REFUSAL BY AGENTS OF LIFE-SUSTAINING MEDICAL TREATMENT

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[*In 1990 the Medical Treatment Act 1988 (Vic.) was amended to allow patients to appoint by enduring power of attorney an agent to make medical decisions on their behalf were they to become incompetent. This article examines the legislative history and policy issues which lie behind the legislation and the legislation itself, including the appointment of agents by enduring power of attorney, the notions of competence and incompetence, revocation of appointments, the grounds on which agents may act and appeals to the Guardianship and Administration Board.*]

When does the law allow decisions to be made refusing life-sustaining medical treatment? Many factors need to be taken into account in answering that question. However, a start can be made by recognizing three broad situations. The first is that where a competent patient himself or herself makes the decision to refuse treatment which is proposed to be given. The second arises where a competent patient wishes to make or influence a decision prospectively or conditionally. This is the situation where the patient is not currently in need of life saving treatment but foresees that the time may come when he or she will need that form of treatment but may not then be competent to make the decision. The third broad category is that where the patient has never been competent to make the decision or has never while competent given any indication of what the decision would be.

The first type of case, covering decisions by competent patients, has been examined in an earlier article.[1] The third relating mainly to incompetent patients will be discussed in a later one. The second situation has provoked a number of legislative and judicial attempts to give competent prospective patients a right to make decisions in advance or influence decisions yet to be made. The first solution is to allow for the making of what is generally known as a living will. The second is to provide for the appointment of an agent to make decisions when the patient is incapable of making them.

This article is concerned primarily with the second solution and takes as its model the Medical Treatment Act 1988 (Vic.) which was amended on 6 August 1990 to allow for the appointment of agents by enduring power of attorney.

The article first looks at the history of the legislation and considers some of the responses and concerns that were raised by the community. Included in this is a discussion of the 'slippery slope' argument which was seen by some as an inevitable peril of the legislation. The second part of the article considers the

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

legislation including the meaning of competence and incompetence — pivotal concepts within the Act.

I *THE HISTORY OF THE LEGISLATION*

Legislation dealing with the right of the individual to refuse medical treatment was first proposed in Victoria in 1980. A private member's Bill, the Refusal of Medical Treatment Bill 1980 (Vic.), was introduced (and subsequently defeated) which allowed an adult who was suffering from an irreversible and fatal disease or injury to declare that life-sustaining procedures should be terminated.

In 1983 South Australia introduced similar legislation. The Natural Death Act 1983 (S.A.) allowed an adult to direct that in the event of terminal, irrecoverable illness, he or she should not be subjected to extraordinary measures. This was at the time the only piece of legislation in the Australian states that recognized the individual's right to declare in advance that life-sustaining measures should be withheld.[2]

In March 1986 the Social Development Committee (a Victorian Parliamentary Committee) published its *First Report on Inquiry into Options for Dying with Dignity: Incorporating a Discussion Paper: A Range of Views of Options for Dying with Dignity*. Submissions and comments were invited from specific individuals, organizations and institutions, and from the public. Public hearings were also arranged throughout Victoria, as were visits by the Committee to hospitals and other health care institutions.

In all, 1379 submissions were received and 152 witnesses gave evidence.[3] Many of the submissions and much of the evidence revealed highly charged, emotive and diverse reactions, ranging from those entirely convinced that legislation was appropriate and necessary, to those at the other end of the spectrum who likened the proposals to the doctrines of Nazi Germany.

References to Nazi Germany were made at various points in the history of what was to become the Medical Treatment Act 1988 (Vic.).[4] These references are primarily concerned with the slippery slope argument, an argument often raised when legislation touching on matters of life and death is mooted. It is worth examining this argument before tracing the later developments of this particular legislation. In this context the slippery slope argument is that legislation permitting one person to make medical treatment decisions on behalf of another is one step away from the mentality of the Nazis, diminishing society's obligation to care for the disabled and aged.[5] It has been suggested that decisions by another that one person's life is not worth living devalue life itself and reflect a disturbing and increasing trend that life of 'lesser quality' is not worth living.[6]

[2] Victoria, Parliament, Social Development Committee, *Report Upon the Inquiry into Options for Dying with Dignity: Second and Final Report* (April 1987) 48.

[3] *Ibid.* 4.

[4] *E.g.* in letters to the Social Development Committee. These letters are kept by the Committee at Nauru House, Melbourne. See also Mr Hann, during debate of the Second Reading Speech on the Medical Treatment Bill, Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 1988, 2246-53; Barnard, M., 'Step on the Road to Disposable People', *Age* (Melbourne), 10 May 1988.

[5] Fink, J., 'Book Review' (1989) 23 *Columbia Journal of Law and Social Problems* 115, 135, reviewing Gervais, K. G., *Redefining Death* (1988).

[6] *In Re Guardianship of Grant* 747 P.2d 445 (1987), 463 *per* Goodloe J.

Arguing that judgments about the 'social worth' of individuals must be avoided,[7] some foresee great difficulties in the assessment of quality-of-life points where someone is severely disabled but conscious.[8]

Those concerned about the slippery slope argument contend that once the slippery slope has begun it is difficult to terminate.[9] However, others have rejected the notion of the slippery slope, arguing that it is 'perfectly possible for the law . . . to put up a barrier so that people do not have to slither further down the slope than they wish to go'[10].

That, however, is only part of the answer. Effectively drafted safeguards may act as a brake on undesirable developments but such safeguards can be removed by later legislation. This possibility was considered by Sir Frank Little, Roman Catholic Archbishop of Melbourne, in a statement quoted by the Hon. Mr McCutcheon, Attorney General, in his second reading speech on the Medical Treatment Bill 1988 (Vic.): 'Should any attempt be made in future years to alter [the Bill's] orientation a battle may have to be fought at that time.'[11] Even so the battle may be harder to fight and may be lost because of the gradual acceptance of the earlier developments. So some examination of the substance of the slippery slope argument must be undertaken.

