Self-Determination, Dignity and End-of-Life Care

Regulating Advance Directives in International and Comparative Perspective

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A COMPARATIVE PERSPECTIVE ON AUSTRALIAN END-OF-LIFE LAW

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I. INTRODUCTION

The Italian Eluana Englaro Case and the related Italian Bill “Dispositions in matter of therapeutic alliance, informed consent and advance directives” (“the Bill”) highlight a number of significant points of divergence with regulation of end-of-life decision-making and advance directives under Australian state and federal law. This chapter aims to provide a comparative overview of Australian case law and statutory provisions in this area. It discusses these differences in the context of a view that regardless of the deontological importance of respecting individual patient rights in end-of-life decision-making, the financial constraints upon governments to care for an ageing population will increasingly provide consequentialist interest not only in facilitating advance directives that allow technically ‘futile’ treatment to be withdrawn or withheld from incompetent patients, but in permitting physician-assisted suicide when requested by competent, non-depressed patients with a terminal illness who have already received reasonable palliative care.

A. Initial Comparisons of the Eluana Englaro Case and Australian Law

The Eluana Englaro Case concerned an application to the Supreme Court of Italy (after an earlier decision by the Appeal Court of Milan) of a guardian (the father) to obtain an authorization to cease the artificial nutrition of Eluana who had been in vegetative state since 1992 following to a car accident. The application was opposed by the Public Prosecutor of Milan

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1 Italian Supreme Court of Cassation, United Civil Sections, Judgment 11–13 November 2008, no. 27145.
2 “Dispositions in matter of therapeutic alliance, informed consent and advance directives” Bill approved by the Senate of the Italian Republic on 26 March 2009 and discussed by the Chamber of Deputies as Bill No. 2350.
who sought to impugn the Milan Court of Appeal’s finding (on expert testimony) that the patient was in a persistent vegetative state. The patient had made no advance directive.

As will be shown, this type of case is uncommon in Australia where intensive care physicians are normally able to make decisions to withdraw treatment from patients when treatment is technically futile (“no reasonable prospect of returning to a meaningful quality of life”) without having to apply to either a hospital clinical ethics committee or a court. Applications to such a committee or court tend to be reserved for those situations where the treating physicians and the patient’s family have become involved in a protracted dispute over whether treatment should be withdrawn or withheld.

Where a patient requiring an end-of-life decision is incompetent in Australia legislation in different states generally requires that doctors approach a hierarchy of next of kin to act as a surrogate decision-maker. The situation is also covered by case law permitting the treating doctors to make a decision in the best interests of the patient, usually in close association with the patient’s family.

Australian cases similar to Eluana Englaro’s are not common but do exist. In 2004, for example, in the Messiha Case a 75 year old man with a history of cardiac surgery and cardiac arrest was admitted to an intensive care unit after an out of hospital heart attack with 25 mins cerebral hypoxia. The treating doctors soon formed the view that there was no reasonable prospect of the patient returning to a meaningful quality of life (treatment was technically ‘futile’). This conclusion was opposed by the family despite consultation and the matter was taken before a judge who confirmed the capacity of the doctors to withdraw treatment.

In 2009 the Supreme Court of Western Australia heard the case of Brightwater v Rossiter. Mr Rossiter was a mentally competent quadriplegic who required 24 hour care at Brightwater nursing home. He was fed via a percutaneous endoscopic gastrostomy (PEG) tube surgically inserted into his stomach and communicated through a trachostomy. On multiple occasions Mr Rossiter requested that the staff of Brightwater nursing home cease his nutrition and hydration such that he might starve to death as he had no other means by which to commit suicide. The nursing home

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brought the case to the Supreme Court in order to seek declaratory relief as to whether they were legally obliged to obey Mr Rossiter’s request and effectively cause his death or whether as a medical service provider their duty of care refrains them from doing so. In addition to this they sought declaratory relief from criminal prosecution if they were to prescribe analgesics to Mr Rossiter if his starvation were to eventuate. Chief Justice (CJ) Martin ruled that Brightwater had the duty to provide the necessities of life through medical treatment. Mr Rossiter, however, also being of full age and mental capacity was capable of legally refusing medical treatment provided that his refusal was an informed decision and that he could revoke his refusal at a later stage if he so wished. On the second issue the court permitted only the provision of medication such that it would neither cause nor hasten the death of Mr Rossiter.5

The cases of Messiah and Brightwater v Rossiter highlight public debate in Australia over the rights of patients, their family and doctors to make decisions ending the lives of patients whose treatment is deemed ‘futile’ either on objective clinical criteria determined by doctors (for an incompetent patient) or by a competent but terminally ill patient according to more subjective criteria (a situation more likely to be referred to as euthanasia).

II. Euthanasia Debate in Australia

Each year in Australia there are 77,000 deaths from chronic terminal disease.6 Unsurprisingly many of these deaths are brought on prematurely as patients seek to alleviate their pain and suffering through euthanasia, despite having access to excellent palliative care. It is anticipated that the problem of the legality of euthanasia will be given increased attention as the population ages, chronic disease becomes more prolific and the consequent public and private costs increase.

