

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.

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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