide treatment the cause of death or is the cause of death the underlying disease? Does the criminal law apply when there is no clear intention to kill but the

decision not to resuscitate is made to allow the disease process to take its natural course? Some authors believe the criminal law in this area is less than certain.⁶⁰

Many institutions and employers have developed policies that are intended to guide clinical practice. These should be openly discussed and staff should have a clear understanding in relation to their professional roles and responsibilities. Health professionals must balance their duty of care to their patients and the patient’s wishes within the existing legal parameters. The term ‘no cardiopulmonary resuscitation’ (‘no CPR’) has been used in preference to NFR or DNR in some institutions. This is because it unequivocally states which treatment is to be withheld and avoids the implications of decisions not to resuscitate. For a valid ‘no CPR’ or NFR order, the following criteria are suggested:

- 1 the patient or patient’s agent or guardian should be involved in the decision, together with key members of the healthcare team;
- 2 the order should be clearly written in the patient’s notes; and
- 3 the order should be reviewed regularly.

If the patient’s condition dramatically improves or the patient has a change of mind, the order may be overturned.

Ultimately, when a patient is incompetent and decisions regarding treatment need to be made, the health professional must be cognisant of the current legal requirements. Table 7.1 provides a summary of the type of treatment an incompetent patient may require and the necessary considerations health professionals should address prior to providing treatment.

Type of treatment	Consent considerations
Emergency/life threatening.	No consent required.
Routine observation, includes non-intrusive examination.	
All other care minor/major.	Has the patient specified treatment according to the relevant legislative framework? Has an agent or guardian been appointed?
	Are there any guidelines (e.g. from the NSW or Tasmanian health departments)?
	Does the guardianship board have a ‘person responsible’ list to guide health professionals?
	If no next-of-kin or relatives are in disagreement and the healthcare team is uncertain then consult the guardianship board.
*Controversial care, special care or where there is disagreement as to care by family and/or healthcare team.	Guardianship board or court.
*Special or controversial care could include any experimental procedures, sterilisation, termination of pregnancy, and any aversive treatment or withdrawal of life support. Disagreement between family or health-carers may be in relation to any care provided.	

REVIEW QUESTIONS AND ACTIVITIES

- 1 What is meant by the term advance care planning?
- 2 Is an advance care directive the same as a not for resuscitation order?
- 3 Identify your state or territory's current legal requirements and compare with one of the other Australian jurisdictions. How do they differ? Which jurisdiction provides a clearer framework?
- 4 In which particular areas of care and decision making does the common law provide guidance?
- 5 Is there a difference between palliative care and medical treatment?
- 6 What is the difference between a guardian and a medical treatment power of attorney? In which particular circumstances would each be appointed and how are they appointed? (In other words, what are the advantages/disadvantages of each mechanism?)
- 7 Who may be a 'person responsible' and what role do they play in patient care?
- 8 A patient is admitted to your unit and the family insist that all care be continued. This is despite the fact that the treating team believe that palliative care is the best option for the patient. What course of action should you take?
- 9 What are the legal responsibilities of health professionals with regard to withdrawing treatment from defective neonates?

Further reading

- Austin Health (2004). Respecting patient choices program. Online. Available from: www.austin.org.au/Assets/Files/spring2005.pdf (accessed 19 May 2014).
- Biegler, P, Cameron, S, Savuiescu, J, Skene, L, (2000) 'Determining the validity of advance directives'. 172 *Medical Journal of Australia* 545–548.
- Bowen, T. (2013). An unexpected withdrawal-of-treatment case. *Australian Health Law Bulletin*, 21(3), 220–222.
- Butson, L., Shircore, M., & Butson, B. (2013). A right to refuse: Legal aspects of dealing with intoxicated patients who refuse treatment. *Journal of Law and Medicine*, 20, 542–559.
- Cavell, R. (2008) 'Not-for-resuscitation orders: The medical, legal and ethical rationale behind letting patients die', *Journal of Law and Medicine* 16: 305.
- Corke, CF, Stow, PJ, Green, DT, Agar, JW, Henry, MJ, (2005). 'How doctors discuss major interventions with high risk patients: An observational study' 330 (7484) *British Medical Journal* 182–185.
- Detering KM, Hancock AD, Reade MC, Silvester W. (2010) The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*. Mar 23(340):1345.
- Edburn, M, (1994) 'Withdrawing and refusing emergency resuscitation' 2 *Journal of Law and Medicine* 131–146.
- Freckelton, I. (2011). Patients' decisions to die: the emerging Australian jurisprudence. *Journal of Law and Medicine*, 18(4), 427–438.