Currently Australian law distinguishes between the following different forms of euthanasia (although some of these categories are not referred to as ‘euthanasia’ by the medical or legal systems because of the negative connotations of that word):

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5 Brightwater Care Group (Inc) v Rossiter [2009] WASC 229.
1. Voluntary active euthanasia:
   a. where a person's life is ended through some form of medical intervention at their request;
2. Involuntary active euthanasia:
   a. where a decision to terminate life by medical intervention is made by another because the person concerned lacks the necessary capacity to consent to such termination, OR
   b. where the person concerned may possess the capacity to consent but their life is terminated against their will (both are also recognised as murder/manslaughter, but are distinguished by Australian law from situations where treating physicians withdraw or withhold ‘futile’ treatment from an incompetent patient, even though such withdrawal can involve actions (for example extubation) highly likely to lead to death);
3. Voluntary passive euthanasia:
   a. Where the patient requests that treatment be withheld and symptomatic pain relief provided such that premature death results (e.g. hospice and palliative care).
4. Involuntary passive euthanasia:
   a. Where a decision is made to terminate life is made by another because the person concerned lacks the necessary capacity to consent to termination (if the person making the decision is a treating physician then this can fall within the category of lawful withdrawal and withholding of ‘futile’ treatment).

In 1997 Kuhse, Singer et al. undertook a study which revealed that active voluntary euthanasia and physician-assisted suicide play a role in approximately 1.8% of all Australian deaths. The results of this study are still accepted as reasonably accurate and as highlighting the dangers inherent

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7 To complicate matters further, the study showed that in 0.5% of the cases confronted by the doctors in the study, the doctors felt that hastening the death of the patient would be in the patient's best interest and that discussing this option with the patient might cause undue distress and was therefore not undertaken. The study also uncovered that the decision not to treat with the objective of quickening death or not extending a patient's life occurred in an estimated 24.7% of all Australian deaths, 14.3% of such deaths were preceded by a medical decision. Of great concern is that only a tenth of these decisions were made at the patient's request and of the remainder, dementia and handicap only accounted for 1.6% of cases where such a request may not be possible and 6.5% of all Australian deaths pain or symptoms were alleviated with opioids with the secondary intention of hastening death. Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, "End-of-life decisions in Australian medical practice", 166 Medical Journal of Australia (1997), pp. 191–196.
within the relatively unregulated practice of doctors making and acting on end-of-life decisions. They confirm the existing system is more open to abuse than a regulated, transparent voluntary euthanasia scheme which takes appropriate advantage of advance care directives.

Opposition to euthanasia continues, particularly from the Australian Catholic church, Aboriginal groups, the Australian Association for Hospice and Palliative Care and the Australian Medical Association. A poll conducted in 2007 however found that 80 percent of Australians favoured the terminally ill possessing the rights to choose a medically assisted death. In 2010 another poll revealed that three out of four Australians support legalizing euthanasia. Despite this community support for regulated euthanasia many Australian politicians (out of personal religious conviction or respect for religious pressure groups) remain reluctant to openly support it.

A. The Brief History of Legislated Active Voluntary Euthanasia in Australia

Euthanasia legislation has been an area of considerable controversy in Australia. Due to the constitutional split of Federal and State power in Australia, the Commonwealth of Australia has limited capacity to legislate nationally on end-of-life matters. Despite the six Australian States possessing legislative power with respect to euthanasia and advance care directives, the Australian Commonwealth retains legislative control over the two territories of Australia (Australian Capital territory and Northern Territory) by means of s122 of the Commonwealth Constitution.

In 1997 in an effort to prevent pro-euthanasia legislation in the Northern Territory and the Australian Capital Territory, the Australian federal government enacted the Euthanasia Laws Act 1997. Schedule 1 of the Euthanasia Laws Act 1997 altered the legislative powers of the Northern Territory government by way of amending s50A of the Northern Territory (Self Government) Act 1978 such that they lacked the ability to make laws

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10 Matters upon which the Commonwealth may legislate are listed under s51 of the Commonwealth Constitution and all residual legislative power falls upon the State governments Commonwealth of Australia Constitution Act s51.
11 Commonwealth of Australia Constitution Act s122.
in “the form of intentional killing of another called euthanasia (which includes mercy killing) or assisting of a person to terminate his or her life.” This amendment went further and explicitly withdrew the force of the previous NT advance care directive legislation, Rights of the Terminally Ill Act 1995, with the exception of actions taken prior to the commencement of the amendment.

Schedule 2 of the Euthanasia Laws Act 1997 similarly amended the Australian Capital Territory (Self Government) Act 1988 by inserting into it subsections s23(1)(1A) to prohibit the Territory’s capacity to legislate on the subject. This situation persists despite the ACT having a Human Rights Act 2004 (ACT) that recognises the right to protection from torture and cruel, inhuman or degrading treatment.