As noted above the Nazi march from euthanasia to genocide is often cited as an example of the existence of the slippery slope in debates about the right to die. The argument is eloquently and cogently put by Dr Leo Alexander, consultant to the United States' Secretary of War on duty with the Office of Chief of Counsel for War Crimes, Nuremberg:[12]

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life unworthy to be lived. This attitude in the early stages concerned itself merely with the severely and chronically sick.[13]

The difficulty with relying on this as an example of the slippery slope is that it seems to suggest that the first step down the slope was only a little one. But it is clear from Dr Alexander's article itself that the Nazis had genocidal intentions

[7] Rothenberg, K. H., 'Foregoing Life-Sustaining Treatment: What are the Legal Limits in an Aging Society?' (1989) 33 *Saint Louis University Law Journal* 575, 594.

[8] Hentoff N., 'The Church, the Law, and the Advancing Armies of Death' (1990) 33 *The Catholic Lawyer* 1, 6.

[9] Kamisar, Y., 'Some Non-Religious Views against Proposed Mercy-Killing Legislation' (1958) 42 *Minnesota Law Review* 969.

[10] Baroness Warnock, Mistress of Girton College, Cambridge presenting an oral submission to the Social Development Committee on 30 July 1986, 6. Submissions to the Committee are kept by the Social Development Committee at Nauru House, 80 Collins Street, Melbourne, Victoria 3000. See also *In Re Guardianship of Browning* 543 So 2d 258, 269 (1989), affirmed 568 So. 2d 4 (1990) 13; Smith, G. P., 'All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination' (1989) 22 *University of California Davis Law Review* 275, 417.

[11] Victoria, *Parliamentary Debates*, Legislative Assembly, 5 May 1988, 2168. See also Kuhse, H. and Singer, P., *Should the Baby Live* (1985) 95.

[12] Alexander, L., 'Medical Science under Dictatorship' (1949) 241 *New England Journal of Medicine* 39. In the last year of his life, 1985, Dr Alexander saw similarities between America in the 1980s and Germany in the 1920s and 1930s; Koop, C. E. and Grant, E. R., 'The Small Beginnings of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy Killing' (1986) 2 *Journal of Law, Ethics and Public Policy* 585, 590.

[13] *Ibid.* 44.

some time before Hitler began his euthanasia programme.[14] The racial purity programme, of which so called euthanasia and genocide were parts, had to start somewhere. In numerical terms there were fewer disabled victims than non-German victims, but qualitatively there is no difference between putting to death a person who is chronically sick and putting to death a person who is not a German. The order to kill the disabled was not a marginally acceptable development which by gradual increments of diminishing sensitivity would lead eventually to the unthinkable. It was a leap straight off the precipice.[15]

While slope arguments should not be dismissed lightly, the Nazi outrage is far removed both procedurally and substantively from the development of the Victorian legislation in this area. After extensive consultation with the community, the Social Development Committee completed the second and final report, *Inquiry into Options for Dying with Dignity*, in April 1987. Some of the recommendations of the report were enacted in the form of the Medical Treatment Act 1988 (Vic.).[16] However, provisions dealing with the appointment of an agent to make decisions on behalf of the appointor were defeated.

Amendments to the provisions tightening the safeguards to the individual were introduced in the Legislative Council in May 1989. The matter was adjourned until September 1989 when heated debate continued, particularly over the procedural safeguards in the proposed legislation. These issues were adjourned for further debate before the Legislative Assembly in April 1990 when consensus was achieved. After substantial revision from its initial form, the legislation was enacted in April 1990.

The new provisions, dealing with agents, were brought into force on 6 August 1990. Just before that a seminar was held by the Victorian Hospitals Association and the Office of the Public Advocate (VHA Seminar). A number of speakers closely associated with the history and administration of the legislation explained its purpose and intended effect. Various points raised at that seminar will be dealt with in the course of this article.

II *THE LEGISLATION*

A *General*

The mechanism that allows a competent person to appoint another to make medical decisions on behalf of that person is contained in sections 5A to 5D of the Medical Treatment Act 1988 (Vic.). Section 5A provides that a person may appoint an agent by way of an enduring power of attorney (medical treatment) in the form of Schedule 2.[17]

[14] *Ibid.* 40.

[15] Weindling, P., in *Health, Race and German Politics between National Unification and Nazism 1870-1945* (1989) 9, records that the Nazi takeover marked a fundamental change in the course of German eugenics with a great emphasis on racial factors.

[16] For a discussion and analysis of the Medical Treatment Act 1988 (Vic.) see Lanham, D., 'The Right to Choose to Die with Dignity' (1990) 14 *Criminal Law Journal* 401.

[17] S. 11 of the Act amends s. 117 of the Instruments Act 1958 (Vic.) by inserting '(5) An enduring power of attorney, whether made before or after the commencement of the Medical Treatment (Enduring Power of Attorney) Act 1990, does not authorize the attorney to make a decision about the medical treatment of the donor of the power'.

The enduring power of attorney must be witnessed by two persons, one of whom must be a person authorized by law to witness the signing of a statutory declaration. Those appropriately qualified are listed in section 107A of the Evidence Act 1958 (Vic.), and include lawyers, Members of Parliament, doctors, school principals and police officers. The requirement of this kind of witness highlights the importance of the decision to the individual and to the community.[18] Neither of the witnesses may be the agent to be appointed, thus providing one of a number of procedural safeguards in the legislation.