- Giles, D, & Townsend, R, (2006) 'End of life decisions and the New South Wales Guardianship Act: A square peg in a round hole? The law and clinical practice' *Australian Health Law Bulletin* 15(1): 4–7.
- Griffiths, D. (2013) Understanding law in clinical practice: Theory or reality? *Journal of Law and Medicine*. 20(4): 728–733.
- Hafford, K. (2012). When not to resuscitate a profoundly disabled child — difficult decisions for the courts and practitioners. *Australian Health Law Bulletin*, 20(10), 157–8.
- Hamblin, J, (1999) 'Blood transfusions and the limits of autonomy' *The Australian Health Law Bulletin*, 7(5): 49–51.
- Hope, T. & McMillan, J. (2011) Advance decisions, chronic mental illness, and everyday care. *Lancet* 377(9783): 2076–7.
- Linden, S, (2003) 'BWV — refusal of medical treatment' *Australian Health Law Bulletin*, 12(2): 17–19, 28.
- Linden, S, (2003) 'Refusal of medical treatment — clarification of rights and responsibilities' *Australian Health Law Bulletin*, 11(6): 61–64.
- Maria J. Silveira, Scott Y.H. Kim, and Kenneth M. Langa. (2010) Advance Directives and Outcomes of Surrogate Decision Making before Death. *New England Journal of Medicine*, 362:1211–121
- Polkinghorn, R, Schmidt, G (2007). What they didn't tell you about CPR and PEG feeds. Online. Available from: www.publicadvocate.vic.gov.au/News/Latest-News/What-they-didnt-tell-you-about-CPR-and-PEG-feeds.html (accessed 19 May 2014).
- Seal, M, (2007) 'Patient advocacy and advance care planning in the acute care hospital setting', *Australian Journal of Advanced Nursing*, 24(4):29–36.
- Sidhu, NS, Dunkley, ME, Egan, MJ, (2007). 'Not-for-resuscitation' orders in Australian public hospitals: Policies, standardised order forms and patient information leaflets. *Medical Journal of Australia*, 186(2):72–75.
- Stewart, C, (2006) 'Advance directives: disputes and dilemmas', in Freckelton, I, Peterson, K (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney.
- Taylor, DMcD, Ugoni, AM, Cameron, PA, McNeil, JJ, (2003) 'Advance directives and emergency department patients: Ownership rates and perception of use', *Internal Medicine Journal*, 33(12): 586–591.
- The Australian Health Ministers' Advisory Council (AHMAC). (2011). *A National Framework for Advance Care Directives*. Canberra: AHMAC.
- Thiagarajan, M, Savulescu, J, Skene, L, (2007). 'Deciding about life-support: A perspective on the ethical and legal framework in the United Kingdom and Australia', *Journal of Law and Medicine*:14(4) 583–596.

Endnotes

- 1 NSW Department of Health, *Using advance care directives* (2004). Online. Available: www.health.nsw.gov.au/pubs/a-z/u.asp (accessed 11 May 2014).
- 2 Griffiths, D, *Agreeing on a way forward: Management of patient refusal of treatment decisions in Victorian hospitals*, (2008) PhD Thesis, Victoria University, Melbourne.
- 3 Medical Treatment (Health Directions) Act 2006 (ACT); Natural Death Act 1988 (NT); Powers of Attorney Act 1998 (Qld); Consent to Medical Treatment & Palliative Care Act 1995 (SA); Medical Treatment Act 1988 (Vic); Consent to Medical Treatment Act 2006 (WA).
- 4 The Clinical, Technical, and Ethical Principal Committee, of the Australian Health Ministers' Advisory Council (AHMAC). *A National Framework for Advance Care Directives*. Canberra: AHMAC; 2011.
- 5 Griffiths, D. (2013). Understanding law in clinical practice: Theory or reality? *Journal of Law and Medicine*. 20(4): 728–733.
- 6 Clark, K, 'The Medical Treatment Act 1988: Safeguarding patient rights or risking patient welfare?' (1989) 6 *Law Institute Journal* 473.
- 7 *Gardner; Re BWV* [2003] VSC 173 (29 May 2003).
- 8 *Ibid*, at [76].
- 9 *Ibid*, at [78].
- 10 *Ibid*, at [80].
- 11 *Ibid*, at [81].
- 12 *Ibid*, at [85].