Within the Northern Territory there had been a great deal of conflict over the introduction of the Rights of the Terminally Ill Act 1995 (NT) prior to the interference of the Euthanasia Laws Act 1997 (Cth). During this brief 2 year timeframe there were 5 legally identified voluntary active euthanasia deaths (all certified as terminally ill and not depressed) some of which were performed by Dr Phillip Nitschke who famously said the following of active voluntary euthanasia:

I would see this as an act of compassion, an act of concern, an act of love, in fact consistent with good medical practice.

Dr Djiniyinni Gondarra, an Aboriginal Minister of the Uniting Church and Dr Chris Wake, the President of the Northern Territory Branch of the AMA, disagreed with Dr Nitschke and appealed a decision by the Northern Territory Supreme Court to the High Court of Australia on the validity of

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14 Id.
15 Id.
16 Human Rights Act 2004 (ACT) s10.
17 However, there is the potential for conflict within the legislation as the Act also recognizes the right to life and states no life “may be arbitrarily deprived”, Human Rights Act 2004 (ACT), s9. In 2004 there was an unsuccessful attempt to repeal the Euthanasia Laws Act 1997 (Cth), restore the Rights of the Terminally Ill Act 1995 to the NT and reinstate the ability of the ACT and Norfolk island to legislate on euthanasia. The argument for the repeal was largely focused on two grounds being that the Commonwealth was wrongly interfering with the democratic right of the people within the territories self governing jurisdiction and further the Commonwealth was discriminating between the states. Notably the moral or ethical principles of euthanasia and content of the schedules were not considered in great detail or represented as a driver for the repeal.
the Rights of the Terminally Ill Act 1995 (NT). The High Court adjourned the application in anticipation of the Euthanasia Laws Act 1997 (Cth) being passed in the Senate.

B. Present Statutory Law on Euthanasia in the Australian States

The common law of Australia has transitioned from seeing suicide as indicative of mental illness to accepting it as a situation where possible psychiatric or psychological issues may exist but not necessarily to the extent that testamentary capacity is extinguished. This shift in collective judicial thinking facilitated the move to have suicide decriminalized in all states. Queensland, Tasmania and Western Australia criminal legislation and codes omit suicide as an offence.

However, legislation in Western Australia and Queensland holds that aiding suicide is a crime where “a person procures, aids or counsels to induce another to kill themselves”. The Tasmanian Criminal Code is more succinct in finding it a crime to either instigate or aid another to kill himself. South Australia, New South Wales, Victoria and the Australian Capital Territory use near identical language in finding an indictable offence where a person ‘aids, abets or counsels the suicide of another, or an attempt by another to commit suicide’. However, South Australia takes the offence one step further in finding that actions of ‘fraud, duress or undue influence’ that procure suicide or an attempted suicide are crimes of murder or attempted murder depending on the circumstance. The Northern Territory legislation is much like that of NSW and the ACT, however, it omits the language of ‘abetting’ or ‘counselling’ and complicates the offence by requiring that accused have intended his or her conduct to assist the other to commit suicide.

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90a Id.
92 Crimes Act 1900 (NSW) s31A, Criminal Law Consolidation Act 1935 (SA) s13A(1), Crimes Act 1958 (Vic) s6A, Criminal Code (WA) s288, Criminal Code (QLD) s311, Criminal Code (Tas) s163.
93 Criminal Code (WA) s288, Criminal Code (QLD) s311.
94 Criminal Code (Tas) s163.
95 Criminal Consolidation Act 1935 (SA) s13A, Crimes Act 1900 (NSW) s31C, Crimes Act 1900 (ACT) s17.
96 Criminal Code (SA).
97 Criminal Code (NT) s162(2).
Regardless of the language used all of the legislation can be categorised as applicable to situations of voluntary active euthanasia or a mercy killings and such actions attract a criminal penalty from 5 years to life imprisonment.

In Western Australia s288 of the Criminal Code (WA) carries the penalty of imprisonment for life for the crime of aiding suicide. Hence, when Mr Rossiter requested assistance from his doctor in Brightwater v Rossiter his doctor sought declaratory relief from criminal prosecution in his compliance with the request.\(^{28}\) Declarations of this sort against proposed future criminal conduct can be a valid form of protection but such protection cannot be afforded for conduct already performed.\(^{29}\) The Criminal Code (WA) further supplements the protection from euthanasia granted by s288 by stating there is a duty to provide the necessaries of life where a person has the charge of another who is unable to provide themselves with the necessaries of life due to age, sickness, mental impairment, detention, or other cause.\(^{30}\) There is a corollary to this under another provision of the Criminal Code (WA) concerning surgical and medical treatment such that:

a person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) if that course is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.\(^{31}\)

The usage of the words ‘all circumstances’ is intentionally broad and might facilitate a defence against any charges of aiding or abetting suicide if informed consensual treatment of a patient using pain medication were given such as in Mr Rossiter’s situation.