B *The Agent*

A number of points about agents were raised at the VHA Seminar. One was whether a person could appoint more than one agent. The usual rule in interpreting legislation is that the singular includes the plural.[19] The appointment form contains room for only one name to be entered, but Mr Lawson, the President of the Guardianship and Administration Board, took the view that the form could be adapted to enable more than one name to be entered. However, another member of the seminar panel, Mr Snowdon, legal adviser to the Victorian Hospital Association, warned of the possible confusion which could be occasioned if more than one agent were appointed. On the whole it would seem better to limit the appointment to one agent. If that agent were to die or become unwilling to act while the patient was still competent, the patient could make a fresh appointment naming a new agent. There is, however, the possibility that the agent may die or become incapacitated or unsuitable without the knowledge of the appointor or in circumstances where there is no time to make a fresh appointment. One example would be the case where the appointor and agent, say husband and wife, were badly injured in the same car accident. To eliminate or reduce the risks in this kind of situation the appointment of a second agent would be sensible. Care would have to be taken, however, to indicate that the second agent would have authority only if the first agent became incompetent or otherwise unavailable,[20] unless the appointor contemplates a joint decision. The risk of disagreement between the agents in such a case may well outweigh the risk of a common tragedy.

One case where more than one agent may be advisable is where either the agent or the patient does a lot of travelling outside Victoria. It may be that a patient would prefer a decision on the spot by the agent of his or her second choice rather than by the agent of first choice who may be far away or incommunicado. Again the complexity of such an arrangement may outweigh

[18] This view was expressed by Mr Tony Lawson, President of the Guardianship and Administration Board, at a seminar held on 23 June 1990 at the offices of the Guardianship and Administration Board, Melbourne.

[19] See the Interpretation of Legislation Act 1984 (Vic.) s. 37.

[20] The Law Reform Commission of Western Australia has recommended that there should be power to appoint successive agents: Western Australia Law Reform Commission, *Report on Medical Treatment for the Dying*, Project No. 84 (1991). See also Bos, J. E., 'The Durable Power of Attorney' [1985] *Michigan Bar Journal* 690, 694.

the theoretical advantages and there is much to be said for keeping the system as simple as possible.[21]

C *Competence and Incompetence*

Whoever the agent is, he or she has power to act only if the person giving the power becomes incompetent (s. 5A(2)(b)). However, the Act is silent on the meaning of incompetence. Although the Social Development Committee in their second report defined incompetence for the purposes of their work,[22] no definition was adopted in the legislation. During debate on the Bill in the Legislative Council, it was suggested that competence is a matter of clinical judgment best left to the medical profession,[23] and it was expected that eventually the government would introduce a legal definition of competence.[24] The Guardianship and Administration Board and the Public Advocate later adopted guidelines on this aspect of competence which read as follows:

> There is no general test of competence. A lay person will make a judgment on what he or she sees, hears and believes after a discussion with the person.
> Two tests of competence are generally used.
> The *legal test of competence* requires that a person understands (perceives the meaning of) the nature and effect of what he or she is doing or signing.
> The *medical test of competence* requires that a person is orientated in space and time, has some degree of rational thought and a reasonable understanding of issues involved. This is ascertained using standard questions.
> In practice the tests probably require the same degree of competence on the part of the person.[25]

The guidelines go on to point out that a person signing an enduring power of attorney (medical treatment) would need to understand that the power allows the agent to make decisions about medical treatment (including refusing treatment) when the giver becomes incompetent.[26]

Although there is currently no statutory definition of competence and incompetence, in most cases the distinction between competence and incompetence will be clear. Incompetence will generally occur where the individual is unconscious, in a coma or persistent vegetative state, or is mentally incapacitated.[27]

Great difficulty exists where the person has suffered illness or injury that has left him or her able to communicate to a limited degree and medical opinion is divided or equivocal on the extent of the person's understanding. In such cases that have found their way to court (primarily on the issue of the termination of life-supporting treatment), the court becomes the arbiter on the question of

21 The Medical Treatment (Agent's) Bill 1992 (Vic.) would allow the appointment of alternate agents.

22 Social Development Committee, *op. cit.* n. 2, 174-5. An incompetent patient is one who is not capable of understanding the nature, consequences and risks of the proposed medical treatment and the consequences of non-treatment, and who is thus incapable of consenting to, or refusing, medical treatment, but does not include an incompetent patient during a period of competency. The Committee also pointed out that refusal of treatment is not in itself grounds for declaring a person incompetent: 157, 167, 169.

23 Victoria, *Parliamentary Debates*, Legislative Council, 6 September 1989, 254.

24 Victoria, *Parliamentary Debates*, Legislative Council, 5 September 1989, 170.

25 Office of the Public Advocate, *Tests of Competence for the Medical Treatment Act* (1991) 1.

26 *Ibid.* 4.

27 *In Re Conroy* 486 A. 2d 1209 (1985) the New Jersey Supreme Court refused to limit incompetence in this context to unconsciousness. See also Homes, C. C., 'The Elderly Incompetent — the Right to Die with Dignity' (1990) 13 *Campbell Law Review* 57.

competence. In Australia and England, few cases have been litigated over the right of an individual or her or his family to terminate such treatment. However, substantially more cases exist in the United States on the termination of life-supporting treatment, and some of these cases consider incompetence (although, in the vast majority of cases, this is not at issue as the individual is clearly incompetent). Consideration of these cases may provide assistance to Victorian administrators and courts on the meaning of incompetence. While many of these cases grapple with the definition of incompetence to determine whether the individual is capable of consenting to or requesting the termination of treatment, the issue of what constitutes incompetence is relevant to the Victorian situation because the provisions of the legislation appointing an agent become effective only when the appointor becomes incompetent.

