Living Wills and New Zealand Law

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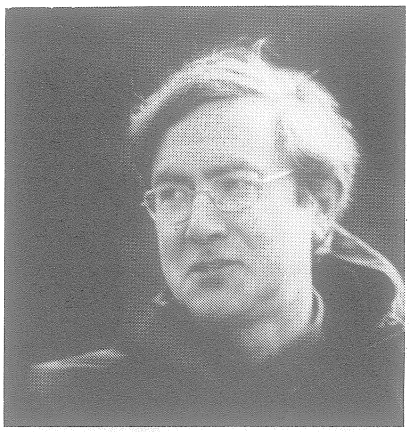
The term 'living will' is sometimes used to refer to documents which provide both for the making of an advance directive and the appointment



of a health care proxy (see for example the interesting form developed by the Terrence Higgins Trust and the Centre of Medical Law and Ethics, King's College, London, which is available from the Trust at 52-54 Grays Inn Road, London WC1X 8JU). The term is used in this extensive sense in this article.

This article does not examine the many practical and ethical issues to which living wills give rise. It focuses on two issues of New Zealand law. The first is whether a competent adult can make an 'advance directive' which will have the effect of rendering unlawful the provision of life-prolonging treatment that would otherwise be lawful. The second is whether a competent adult can appoint a 'health care proxy' who has the power to prohibit otherwise lawful life-prolonging treatment, if the appointer becomes incapable of giving or refusing consent.

Advance Directive

In New Zealand law, competent patients have a right to refuse medical treatment. The right is now enshrined in the New Zealand Bill of Rights Act 1990, section 11 of which states that "Everyone has the right to refuse to undergo any medical treatment" (s11; see also ss3, 5, and Re S [1992] 1 NZLR 363, 374). The right is a long-established one: more than a quarter of a century ago a New Zealand judge said that `An individual patient must, in my view, always retain the right to decline...treatment however unreasonable or foolish this may appear in the eyes of his medical advisers' (*Smith v Auckland Hospital Board* [1965] NZLR 191, 219 per T A Gresson J).

The link between the right of a competent adult to refuse medical treatment, and the right to make an advance directive to take effect once competence is lost, is apparent in some of the judgements delivered in the House of Lords, the highest court in the English legal system, in the recent case of *Airedale NHS Trust v Bland* [1993] 2 WLR 316. Lord Goff stressed the importance of the principle of self-determination. He said that

> **if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so.**

There is every reason to believe that a suitably worded advance directive will be effective in New Zealand law, to prevent a doctor lawfully administering treatment that would otherwise be appropriate.

"To this extent," Lord Goff said, "the principle of the sanctity of human life must yield to the principle of self-determination". He went on to say that

> **the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it.**

(He went on to stress that in such circumstances special care may be necessary to ensure that the prior refusal applies to the circumstances in question.)

The same link was made by Lord Keith. He pointed out that "it is unlawful...to administer medical treatment to an adult, who is conscious and of sound mind, without his consent". He said:

> **Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. This extends to the situation where the person, in anticipation of his ... entering into a condition such as P.V.S., gives clear instructions that in such event he is not to be given medical care, including artificial feeding, designed to keep him alive.**

The Canadian case of *Malette v Shulman* (1990) 67 DLR (4th) 321 provides a good illustration of the relevant principles. Mrs Malette was seriously injured, and rendered unconscious, in a road accident. She was taken to hospital where a nurse discovered a signed card in Mrs Malette's purse, which identified her as a Jehovah's Witness and requested that 'no blood or blood products be administered to me under any circumstances'. Dr Shulman was advised of the card and its contents, but when her condition became critical he administered a blood transfusion to preserve her life. Mrs Malette sued Dr Shulman for administering the blood transfusion, and was awarded $20,000 damages for 'battery'. The decision was upheld on appeal.

The right of competent adults to refuse any medical treatment, and to give in advance a directive prohibiting medical treatment once they lose decision-making capacity, is now well-established. Hence even where there is a general statutory duty to provide a patient with the 'necessaries of life', an appropriately worded advance directive will provide the doctor with a 'lawful excuse' for omitting to do so. In such circumstances, an omission to prolong life will not result in liability for murder or manslaughter. If doctors were to override an appropriately worded advance directive they would commit a criminal assault. An action for exemplary damages, and disciplinary proceedings, could also follow.