The law relating to assistance in the form of a suicide pact varies significantly in Australian legislation. For instance the Crimes Act 1900 (NSW) exempts a suicide pact participant from murder or manslaughter charges if the accused can prove the existence of the pact on the balance of probabilities\(^{32}\) However, the Crimes Act 1958 (VIC) states that the party who survives a suicide pact is guilty of manslaughter.\(^{33}\)
C. Australian Common Law and Mercy Killing

Interestingly Australian courts have been inconsistent in relation to verdicts about mercy killing crimes. In *R v Maxwell* [2003] and *R v Hood* [2002] both defendants received suspended sentences. Coldrey J who presided over both cases commented:

> The law may be seen as life-affirming and not life-denying and directed at discouraging suicide as a response to the emotional vicissitudes of life. The degree of moral blame attributable to a person who assists or encourages an act of suicide may vary greatly from case to case. At one end of the spectrum may be placed a person who assists or encourages a person to commit suicide in order to inherit property or for some other ulterior motive; at the other end, there is the individual who supplies potentially lethal medication to a terminally ill person, perhaps a loved one who is in extreme pain and who wishes to end that suffering at the earliest possible opportunity.

He went on to say that there existed such situations where ‘justice may be tempered with mercy’ such that minimal punishment might be imposed where the act is performed out of kindness.

The above decisions contrast sharply with the rulings in cases such as *R v Justins* [2008]. In *R v Justins* [2008] Shirley Justins was found guilty by a jury of assisting the suicide of Graham Wylie (negligent manslaughter) and sentenced to a non parole period of 22 months with a balance of term of 8 months. In this trial the judge emphasised the deceased had the right to making the decision to commit suicide himself and not have it made by another on his or her behalf despite the fact that the deceased had undertaken many avenues in which to take his own life previously. On the facts this case differed from that of *R v Hood* and *R v Maxwell* in that the defendant was extensively involved in the planning process of the death and somewhat dishonest in admitting a potential ulterior motive, the deceased was somewhat compromised mentally.

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34 *R v Maxwell* [2003] VSC 278.
36 Id.
37 Id.
38 *R v Justins* [2008] NSWSC 1194.
39 Id.
40 Id.
41 *R v Hood* [2002] VSC 123.
42 *R v Maxwell* [2003] VSC 278.
It is in such cases that Australian law struggles to clarify its position on voluntary and involuntary active euthanasia and cases are very much decided on a case-by-case basis rather than on a broader policy position. Indeed, if there is a consistent position amongst these cases it is that the court will discourage a secondary person’s involvement in the voluntary death of another even for the relief of suffering (under the ethical doctrine of ‘double effect’), unless that person is a doctor. There have been no cases of a doctor having been prosecuted for assisting a patient to die in Australia despite numerous studies highlighting the existence of that practice.

III. Difference between Euthanasia and Withdrawing Treatment

The involuntary aspect of involuntary euthanasia derives from the incapacity or refusal of the patient to grant consent to the termination of their life. The refusal to consent to termination of life by a competent person falls neatly into the categories of murder and manslaughter but where a patient lacks the capacity to communicate his/her wishes it is infinitely more complex in Australian law. This incapacity can take many forms including as dementia and mental incapacity (R v Justins)\(^{43}\) and as a persistent vegetative state, which in Australia’s leading case in this area was considered in Re BMV, Ex parte Gardner.\(^ {44}\) In Re BMV the Victorian Supreme Court ruled that artificial nutrition and hydration was a medical procedure, not palliative care or passive in nature, and could therefore be legally withdrawn from a person in persistent vegetative state regardless of its use to sustain life.\(^ {45}\) The case also reaffirmed the rights of patients (or their appointed guardians if the patient is incompetent), to refuse treatment even if to do so would result in their death. This is consistent with the court’s position on upholding the rights of the individual to bodily inviolability.

Involuntary active euthanasia attracts criminal liability in all States and Territories of Australia under the offences of manslaughter and murder. Each state and territory of Australia has legislation to the effect of it being ‘unlawful to kill any person unless such killing is authorised or justified or

\(^{43}\) R v Justins [2008] NSWSC 1194.

\(^{44}\) Re BMV, Ex parte Gardner [2003] VSC 173.

\(^{45}\) The Australian Capital Territory (ACT) legislation differs from this position. It states that palliative care cannot be refused and the provision of reasonable food and water is a requirement of the Medical Treatment (Health Directions) Act 2006.
excused by law. Murder specifically being where the conduct engaged is intentional or there exists reckless indifference to human life and death of another occurs. Manslaughter, being the residual form of homicide if murder is not satisfied on the facts, is where the requisite intention is lacking or where the death results by way of reckless or negligent conduct.