In the case of *In Re Guardianship of Browning*,[28] the guardian of an 89 year old woman who had suffered a massive stroke sought the Court's permission to terminate the patient's nasogastric feeding. The patient had suffered major and permanent brain damage although she responded to painful stimuli. Though not comatose she was not able to communicate. She appeared alert and would follow a visitor with her eyes. However she would not blink in response to simple questions. There was evidence that she had tried to speak but the words were unclear and the speech was garbled. A neurologist gave evidence that she was in a persistent vegetative state.[29] The court concluded that Ms. B. was incompetent, and that her guardian could decide to withdraw treatment on the basis of substituted judgment.

In the case of *In The Matter of Westchester County Medical Center Re O'Connor*,[30] a hospital (on appeal) sought the Court's permission to administer a nasogastric feeding tube to a 77 year old patient suffering from multiinfarct dementia which substantially impaired her cognitive ability. She was capable of responding to simple questions and requests either verbally or by squeezing the hand of the questioner. She was also sensitive to noxious stimuli although not in pain. Her treating physician testified that her mental awareness was improving and that she might become more alert in the future. One medical expert testified that the patient was able to converse in short sentences of two to three words. However, another medical expert considered that the patient was unable to comprehend complex questions and doubted that she would regain significant mental capacity.[31] The Court concluded that the patient was incompetent. However, the Court held that the hospital should be allowed to administer the nasogastric feeding because there was no clear and convincing proof that the patient had declared firmly her wish to decline artificial life support.

A similar conclusion was reached in *In the Matter of O'Brien*[32] where the Court held that an 83 year old man who had suffered a major stroke was capable of understanding and reacting to his basic needs and wants, but not competent to

[28] 568 So. 2d 4 (1990).
[29] *Ibid.* 9.
[30] 531 N.E. 2d 607 (1988).
[31] *Ibid.* 609-10.
[32] 517 N.Y.S. 2d 346 (1986).

make profound decisions about medical treatment. He was being fed through a gastrostomy tube. Because of conflicting psychiatric testimony on the issue of competence, the Court visited the patient in hospital and found that his degree of alertness varied considerably. The Court concluded that his depth and degree of understanding of his condition was open to question, and without clear and compelling indications from Mr O. that he wished to have the gastrostomy tube removed, the Court allowed the hospital to continue the treatment.

Considerable practical difficulties arise where the patient's ability to communicate has been significantly affected and the level of functioning and awareness cannot be readily ascertained.[33] Thus in *Ross v. Hilltop Rehabilitation Hospital*,[34] a 34 year old man who suffered a cerebral vascular stroke 'was left in a locked-in state in which his mind was intact and functioning, but his body was severely physically disabled.'[35] Mr R. was unable to speak although he could respond to yes-no questions by moving his head and was able further to communicate through the use of a letter board. Mr R. advised a hospital aide, using the letter board, that he no longer wanted to continue medication, nutrition and hydration by the gastrostomy tube. The Court held, after considering the evidence of experts in psychiatry, psychology, neurology and other specialists, that Mr R. 'retained the ability to comprehend and communicate his thoughts, and that he did not suffer from a mental disability.'[36]

One of the most disturbing aspects of determinations of incompetence is the possibility of spontaneous recovery. Hentoff[37] chronicles episodes where individuals have regained consciousness despite unanimous and unequivocal medical opinion that chances of recovery were nil.[38] While such instances provoke concern about the inevitable uncertainty of medicine, they should not be allowed to govern the vast majority of cases where the prognosis is correct.[39]

A problem also arises where the patient who is now mentally disabled seems to be enjoying his or her new existence. Should he or she be protected from his or her former competent self?[40] As Fink notes,[41] people's opinions change and what they may suppose to be intolerable may not in fact be intolerable. This is particularly relevant where a person suffering from dementia remains responsive

33 See *In The Matter of George Clark* 510 A. 2d 136 (1986) 137.
34 676 F. Supp. 1528 (1987).
35 *Ibid.* 1530.
36 *Ibid.* 1532.
37 Hentoff, *op. cit.* n. 8, 1. See also the evidence of the Hon. Dr M. Mackay, Chairman Brain Injury Division, Australian Brain Foundation submitted to the Social Development Committee (1986) Transcript 931-2, available at Nauru House, Melbourne. See n. 10.
38 Hentoff, *op. cit.* n. 37, 8-9.
39 There are estimates that in the United States there are 10,000 people in a vegetative state with no hope of recovery. For further discussion see Pedrick, W. H., 'Arizona Tort Law and Dignified Death' (1990) 22 *Arizona State Law Journal* 63, 87; Schwartz, R. L., 'Euthanasia and the Right to Die: Nancy Cruzan and New Mexico' (1990) 20 *New Mexico Law Review* 675, 690 pointing out that the miraculous recovery argument could be applied to brain death.
40 Dresser discusses the concept of new and old 'self' and suggests that the incompetent patient's former competent preferences may conflict with the patient's present well-being. See Dresser, R., 'Relitigating Life and Death' (1990) 51 *Ohio State Law Journal* 425, 431-2; Oxman, M. L., 'The Encouragement of Empathy: Just Decisionmaking for Incompetent Terminal Patients' (1988-9) 3 *Journal of Law and Health* 189.
41 Fink, *op. cit.* n. 5, 134.

to and aware of their environment. Although the courts appear not to have confronted this issue, it is suggested that a presumption in favour of life would operate.

It has been argued that in order to achieve a consistent and coherent assessment of competency, the issue should not be left to the medical profession but rather the legislature should enact a definition of competency.[42] This approach has been adopted in some of the United States' statutes. For example in the proposed Health Care Surrogate Law of Missouri (Senate Bill 139), a surrogate would make the decisions for a person who no longer has decisional capacity (the ability to make and communicate health care decisions).[43] However, despite the definition, the difficulty still remains in determining when it should apply.