- 13 Ibid, at [86].
- 14 *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45, unreported, 17 September 1998.
- 15 See <http://www.advancecaredirectives.sa.gov.au/>
- 16 Devereux, J, 'Medical law reporter' (1999) 6 *Journal of Law and Medicine* 332.
- 17 NSW Health, *Guidelines for end-of-life care and decision making* (2005). Online. Available at: www.health.nsw.gov.au/pubs/2005/pdf/end_of_life_care.pdf (accessed 11 May 2014).
- 18 NSW Health, *Using Advance Care Directives*, 2004. Online. Available at: www.health.nsw.gov.au/policies/gl/2005/GL2005_056.html (accessed 11 May 2014).
- 19 Crimes Act 1900 (ACT), s 18; Crimes Act 1900 (NSW), Criminal Code Amendment Act 1996 (NT), s 574B; Crimes Law Consolidation Act 1935 (SA), s 13(a); Crimes Act 1958 (Vic), s 463B.
- 20 *Stuart v Kirkland-Veenstra* [2009] HCA 15.
- 21 *Re PVM* [2000] QGAAT 1.
- 22 *Brightwater Care Group v Rossiter* 20 (2009) WASC 229.
- 23 For example, Powers of Attorney Act 1998 (Qld).
- 24 Instruments (Power of Attorney) Act 2003 (Vic), s 125D.
- 25 Guardianship and Management of Property Act 1991 (ACT); Adult Guardianship Act 1988 (NT); Guardianship Act 1987 (NSW); Guardian and Administration Act 2000 (Qld); Guardianship and Administration Act 1993 (SA); Guardianship and Administration Act 1995 (Tas); Guardianship and Administration Board Act 1986 (Vic); Guardianship and Administration Act 1990 (WA).
- 26 *Re AG* [2007] NSW GT 1, 5 February 2009.
- 27 *Re RWG* [2000] QGAAT 2.
- 28 *Re HG* [2006] QGAAT 26.
- 29 *BTO* [2004] WAGAB 2.
- 30 Lord Goff in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 75.
- 31 *Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218 at 246.
- 32 Guardianship and Administration Act 1986 (Vic), s 42K.
- 33 Section 37 of the Act sets out a list of responsible people including an agent appointed under an Enduring Power of Attorney (Medical Treatment), a guardian appointed by the Victorian Civil and Administrative Tribunal (VCAT), an enduring guardian, the last person appointed in writing by the patient to make such decisions, the patient's spouse or primary carer or the patient's nearest relative.
- 34 Guardianship and Administration Act 1986 (Vic), s 42M establishes the notice.
- 35 See the Victorian Office of the Public Advocate's summary of when guardianship and administration may be necessary. Online. Available from: <http://www.publicadvocate.vic.gov.au/file/file/Research/Discussion/2009/Principles%20and%20values%20in%20Victorian%20guardianship%20legislation.pdf> (accessed 19 May 2014).
- 36 Guardianship and Administration (Amendment) Act 1999 (Vic), Guardianship and Administration Act 1995 (Tas).
- 37 *Airedale NHS Trust v Bland* [1993] 1 All ER 821.
- 38 *Frenchay Healthcare NHS Trust v S* [1994] 2 All ER 403.
- 39 *Melo v Superintendent of Royal Darwin Hospital* (2007) 21NTLR 197.
- 40 *Northbridge v The Central Sydney Area Health Service* [2000] NSWSC 1241 at para 24.
- 41 *Messiha v South East Health* [2004] NSWSC 1061.
- 42 *Re Herrington* (2007) VSC151.
- 43 *Auckland Hospital v Attorney General* [1993] 1 NZLR 235.
- 44 *St George's Healthcare NHS Trust v S, R v Collins; Ex parte S* [1998] 3 All ER 673.
- 45 Ibid, at 692.
- 46 Ibid, at 703.
- 47 National Perinatal Epidemiology and Statistics Unit (NPESU). Online. Available from: <http://www.npesu.unsw.edu.au/> (accessed 10 May 2014).
- 48 *The Times*, 6 October 1981, unreported judgment of Leicester Crown Court, discussed in M Gunn and J C Smith, 'Arthur's Case and the right to life of a Down's syndrome child' (1986) *Crim Law Review* 705.
- 49 *R v Young* [1969] Qd R 417.
- 50 *R v Charlotte Smith* (1865) 10 Cox CC 82 at 94.
- 51 *Re B (a Minor)* [1981] 1 WLR 1421.
- 52 Ibid, at 1424.

- 53 *Re C (a Minor)* [1989] 2 All ER 782.
- 54 *Re J (a Minor)* [1990] 3 All ER 930.
- 55 *Re F; F v F* unreported judgment of the Supreme Court of Victoria, 2 July 1986.
- 56 *Re Baby M* unreported case No 3149/89, 1991.
- 57 *Ibid.*
- 58 Kerridge, I, Mitchell, K, Myser, C, 'The decision to withhold resuscitation in Australia: problems, hospital policy and legal uncertainty' (1994) 2 *Journal of Law and Medicine* 127.
- 59 *Ibid.*, at 128.
- 60 *Ibid.*, at 129. Also see Chapter 9 on criminal law issues.