In the Australian context, doctors and lawyers alike are realising that it is a fine line between active euthanasia, attracting the offence of murder/manslaughter, and that of physicians withdrawing and withholding futile treatment, where liability is non-existent. This is despite the fact that in the latter cases patients are routinely administered respiratory depressive opioids which in reality hastens death not unlike other forms of assisted death. Studies like Kuhse and Singer’s demonstrate that doctors administer this form of “pain relief” without discussing it with the patient and/or their guardian first. The crucial distinction seems to be that with withdrawal of futile treatment the doctors involved are never certain that death will result—some patients may rally physiologically and if this occurs treatment is continued.

V. PATIENT AUTONOMY AT THE END OF LIFE

A. Overview

Despite legislation facilitating written and oral advance directives, government-funded research projects and a plethora of official policies promoting them, very few elderly or terminally ill patients make advance directives in Australia. Some senior Australian physicians still refuse to make not-for-resuscitation orders despite manifest and accepted futility of treatment for the patient in question, owing to irrational fears of legal liability. Cardiac arrests in such situations can result in the phenomenon of a ‘slow-code’ where doctors and nurses go through the outward forms of resuscitation to permit documentation required of them as a result of desuetude and/or ignorance of the law by the treating physician.

If an Advance Care Directive (ACD) does exist an Australian medical team will discuss the process of withdrawal or withholding of treatment

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46 Criminal Code Act 1913 (WA) s268.
47 Crimes Act 1900 (NSW) s18.
48 Criminal Code (NT) s160.
49 Barry M. Kinzbrunner; Neal J. Weinreb and Joel S. Policzer, 20 Common Problems in End of Life Care (New York, 2002).
with the patient and/or their family in most settings. If treatment is declared clinical futile and treatment is withdrawn or withheld in accordance with an ACD, the cause of the patient's death is noted on the medical record and death certificate as the disease process or injury that was the underlying causative factor. In states that have legislated on ACDs there are broad protections available for staff who act in good faith (prioritising basic medical ethics principles such as beneficence over autonomy) either to accept or ignore an ACD.

Just as in the Italian case, informed consent is an essential component to recognising the weight of the autonomy of the patient in this setting. The Australian High Court in a series of cases (*Rogers v Whitaker*, *Chappel v Hart*, and *Rosenberg v Percival*) has determined that the doctor's duty of care requires provision of information not just about the broad nature and effect of any treatment (or withholding/withdrawal of treatment), but also of reasonably likely material risks or those of particular concern to this patient. If the patient indicates he or she would go ahead with the decision regardless of what material risk information is presented then failure to provide such information does not create tortuous liability.

In *F v R* with King CJ elaborating the disclosure process stated:

> the nature of that matter to be disclosed; the nature of the treatment, the desire of the patient or information, the temperament and health of the patient; and the general surrounding circumstances.

In *Hunter and New England Area Health Service v A* the court adopted the UK decision in *Re MB (Medical Treatment)* whereby a person of full age is deemed capable of having the capacity to consent to or refuse medical treatment. Provided that the duty of care is satisfied and patients are sufficiently informed the High Court of Australia ruled in *Secretary of Department of Health and Community Services v B* that patients possess the right to refuse treatment. It was acknowledged that such a rule

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56 Id.
57 *Re MB (Medical Treatment)* [1997] EWCA Civ 1361.
was to be applied regardless of ‘irrational, non-existent or incomplete knowledge of the patient’s reasoning in making their decision to refuse treatment’.60

B. The Rights of Children to Refuse Treatment in Australia

In Australia there is a presumption that all adults are competent to accept or refuse medical treatment unless the alternative is evidenced. At common law however the presumption is that children under the age of 18 lack such competence unless they can demonstrate they have achieved ‘a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.’61 Despite this potential for children to refuse medical treatment, the outcome of cases heard in the Australian courts suggests that where the refusal of treatment of a child will result in the child’s death even if the decision is made by a ‘competent’ child, the courts will override the child’s refusal.62 It is interesting to note that in two of these cases the children were refusing blood transfusions on the basis of their religious beliefs.

South Australian legislation better captures this position. The Consent to Medical Treatment and Palliative Care Act 1995 (SA) facilitated the informed refusal of medical treatment of children provided they are over 16 years of age including where the treatment might be life sustaining and where it might be anticipatory refusal.63 The legislation provides, however, that the child’s decision may be overridden by a parent or guardian and that two doctors are required to have consensus on the child and ensure there is a full understanding of the implications of such refusal.64

In practice in Australia many physicians will prioritise the ethical principle of beneficence over that of autonomy where a child is refusing life sustaining treatment because of religious views. They reason that adults can risk their lives in this way, but the risk of mental manipulation and immaturity of understanding is too great to allow children to risk their lives for an ideology that in their maturity they may or may not reject.

61 Known as Gillick competence after Gillick v West Norfolk AHA [1986] AC 112.
63 Consent to Medical Treatment and Palliative Care Act 1995 (SA).
64 Id.
C. Legislation on Advance Care Directives in Australia

The primary mechanism by which the recognition of an adult’s voluntary anticipatory refusal of medical treatment is achieved in Australia is through living wills and enduring powers of attorney. The most important component of an ACD (rarely included) for a guardian or clinician making an end-of-life decision about an incompetent patient, is a clear statement of the minimum level of a meaningful quality of life that the particular patient is willing to accept.