It may be that some of the problems with mentally disabled patients can be solved by recognizing that the test of competence varies even within the refusal of treatment situation.[44] A greater competence is required to understand the nature and consequences of a decision to sign one's life away than the competence necessary to cling onto a life which the patient might earlier have thought to be intolerable.[45]

D *Revocation of an Enduring Power of Attorney*

Section 5A(3) provides that an enduring power of attorney automatically revokes any earlier power of attorney. Subject to the three exceptions in s. 5A(4), revocation is also achieved in any other way that a general power of attorney is revoked.

An enduring power of attorney may be revoked by the grantor (while he or she is competent) either in writing or orally.[46] Normal agency principles suggest that notice to the agent is required,[47] and this approach has been adopted by the Office of the Public Advocate[48] which recommends that the grantor should notify the agent and request that he or she return the document. The Office of the Public Advocate goes on to suggest that in the event that the document is not returned, the grantor should attempt to contact the agent by placing a notice in the newspaper. While this is clearly the most prudent strategy, it is suggested that notice is not a necessary requirement. It may be sufficient in some situations (where the agent is abroad or uncontactable) for the grantor to inform as many

42 Woolf, K. R., 'Determining Patient Competency in Treatment Refusal Cases' (1990) 24 *Georgia Law Review* 733, 751.

43 Miltenberger, B., 'The Dilemma of the Person in a Persistent Vegetative State: A Plea to the Legislature for Help' (1989) 54 *Missouri Law Review* 645, 662.

44 For a different view see Moore, D. L., 'The Durable Power of Attorney as an Alternative to the Improper Use of Conservationship for Health Care Decision Making' (1986) 60 *St John's Law Review* 631, 662.

45 One solution is to recognize that a lesser degree of competence is necessary to revoke an agency than to appoint an agent. See also section D *infra*.

46 *The Margaret Mitchell* (1858) Sw. 382; (1858) 166 E.R. 1174; *R. v. Wait* (1823) 11 Price 518; (1823) 147 E.R. 55.

47 Reynolds, F. M. B., *Bowstead on Agency* (15th ed. 1985) 520.

48 Office of the Public Advocate, *Information About the Medical Treatment Act* 6 August 1990, 2.

relevant people as possible (relatives, friends, medical practitioners, the hospital) that he or she no longer wishes the agent to act on his or her behalf.

It is instructive to consider the approaches taken by other jurisdictions on the matter of revocation. The proposed Missouri legislation expressly provides for revocation orally, in writing, by destruction of the document, or at the direction of the grantor (where the grantor has decisional capacity).[49] However, as Miltenberger notes,[50] other statutes (including the legislation of Arkansas, Delaware and Washington) provide for revocation of the declaration despite mental incapacity.[51] Although most statutes provide for oral revocation, some require that the statement be made before witnesses (*e.g.* Delaware).[52] Section 6 of the model Right to Refuse Treatment Act[53] requires that the intent to revoke be a specific intent. The commentary explains that merely signing a blanket hospital admission form giving consent to whatever treatment doctors wish to administer is insufficient indication of revocation. This makes good sense and the Victorian legislation should be interpreted in the same way.

As indicated above, there are three express situations where the power of attorney is not revoked. The first of these is where the donor becomes subsequently incapacitated (s. 5A(4)(a)). Clearly, if this were not the case, the legislation would be of no effect. The second situation arises where the donor becomes a represented person within the meaning of the Guardianship and Administration Board Act 1986 (Vic.) (s. 5A(4)(b)(ii)). Thus, an agent retains the right to act on the patient's behalf even if an administrator or non-medical guardian is subsequently appointed under the Act. The third situation occurs if the donor becomes a protected person within the meaning of the Public Trustee Act 1958 (Vic.) (s. 5A(4)(b)(i)).[54] This scheme makes good sense. In some cases the person appointed as agent to make medical treatment decisions on the patient's behalf may not be the most appropriate person to deal with other matters such as finance. Thus, where a patient has appointed her husband as her agent under the Medical Treatment Act 1988 (Vic.), the subsequent appointment of another person under the Guardianship and Administration Board Act 1986 (Vic.) or the Public Trustee Act 1958 (Vic.) to administer the patient's financial matters will not erode the authority of the agent in making medical treatment decisions.

The position appears to be different, however, where a person who has appointed an agent becomes an involuntary patient under the Mental Health Act 1986 (Vic.). This situation is not expressly dealt with in the Medical Treatment Act 1988 (Vic.) but powers under the 1986 Act are preserved by s. 4(3) of the 1988 Act which provides that the legislation does not limit the operation of any

49 Miltenberger, *op. cit.* n. 43, 664, 670.

50 *Ibid.* 670.

51 A similar provision has been recommended by the Law Reform Commission of Western Australia, *op. cit.* n. 20.

52 Miltenberger, *op. cit.* n. 43, 670.

53 Legal Advisors Committee, Concern for Dying, 'The Right to Refuse Treatment: A Model Act' (1983) 73 *American Journal of Public Health* 918, 921.

