End of Life

1. Introduction
   1. It is a well established legal principle that competent adult patients are able to refuse treatment even where that treatment may save their life *(Re B; Re C; Malette v Shulman).* This stems from the notion of self determination and there is no requirement to establish that reasons for doing so are rational or reasonable.
   2. However, where people making these decisions are at the end of life and the refusal of treatment will cause death, many complex legal and ethical issues are raised which must be considered by doctors, patients and other appropriate decision makers under the Powers and Guardianship Acts.
   3. Doctors must ensure the patient has sufficient capacity to make such a decision however – even though all parties may be in favour of ending the treatment, a doctor is not necessarily provided with a defence to ending treatment which ultimately caused the death of another.
      1. >>>> Does the person wish to end their life?

>> Euthanasia

>> Assisting Suicide

>> Defence: Doctrine of Double Effect

* + 1. >>>> Does the person wish to withdraw life sustaining treatment?

>> Capacity

>> Impaired Capacity

>> Advance Health Directives

Euthanasia/ASSISTED SUICIDE

Euthanasia and assisted suicide involves taking active steps to end the life of another or providing that person with the means to do so themselves which is unlawful almost everywhere despite several attempts to legalise in some jurisdictions.

1. Step One: Definitions of Euthanasia
   1. Voluntary active euthanasia
      1. Lethal injection
      2. Do it of their own accord
   2. Voluntary passive euthanasia
      1. Consent with person affected
         1. i.e. Withdrawing life sustaining measures but there are some instances where you can withdraw measures lawfully – outcry about it being called euthansia
   3. **Moral difference?**
      1. Intention and outcome are the same
2. **Voluntary vs involuntary vs non-voluntary euthanasia**
   1. Voluntary: person with capacity consents
   2. Involuntary: no consent from the person involved, but person has capacity to consent
   3. Non-voluntary: no consent from the person involved but has no capacity to consent
3. **What is not euthanasia:**
   1. Giving increasing amount of pain relief that may also shorten life
   2. Respecting patient’s right to refuse further treatment
   3. Providing person with the means, or the knowledge, to end their own life (Cartwright)
   4. **Physician assisted suicide** 
      1. “the doctor giving a person advice about how to commit suicide, giving the person a prescription for medication to use for suicide, preparing a mixture for the person to take to commit suicide and/or setting up equipment for the person to use to commit suicide”
         * 1. (Cartwright)
4. Criminal Law
   1. In Qld it is a crime to unlawfully cause the death of another, whether by murder or manslaughter (s300 CC) directly or indirectly and by any means whatsoever (s293 CC) unless such killing is ‘authorised or justified or excused by law’ (s291 CC). Subsequently any form of euthanasia where the doctor/nurse intends to bring about the patient’s death will constitute an unlawful killing and give rise to criminal liability. Furthermore, a particular problem arises for doctors in this area as the consent of patient, even where terminally ill, does not provide the doctor with a defence to unlawful killing (s284 CC; *Re Cox*).
   2. However, ‘the degree of moral blame attributable to a person who assists or encourages an act of suicide may vary greatly from case to case. There are two limbs:
      1. Persons who assist suicide to inherit property or some other motive
      2. Persons who assist suicide to a loved one who is in extreme pain and who wishes to end that suffering asap.’ (*R v Maxwell; R v Hood*)

NOTE: (i) and (ii), above, require an analysis of the person’s motive.

1. **>>>> Has the doctor/person committed:**

Murder – s 302

* + 1. Under s302 a person will be criminally liable for unlawfully killing another where:
       1. Offender intends to cause death or GBH
       2. Death is caused by an act done in the prosecution of an unlawful purpose which would be likely to endanger human life
       3. Offender attempts/intends to cause GBH to assist a crime or flee
       4. Death is caused by administering any stupefying or overpowering thing to cause GBH to assist a crime or flee
       5. Death is caused by wilfully stopping the breath of another
  1. **Hastening Death**
     1. A person is also criminally liable where they do any act/omission which hastens the death of another who is suffering from some disorder or disease (s296).
  2. **Necessaries of life**
     1. s285: A person in charge of another is also under a duty to provide the necessaries of life (such as medical treatment) to provide that person with the necessaries of life where they are unable to do so due to:
        1. Age
        2. Sickness
        3. Unsoundness of mind
        4. Detention
        5. Any other cause