South Australia and the Northern Territory legislation allows advance directives but limits their use to situations of terminal illness and for consent or refusal of specified treatments. South Australia additionally provides for circumstances of persistent vegetative state and has legislated similarly to Victoria and the Australian Capital Territory in providing that a competent adult can give effect to an enduring power of attorney. The enduring power of attorney allows the principal competent adult to engage an agent to make medical decisions on their behalf in the event that they are rendered incompetent. Thus, through the agent the principal effectively has a legal means of refusing medical treatment with the caveat that the refusal is consistent with the wishes of the principal and does not conflict with any instructions provided by the principal in the power of attorney document whilst they were competent. In effect the power of attorney legislation facilitates the indirect decision making of the principal prospectively. Notably the legislation does not displace the competent principal’s capacity to give other forms of binding anticipatory refusal for undesired medical treatment.

South Australia introduced the Consent to Medical Treatment and Palliative Care Act 1995 (SA) which renders any health care professional free from both civil and criminal liability if they act in accordance with the directions of the principal; in good faith and without negligence; and in compliance with the professional standards of medical practice.

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66 Consent to Medical Treatment and Palliative Care Act 1995 (SA), Natural Death Act 1988 (NT).


68 Consent to Medical Treatment and Palliative Care Act 1995 (SA).

69 Id.
The Consent to Medical Treatment and Palliative Care Act substitutes the regime founded in the Guardianship and Administration Act 1993 (SA) for the appointment of agents to act under the enduring power of attorney. The new regime provides that a person of sound mind who has attained 18 years of age can implement a medical power of attorney to appoint an agent to act on their behalf regards to medical treatment provided it is written, witnessed by a justice of the peace or similar proclaimed figure.70 71 It is also explicit in this legislation that the medical power of attorney does not empower the agent to refuse the supply of food and water, drugs for pain and distress nor refuse treatment which might enable the principal to regain their capacity to consent unless there is no expectation that the principal might recover or have a ‘remission of symptoms’ in terminal illness.72 Additionally the doctor cannot treat a patient over 16 years of age if he/she is aware of the patient’s anticipatory refusal or existence of an appointed agent where the agent is available.

The current Northern Territory legislation, Natural Death Act 1988 (NT) resembles closely that of South Australian Act in allowing competent terminally ill persons to make written directives for the refusal of ‘extraordinary measures’,73 however, it omits the process for the appointment of an agent under an enduring power of attorney.

Victoria’s Medical Treatment Act 1988 (VIC) allows for advance care directives solely by way of a ‘refusal of treatment certificate’ subsequent to the patient’s either oral, written or otherwise communicated request.74 This legislation restricts the use of such a certificate by requiring the treatment refused be for a current condition, is voluntary and is witness by both a doctor and another person who are satisfied of the patient’s adequate understanding of the consequences of such a decision.75 A doctor who does not comply with the refusal of treatment certificate becomes liable for medical trespass. The Medical Treatment Act 1988 (VIC) was

70 These include:
   (a) a commissioner for taking affidavits in the Supreme Court; or
   (b) a member of the clergy; or
   (c) a registered pharmacist.

71 Consent to Medical Treatment and Palliative Care Act 1995 (SA).

72 Id.

73 “Extraordinary measures” means medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation; - Natural Death Act 1988 (NT).

74 Medical Treatment Act 1988 (VIC).

75 Id.
amended in 1990 and 1992 to permit the appointment of agent and alternate agent in the presence of a justice of the peace and other by way of enduring power of attorney provisions.\textsuperscript{76} Power is acquired by the alternate agent only upon the unavailability, death or incompetency of the original agent. The agent is refrained from refusing palliative care and confined in his/her power to treatments which the agent considers the principal would deem wanton or result in unreasonable distress.\textsuperscript{77} Again a certificate of refusal of treatment is demanded for any decisions of the agent.\textsuperscript{78} The advance directive self terminates should the principal's condition change in such a manner that the directive is not applicable to the current condition\textsuperscript{79} The advance directive self terminates should the principal's condition change in such a manner that the directive is not applicable to the current condition.\textsuperscript{80} In Victoria a guardian under the Guardianship and Administration Act 1986 (VIC) has the same power as that of an agent under the Medical Treatment Act 1988 (VIC).

Advance directives in the ACT, the Medical Treatment (Health Directions) Act 2006 (ACT)\textsuperscript{81} are sculpted upon that of the Medical Treatment Act 1988 (VIC) as is the Queensland legislation Powers of Attorney Act 1998 (QLD), which additionally allows for situations where the patient is dependent upon life-support machinery. Under the Medical Treatment Act 1994 (ACT) an agent may be appointed to make medical decisions under enduring power of attorney but their power is only realised when the doctor declares the principal incapacitated.