54 As the Public Trustee Act 1958 (Vic.) had been repealed before the enactment of s. 5A, this provision would appear to have little, if any, practical effect.

other law. Under s. 12(5) of the Mental Health Act 1986 (Vic.), if an involuntary patient is not capable of consenting to treatment for his or her mental illness, consent may be given by a guardian or if there is no guardian, by an authorized psychiatrist. Suppose then that X appoints A as an agent under the Medical Treatment Act 1988 (Vic.) and instructs A that he does not want psychiatric treatment under any circumstances. If X becomes an involuntary patient X's guardian or the authorized psychiatrist can authorize psychiatric treatment even if the agent wishes to forbid it.[55] Similarly an involuntary or security patient can be subjected to electroconvulsive therapy under s. 73(3) of the Mental Health Act 1986 (Vic.) even if the patient had previously appointed an agent with instructions to refuse the treatment.[56] In addition ss 83-86 of this Act confer powers on authorized psychiatrists, guardians and the Guardianship and Administration Board to consent to non-psychiatric treatment on behalf of involuntary or security patients. These powers also appear to override those of agents appointed under the Medical Treatment Act 1988 (Vic.).[57]

An intermediate situation could arise if a guardian (with power to make medical decisions) were appointed under the Guardianship and Administration Board Act 1986 (Vic.) in cases other than involuntary and security patients. The agent would continue to have authority in relation to the patient's treatment but so would the guardian.[58] However the Office of the Public Advocate regard it as highly undesirable for the Board to appoint a guardian where there is an agent with a medical power of attorney and will take steps to check the existence of an agency with a view to obviating the difficulty.[59]

E *Age and Competence*

While s. 5A confers power to appoint an agent, the section itself does not set any limits on the principal. It does not explicitly require that the appointor must be competent or of age.

However, s. 5 of the principal Act provides that a patient who has been informed about the nature of his or her condition and who is of sound mind and has attained the age of 18 years may refuse medical treatment by completion of a refusal of treatment certificate. It follows then that a person appointing an agent must also be competent to make such a decision. This is made explicit in the enduring power of attorney (medical treatment) form where both witnesses must state that the donor is of sound mind.[60]

While the enduring power of attorney (medical treatment) form makes no

55 See McNamara, M., 'The Implications of the Medical Treatment Act (As Amended) for Mental Health Professionals' (1990) *Memorandum to Members of the Mental Health Review Board* 5.

56 *Ibid.*

57 *Ibid.* 6.

58 *Ibid.* 4.

59 *Ibid.* For a discussion of this problem in United States law, see Fowler, M., 'Appointing an Agent to Make Medical Treatment Choices' (1984) 84 *Columbia Law Review* 985, 1025-30.

60 This is given further support by the operation of s. 5A(2)(b) which permits an appointment of an agent to take effect if and only if the person giving the power becomes incompetent, thereby implying the requirement that the person must have been competent at the time of making the appointment. For the meaning of competence and incompetence see section C above.

reference to the age of the donor, a reference to age does appear on the 'Refusal of Treatment Certificate — Agent or Guardian of Incompetent Person' form where the agent must certify that the patient has attained the age of 18 years before the decision to refuse treatment comes into effect. This seemingly creates an anomaly in allowing a person who is not yet legally of age to appoint an agent but prohibits the agent from refusing medical treatment until the patient attains 18 years of age. On the other hand it may be that the legislative scheme as a whole contemplates that the agency provisions are directed at adults and the requirement in the appointment procedure that the appointor be an adult may have been an oversight.[61]

Further support for the age requirement appears in s. 5A(1)(b) which allows a guardian to make decisions about medical treatment for a person who is a represented person.[62] Section 19 of the Guardianship and Administration Board Act 1986 (Vic.) limits the appointment of a guardian to a person with a disability who has attained the age of 18 years.

F *Refusal of Treatment by an Agent*

Section 5B of the legislation outlines how an agent (or guardian) may refuse treatment on behalf of the patient. Once the power of attorney becomes effective, the agent may refuse medical treatment generally or may refuse medical treatment of a particular kind for the patient's condition (s. 5B(1)(c)&(d)). A medical practitioner and another person (neither of whom may be witnesses to the appointment of the agent) must both be satisfied that the agent has been informed about the patient's current condition to an extent which is reasonably sufficient to enable the patient, if he or she were competent, to make a decision about the refusal of treatment (s. 5B(1)(a)). Further, both the medical practitioner and the other person must be satisfied that the agent understands the information given to him or her (s. 5B(1)(b)).

Section 5B(2) restricts the agent's capacity to refuse medical treatment on behalf of the patient to situations where the medical treatment would cause unreasonable distress or where there are reasonable grounds for believing that the patient, if competent, would consider that the treatment was unwarranted (s. 5B(2)(a) & (b)). Although not explicit, medical treatment that causes unreasonable distress may be construed to include treatment that by its nature is not necessarily distressing but would cause distress to the particular patient, for example a blood transfusion to a Jehovah's Witness. In the absence of such considerations, however, this part of the test appears to be objective so that medical opinion will be important.[63]

61 The Law Reform Commission of Western Australia has recommended that the power to execute an enduring power of attorney should be limited to adults, *op. cit.* n. 20, 15.

62 In this context, the Guardianship and Administration Board Act 1986 (Vic.) s. 22 defines a represented person as one who has a disability and is unable by reason of the disability to make reasonable judgments in respect of all or any matters relating to her or his person or circumstances and is in need of a guardian.

63 See Andrews, K., 'The Medical Treatment Act and the Incompetent Patient' (September 1990) 8 *St Vincent's Bioethics Centre Newsletter* 1, 2.

If the agent or guardian decides that treatment ought to be refused then the legislation stipulates in s. 5B(3) that a refusal of treatment certificate must be completed in the required form, that is, Schedule 3 or the 'Refusal of Treatment Certificate'. This form must be completed by the agent, the medical practitioner and another witness. Thus four individuals other than the agent are required to witness and sign the forms that constitute this scheme, providing another procedural safeguard.