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Health Care Proxy

There are various circumstances in which people may wish to appoint others to act as their proxies, or agents, in matters relating to health care. This discussion will focus on the relevant provisions of a New Zealand statute, the Protection of Personal and Property Rights Act 1988. By virtue of that Act people can appoint others to act on their behalf once they become incapable of making decisions on their own behalf.

In the past, a power of attorney ceased to operate once the person who granted it became mentally incapable. The Protection of Personal and Property Rights Act 1988 makes specific provision for an enduring power of attorney, which is not revoked by the donor's subsequent mental incapacity. A competent person ('the donor') may authorise some other person ('the attorney') to act in relation to their personal care and welfare (s98). Such authorisation can be given in general terms, or in relation to specific matters (s98(1)), such as health care. In either case, the authorisation can be subject to conditions and restrictions specified by the donor (s98(1)). There are, however, some restrictions on the power to authorise the attorney to act in particular circumstances.

An attorney cannot act in relation to the donor's care or welfare unless the donor is 'mentally incapable' (s98(3)). In this context, this means (by virtue of s94(1)(b)) that the donor

(i) **Lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; or**

(ii) **Has the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare, but wholly lacks the capacity to communicate decisions in respect of such matters.**

Once the donor is 'mentally incapable', in this sense, action taken by the attorney in relation to the donor's care and welfare has, with certain exceptions, "the same effect as it would have had if it had been taken by the donor and the donor had had full capacity to take it" (s98(5)).

Some of the exceptions have no application to health care, but others do. In this context, the important restriction is that, by virtue of s98(4) and s18(1)(c), an attorney with an enduring power of attorney has no power:

> **To refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health.**

This restriction limits, very considerably, the value of enduring powers of attorney when it comes to the refusal of life-prolonging treatment. The attorney may prohibit non-standard treatment, but does not have the power to refuse consent to 'any standard medical treatment intended to save [the donor's] life', even if such a power has been expressly granted.

Conclusion

In New Zealand a person who does not wish to receive life-prolonging treatment, in particular circumstances, would best be advised to make use of an appropriately worded advance directive rather than rely on the New Zealand version of a health care proxy.

The current legal position is far from satisfactory, and there are many issues that would benefit from the attention of the Law Commission, the Medical Council, and the Bioethics Research Centre.

This writer, for one, would much rather appoint a health care proxy in whom he has confidence than make use of any form of advance directive. It is regrettable that the current state of New Zealand law may encourage people to make advance directives when their interests could better be served by the appointment of an enduring power of attorney, with the power to prohibit any form of life-prolonging treatment where such a power had been expressly conferred. The current position disadvantages both patients and doctors, and should be changed.

Readers' Views

Health Reforms

June 1993

Dear Editor

I would have thought that intellectual honesty was a prerequisite for writing to a Bioethics newsletter. Not so in the case of Peter Roberts (June).

Dr Roberts has made a number of factually incorrect claims in his attack on Andrew Moore's discussion of the health reform.

He trots out the old hidden agenda line, implying that the Government only took advice from new right ideologues. For the record the Government did **not** receive or accept the advice tendered in the Danzon Report; it was produced by a lobby group, the Business Round Table, just as Dr Roberts' own lobby group, the Coalition for Public Health, also produces reports.

Then Dr Roberts claims that the SOE model has been used for health care with the goal of eventual privatisation. How you can privatise a system which is 80% taxpayer funded I am not quite sure. Any Government which abandoned that public aspect of our health system would be suicidal.

Dr Roberts then claims that the Health and Disability legislation was written by Stephen Franks, from Chapman Tripp. Wrong again. Richard Clarke and Wendell Slatter, from Chapman Tripp Sheffield Young worked on the legislation, along with John Smart from the Department of Health, on behalf of the Parliamentary Counsel.

Dr Roberts claims that the existing system enjoyed a broad popularity with the New Zealand public. How then does he reconcile widespread complaints about waiting times and lack of access in many parts of the country?

It's funny that when something is being done to change things the existing situation suddenly becomes acceptable.

I came to the sad conclusion, long ago, that Peter Roberts hasn't a shred of integrity in marshalling the arguments he does. They are the extreme, ideological and obsessive claims of someone who doesn't want to be confused by facts.

Simon Upton, MP
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