Presently New South Wales lacks any formal legislation relating to end-of-life decisions but it does have non-binding guidelines which indicates that an advance care directive should be considered as sufficient authority for a medical treatment decision provided that it is specific to the disease or injury relevant to the decision, current and made by a competent individual.\textsuperscript{82} Markedly there is no prescribed form in which the directive must take, it is not necessary a witness be present (although encouraged) and

\textsuperscript{76} Id.
\textsuperscript{77} Id.
\textsuperscript{78} Id.
\textsuperscript{79} Id.
\textsuperscript{80} Id.
\textsuperscript{81} Medical Treatment (Health Directions) Act 2006 (ACT).
no health professional is required to have informed the patient prior to the writing of the directive.\textsuperscript{83} It need not even be in writing.

To date Tasmania has not legally attempted to address the topic of advance care directives and so possesses no legislation either allowing directives to be made or followed. Western Australia similarly has not enabled advance care directives by legislating for them, though numerous unsuccessful attempts were made to pass the Medical Care of the Dying Bill 1995 (WA) despite the Western Australian law reform commission advocating its introduction into law.\textsuperscript{84}

With the exception of Tasmania and Western Australia, Australia has a substantial body of legislation dealing with advance directives. Yet the Australian judicial system is reluctant to engage in a dialogue addressing the uncertainties that still exist within much of the current law on end-of-life decisions.\textsuperscript{85}

\section*{D. Guardianship Laws in Australia}

The subjective needs of an individual are difficult to evaluate in situations where a patient is incapable of giving consent to medical procedures. In these circumstances the law in NSW defers to the Guardianship Act 1987 (NSW) which applies to incapable persons above the age of 16.\textsuperscript{86} It functions by providing for proxy consent by an appointed guardian or where one is not available another ‘person responsible’.\textsuperscript{87} The person responsible existing in a form of hierarchy whereby it is in the first instance priority is given to a spouse where there is a strong, long relationship, then the carer and where no carer nor spouse is available the person responsible is assigned to a close relative or friend.\textsuperscript{88} This statutory scheme only permits the person responsible to make decisions on the principal’s behalf where there is a positive action of consent to medical treatment. Prima facie it fails to be a device by which refusal or discontinuation of treatment and so

\textsuperscript{83} Id.
\textsuperscript{86} Guardianship Act 1987 (NSW).
\textsuperscript{87} Id.
cannot be utilised as a form of advance care directive achieved via previ-ous communication in the course of a relationship. In WK v Public Guardian ADT 93 it was identified that another means of recourse by which the guardian might be granted the power of refusal or discontinuation of treatment would be through an application to the NSW Supreme Court for an assessment of the patient’s best interests under *parens patriae* jurisdiction.89

Victorian common law is somewhat more liberal than that of NSW. This can be seen in *Re BWV, Ex parte Gardner*90 where the court ruled that it was the parliamentary intention of the Victorian *Guardianship and Administration Act 1986* that refusal of treatment for a ward be an option able to be adopted by a guardian. *Re BWV, Ex parte Gardner* also is the common law authority stating that where no guardian had been appointed a family member or physician could legally make the decision to withdraw nutrition and hydration where it is considered to be in the patient’s best interests.

With the exception of *Re BWV, Ex parte Gardner* the courts have been reluctant to engage with the subject matter of guardianship and advance care directives. *Qumsieh v Guardianship and Administration Board* was one case which sought to resolve the dilemma of guardians possessing the authority to override patient advance care directives for the refusal of specific treatment. Instead of a definitive ruling the case was dismissed from the Victorian Court of Appeal on the grounds of that the subject matter was moot though there existed some discussion that advance care directives were often of such a specific nature that they are easily made inapplicable and jurisdiction granted to the person responsible.91

V. CONTRASTING AUSTRALIAN AND ITALIAN LAW ON END-OF-LIFE DECISIONS

The Italian legal order appears to adopt a position closer to that of United States courts under the doctrine there known as “substituted judgment”: a legal representative giving voice to the wishes of the patient (insofar as they have been manifested) as to the withdrawal or withholding of ‘futile’

89 *WK v Public Guardian* [2006] ADT 93.
90 *Re BMV, Ex parte Gardner* [2003] VSC 173.
91 Faunce and Stewart, *supra* note 85.
medical treatment. The Australian legal system, on the other hand, appears to prioritise the interpretation of a guardian and/or the patient’s physicians as to the patient’s “best interests”.

The Italian Supreme Court found that the Milan Public Prosecutor’s lacked power to impugn a judicial finding of persistent vegetative state. The Bill (No. 2350), approved by the Senate of the Italian Republic on 26 March 2009 and recently amended by the Chamber of Deputies, prohibits (under articles 575, 579 and 580 of the Italian criminal code) any form of euthanasia and assistance to suicide. This position is similar to most jurisdictions in Australia—although two jurisdictions, the Northern Territory and the Australian Capital Territory (as mentioned) attempted to pass legislation permitting euthanasia in circumstances where the patient is certified independently by two expert doctors to be suffering a terminal illness, to not be suffering mental impairment and to be fully informed about palliative care options.