Although it is possible that all four people and the agent may conspire against the patient, the prospect is remote and, in any case, provision exists for a concerned individual to apply to the Guardianship and Administration Board under s. 5C for a revocation of the agent's authority. A further disincentive for parties to collude against the patient is contained in s. 5F which provides for penalties against those who obtain a certificate through fraud. Thus where a person who by deception, fraud, mis-statement or undue influence, obtains the patient's signature on a certificate, that person forfeits any interest under the will, instrument or intestacy of the patient. Similarly an interest under any instrument where the patient is the donor, settlor or grantor, or an interest in the estate of the patient on the death intestate of the patient would also be forfeited.

To return to s. 5B on the issue of reasonableness, there seems to be a discrepancy between the legislative requirements of s. 5B(2)(a)&(b) and the 'Refusal of Treatment Certificate'. The legislation stipulates that where there are reasonable grounds for believing that the patient would consider the treatment unwarranted, or that the treatment would cause unreasonable distress, then the agent may refuse treatment. From the wording of the provision it seems that the test of reasonableness would require an objective standard to be met. However, the wording on the certificate suggests a more subjective test where the agent need only demonstrate that it was his or her belief that the patient would request that no medical treatment be administered. Thus there has been a shift in emphasis from objectively determining what the patient would consider unwarranted treatment to the more subjective analysis of what the agent believes the patient would request. There are two aspects to this problem.[64] One relates to what the patient would consider unwarranted and the other to the reasonableness of the agent's belief.

The first aspect should be resolved by recognizing that if a patient would refuse treatment he or she would also consider it unwarranted. In other words the Act is concerned with the patient's own set of values, not with what the patient may or may not know about what the law, morality, religion, ethics or other people may think warranted.[65] This interpretation is in line with the position relating to competent patients in s. 5 of the Act and gives full effect to the principle of self-determination which permeates the legislation.[66]

64 For a discussion of 'unreasonable distress' see Andrews, *ibid.*

65 For a different view, that the test incorporates a requirement of proportionality, see Andrews, *op. cit.* n. 63, 2. See also Tonti-Filippini, N., 'Appointing a Medical Agent' (March 1989) 7 *St Vincent's Bioethics Centre Newsletter* 1, 4.

66 Subject to the limitations relating to suicide. This is discussed in the first article in this series: Lanham, *op. cit.* n. 1, 407-15.

The second aspect is not so easily resolved. Section 5B(2)(b) requires reasonable grounds for the agent's belief. The certificate requires the agent to certify his or her belief but makes no reference to the reasonableness of the belief. Nor does the Act provide that the certificate is proof or even evidence of the reasonableness of the belief.[67] However, s. 6 which creates the offence of medical trespass, and s. 9 which provides a defence for those acting in accordance with a certificate, treat the certificate as the principal basis for imposing liability or conferring immunity respectively. This suggests that doctors faced with a certificate should and are entitled to treat it as valid unless there is reason to doubt its validity. In this immediate context this means that doctors are entitled and bound to treat the agent's belief as reasonable unless there is a ground for suspecting that the belief is unreasonable. Such a situation should rarely occur.

Different considerations apply at the stage before the certificate is witnessed by the doctor. The refusal of treatment form provides for the doctor to certify that the agent has sufficient information, that the doctor was not a witness to the enduring power of attorney, the patient's current condition and the incompetence of the patient. It does not require the doctor to certify that the agent has reasonable grounds for his or her belief that the patient would refuse the treatment. But the Act places no obligation on the doctor to witness the refusal certificate.[68] This provides an opportunity for the doctor to require something more of the agent than the bald assertion that the patient would refuse the treatment. The doctor could for example require the agent to provide details of any relevant statement made by the patient. A note of these details could then be appended to the certificate and placed in the patient's notes.[69]

G *Revocation and Suspension by the Guardianship and Administration Board*

As mentioned earlier, an important procedural safeguard is provided by the operation of s. 5C(1). This allows the Guardianship and Administration Board to suspend or revoke an enduring power of attorney on the application of either the Public Advocate, the agent appointed by the patient (although presumably this would be rare), or a person who is considered by the Board to have a special interest in the affairs of the patient (s. 5C(2)). Although the term is not defined, it is likely that 'special interest' will be construed widely to give full effect to this safeguard. Typically those with a special interest would include relatives, friends and the patient's medical attendants.

Under s. 5C(3) the Board may suspend the enduring power of attorney for a specified period where it is satisfied that the refusal of treatment is not in the best interests of the patient. There is no guidance given in the Act as to what may constitute the best interests of the patient but it is clear that the provision could be used to defeat any perceived devious or malicious intention on the part of the agent, or conspiracy between witnesses to the certificates and the agent, or to

67 Under s. 8 the refusal of treatment certificate is evidence that the patient has refused treatment. This seems to relate to certificates by competent patients. It says nothing about evidence of the reasonableness of the agent's belief.

68 Andrews, *op. cit.* n. 63, 4.

69 *Ibid.* 5.

counteract undue influence or family pressure. Section 5C(4) gives the Board authority to revoke the power permanently where the Board is satisfied that it is not in the best interests of the patient for the power to continue or for the power to continue to be exercisable by the agent.

There is a basic, though possibly unintended, contradiction in allowing the primary decision-maker, the agent, to make decisions based on the patient's wishes and allowing the Board to review the decision on a best interest test. The patient's wishes may not be in what others would regard as the patient's best interests, but the respect for self-determination which otherwise permeates the Medical Treatment Act 1988 (Vic.) suggests that the reasonableness of the patient's choice is beside the point. If this is correct, it would be appropriate to interpret best interests to mean what the patient regarded as in his or her best interests.[70]

The last sub-section in s. 5C stipulates that the Board must give written notice of the revocation or suspension to the chief executive officer of a public hospital, denominational hospital, private hospital or nursing home, where the donor is a patient.