The disinclination of Australia to legally embrace or bestow legal certainty in relation to voluntary euthanasia and physician-assisted suicide may become a driver for the popularity of overseas euthanasia tourism.92 The Exit International website created a political storm in Australia and became one of the blacklist targets of proposed mandatory internet censorship legislation.93 Already Exit International has countered the censorship legislation by offering master classes in computer hacking to evade the filtering technology.94

Due to the illegality of physician-assisted suicide, covert euthanasia involving the medical profession is probably widespread in Australia (for example creation of a false clinical pretext enabling the administration of mounting doses of drugs or fabrications as to the official cause of death).95

In its judgment in the Eluana Englaro Case the Italian Supreme Court confirmed that adult fully informed and competent patients have the

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93 Measures to Improve Safety of the Internet for Families Bill 2010 (Cth).
95 In 2004 Roger Magnusson of Sydney Law School reported on interviews he had conducted with doctors who had engaged in voluntary active euthanasia of HIV/AIDS patients. His report details a troubling twenty percent of physician assisted suicide attempts were bungled and occasionally led to suffocation and strangulation. Roger Magnusson, “Underground Euthanasia’ and the Harm Minimization Debate”, 32 Journal of Law, Medicine & Ethics (2004), pp. 486–495.
right to refuse treatment even if such a course is reasonably likely to lead to his or her death.96 This is also the law in Australia.

Like Australia, Italy has endeavoured to prohibit euthanasia and advocate for advance care directives through its Bill.97 The Bill is closely aligned with the current Australian position by criminalising active voluntary and involuntary euthanasia but it achieves this goal in a slightly more explicit manner by identifying murder by consent as a specific crime.98 The Bill facilitates pain therapies along the lines of palliative care much like the Australian law. It allows health professionals to act with their own initiative for the safeguarding of the patient’s health where advance care directives are non-existent. This contrasts with the Australian position of assigning a ‘person responsible’ as a guardian to make similar decisions.

The two jurisdictions are disagree in relation to the provision of artificial nutrition and hydration. The Australian common law enables withdrawal and withholding of such support in situations of clinical futility, under advance care directives (it holds that food and water are a form of medical treatment for the critically ill) and medical treatment refusal, whilst the Italian bill requires such nutrition be maintained until end of life in all circumstances where it sustains bodily functions. Prior to the Bill the Italian courts had a softer stance on the withdrawal of artificial nutrition. It was only in 2008 that they enunciated that guardian possessed the power to make a legitimate decision of this sort where the vegetative state was irreversible and where such an action was perceivably a “true expression” of the patient’s wishes as unequivocally determined by lifestyle, beliefs, personality, declarations and their notion of dignity.

There is a generalised consensus in Australia that advance care directives come into play at any time where a patient is incompetent and has provided a direction of adequate specificity in compliance with the rules of creation. However, the Bill intentionally limits advance care directives to situations of permanent incompetence as declared by a medical board and so are inapplicable where patients might waiver in and out of mental competence throughout their illness.

The Bill also states that advance directives can be only in written and signed form whereas the law in Australia recognises that patients who have certain disabilities or have deteriorated may not be able to sign such a document so oral agreement of advance directives is allowed.

97 See supra note 2.
98 Article 579 Criminal Code (Italian).
Notably the Italian law allows doctors to override patient advance directives in cases of urgency whereas the Australian law does not.

The two countries differ in their methodology for the appointment of competent trustees, the Italians presenting a more streamlined process attached to the creation of the advance directive whilst the Australian law appears to segregate the creation of the advance directive from the law on powers of attorney for appointment of an agent. However, both methods serve the same end and see that the principal’s wishes are observed by the appointed agent. Even so, in Italy it is proposed that the doctor is given authority to disregard both the advance care directive and the trustee after consideration and with reason, this option is not contemplated by the Australian law and doctors have a duty to comply with patient wishes.

Australia has no national regulation on the use of Advance Directives, instead each of the six states and two territories have their own laws (both common law and legislation) that refer to the construction and use of these instruments.99

Despite Australia being a largely secular society, religious groups still influence political decision making and Australia’s lack of any constitutional rights or Bill of Rights has meant that the any explicit ‘right to die’ has largely not been legally considered. It has arguably been dealt with, however, in acknowledging the right to individual bodily inviolability and the recognition of advance care directives as a potential instrument for the expression of this right.100 The enactment of human rights legislation in Australian jurisdictions (particularly that prohibiting cruel, unusual or degrading medical treatment) will become an increasingly important method for protecting their ageing populations facing the prospect of dying in either a hospital intensive care unit or under palliative care.

99 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); Guardianship and Administration Act 1990 (WA); NSW and Tas common law.