Section 5D specifies that where an enduring power of attorney is revoked (either by the patient or through the operation of s. 5C), any refusal of treatment certificate completed by the agent is also revoked. If the Guardianship and Administration Board suspends the enduring power of attorney (pursuant to s. 5C), then any refusal of treatment certificate made by the agent ceases to have effect during the period of suspension (s. 5D(2)).

Let us consider the implementation of ss 5C and 5D by looking at the immediate effect of an application to the Guardianship and Administration Board by, say, an interested relative of the patient who is concerned about the agent's decision to refuse treatment on behalf of the patient. The decision by the agent to refuse treatment has been committed to writing and it is at this point that the relative applies to the Board. If the effect of the application is immediately to suspend the treatment decision from the time the application is lodged and while the Board considers the best interests of the patient, then this may act to defeat the intention of the patient (and, in effect, the intention of the legislation). On the other hand, it would seem an essential requirement of the provision that the decision to refuse treatment be postponed until the Board has adequately considered the application.

For example, assume that a Jehovah's Witness (who has completed the enduring power of attorney form appointing the agent) has conveyed to the agent her firm commitment against the transfusion of blood products. Due to a medical emergency, the Jehovah's Witness subsequently lapses into unconsciousness and medical opinion is that she requires a blood transfusion to save her life. To give immediate effect to the relative's application to the Board would mean not implementing the refusal decision and subsequently administering the transfusion thereby defeating the appointor's wishes. Conversely if the refusal decision

[70] The primacy of the patient's wishes over the best interests test has been recognized by the Law Reform Commission of Western Australia, *op. cit.* n. 20, 18-9, 33. See also Peters, D. A., 'Advance Medical Directives' (1987) 8 *Journal of Legal Medicine* 437, 454-5.

is effected then the application to the Guardianship and Administration Board becomes futile.

It is suggested that, until suspended or revoked, the refusal of treatment certificate is *prima facie* authority permitting and requiring the withholding or withdrawal of the treatment specified. Any challenge to the certificate must be sufficient to raise doubts about the validity of the certificate or of the appointment or the wishes of the patient. This would mean that a challenger, who could suggest no more than that the wishes of the patient were unreasonable or were not in the medical interests of the patient, could not interfere with compliance with the certificate. But if the challenger asserted for instance that the patient had appointed the agent under duress, or had revoked the agency, or had expressed a wish to undergo the treatment refused by the certificate, those concerned would have to decide whether to proceed on the basis of the certificate.

If the giving or maintaining of the treatment will not, in effect, finally overrule the certified wishes of the patient (as it would in the case of the Jehovah's Witness) prudence would suggest that the agent should suspend or if necessary cancel the certificate pending an application to the Guardianship and Administration Board. In formal terms the application would be for suspension or revocation of the power of attorney but these powers between them would seem to permit the Board to make a decision in relation to the particular certificate or proposed certificate if that were appropriate.

If the case is one where a decision either way will be final, as in the case of the Jehovah's Witness whose agent wishes to refuse a life saving blood transfusion, an agonizing choice faces everyone involved. Suppose a relative turns up and says that the patient has lost her faith and no longer believes that blood transfusions are sinful. If the relative is believed, no doubt the certificate (if any) will be cancelled and treatment will go ahead. The Board need not be involved. But if the agent contends that the relative is lying, he or she may insist that the blood transfusion be withheld. If the treatment is withheld in accordance with the certificate the patient's doctor will be able to rely on s. 9 provided the doctor acts in good faith and on reasonable grounds. If the doctor ignores the certificate and gives the treatment, he or she will be guilty of medical trespass under s. 6 unless in the light of the relative's claim the doctor can raise a reasonable doubt that he or she knew that the refusal of treatment certificate applied. If the doctor believes that the relative is telling the truth, the certificate is no longer known to apply and that will be a good defence under s. 6. If in later civil or criminal proceedings it turns out that the relative was lying the doctor should still have a good defence provided that his or her mistake was reasonable. Happily, these problems should not often arise. The Board can act very quickly. A Board member could make a decision over the telephone or go quickly to the place where the patient is being treated and make a decision on the spot.

H *Copies of Refusal of Treatment Certificates*

The penultimate provision in s. 5 relates to the administrative requirements in keeping copies of the refusal of treatment certificate. Under s. 5E(1), where the

appointor is a patient of a hospital (either public or private) or a nursing home, the institution must take reasonable steps to ensure that a copy of the refusal of treatment certificate, or of any notification of the cancellation of the certificate, is kept with the patient's records and given to the chief executive officer of the institution as well as to the Guardianship and Administration Board (this must be done within seven days after the certificate is completed).

Where the appointor is not a patient of a hospital or nursing home, the medical practitioner who signs the verification in a refusal of treatment certificate must take reasonable steps to ensure that a copy of the refusal of treatment certificate is given to the Guardianship and Administration Board within seven days after it is made (s. 5E(2)).

The Act does not deal with notification of cancellation in this latter case but the Public Advocate has stated that procedures set up by the Guardianship and Administration Board will ensure that the medical practitioner who verified the refusal certificate will be notified of any cancellation or revocation.[71]

I *Conclusion*

The agency sections of the Medical Treatment Act 1988 (Vic.) provide a relatively simple and flexible procedure for competent people to influence the course of their treatment in the event of supervening incompetence. Difficulties of interpretation and application can hardly be avoided in such a sensitive area of law but these should be minimized if it is clearly recognized that the Act is designed to give expression and support to the individual's right to self-determination.

[71] Office of the Public Advocate, *The Medical Treatment Act and Explanatory Notes*, note to s. 5E(2).