Manslaughter – s 303

1. A person is guilty of manslaughter where they unlawfully kill another under such circumstances which do not constitute murder (s303 CC)
   1. i.e. no intention to kill
   2. Aiding Suicide – s 311 CC
      1. A person who
         1. procures another to kill himself or herself; or
         2. counsels another to kill himself or herself and thereby induces the other person to do so; or
         3. aids another in killing himself or herself;
         4. is guilty of a crime, and is liable to imprisonment for life.
      2. A doctor who prepares a lethal dose of a drug for administration by the patient themselves is criminally liable
      3. Onlookers may be liable for aiding suicide (i.e. Nancy Crick supporters) however it is likely that in order to be convicted the aider must be proved to have had intention (guilty mind)they wanted person to commit suicide
      4. An onlooker may simply not want the person to commit suicide but if they did, did not want person to be alone

***Re Cox***

* *Patient was 70 years old – suffering from rheumatoid arthritis and at the end of life in agonising pain*
* *All other methods of alleviating pain failed*
* *Doctor treated patient for 13 years*
* *Doctor administered patient with a lethal dose of potassium chloride – which was not a pain killing drug*
* *Doctor said only way to relieve her pain was to answer her plea to end her life*
* *Doctor was convicted of attempted murder (prosecution unsure if they could prove murder/intent to kill patient)*
* *However only received a suspended sentence*

***R v Maxwell***

* *Husband and wife – wife dying if breast cancer, she read book about how to die and persuaded husband to help her*
* *Husband assisted her to die by sedating her, placing plastic bag over her head with gas in it and left it in place until she died*
* *Pleaded guilty*
* *HELD: given 18 month suspended imprisonment sentence*

1. DEBATES: THE LAW ON EUTHANASIA
   1. **Australia**
      1. There have been 10/11 attempts in Australia to introduce legislation allowing euthanasia however none have ever succeeded except briefly in the NT in 1995 until it was overturned by Cth legislation in 1997
         1. The RTI Act allowed a terminally ill person in certain circumstances the right to request assistance from a medical practitioner to voluntarily terminate his or her life in a humane manner
         2. Was challenged as being contrary to the legislative power of NT (*Wake v NT)*
         3. A Bill has since been introduced into the Upper House in Feb which overturns the Cth legislation
            1. Currently Greens are negotiating with Gov as to whether or not there is any time to debate NT legislation. It appears K Rudd will allow his members to have a conscious vote
            2. Where the Bill is passed the NT, ACT are allowed to enact legislation permitting voluntary euthanasia
   2. **Oregon** (1994) – law to allow physicians to write prescriptions for people who were terminally ill
   3. **Netherlands** (2001)
   4. **Belgium** (2002)
      * 1. A two-tier test
           1. The patient must be in a hopeless medical situation, and be constantly suffering physically or psychologically.
           2. Request must be in writing.
           3. Where the patient is in the terminal phase of her or his illness, only one doctor need be involved.
           4. If the patient wishes to die at an earlier time, however, the doctor must consult with a second medical practitioner.
   5. **United Kingdom** (Bill – 2005) – private members bill generated lots of debate but was ultimately defeated
   6. **Israel, Switzerland** (Aus doctor because Swiss law is open to non-nationals to end their lives), Albania
2. WHAT REALLY HAPPENS?
   1. The ‘Melbourne 7’ – mid 90’s – 7 doctors published and signed a letter in front page of the Age that they had overseen and administered euthanasia – were championing a Bill by voluntary euthanasia society – investigations by police and medical board but no action was taken because of lack of evidence
   2. Philip Nitschke – claims to have seen over 15 of assisted deaths since NT legislation – 4 deaths while NT law still in action and continued to oversee assisted suicide
   3. Jack Kevorkian (US) – assisted many people to die – went on 60 minutes and gave lethal injection on the program – said you must charge me or you are making a mockery of the law – served 10 years
3. Legislative reform for voluntary passive euthanasia
   1. Arguments for:
      1. If person has capacity to make such a decision
      2. Logic and rationality in the law
         1. Suicide lawful then why not euthanasia
         2. If you have the ability to commit suicide then why should you be able to end your life but someone who has paralysis and is unable to commit can’t? Should not depend on your disability on whether you are able to take your life
      3. Right to die with dignity
      4. Guidelines can ensure appropriate use of euthanasia
      5. Self-determination
         1. It’s their own life they are making a decision about
      6. Public opinion – 85% Australians believe in voluntary euthanasia
      7. Economical considerations in keeping these people alive – money could then go to something else
      8. What actually happens in euthanasia – the processes
         1. Law should reflect practice
      9. Quality of life factors
      10. Suicide v Assisted suicide
      11. Human rights considerations
      12. Law reflecting practice
      13. Failure to enforce law brings laws into disrepute
      14. Discriminatory outcome of illegality
          1. You can get euthanasia – need to know right doctors
          2. Older people – most common form of euthanasia is hanging
      15. Regulation promotes good practice
          1. If there is regulation bad practice should decrease
   2. Arguments against
      1. Should there ever be a reason to allow suicide
      2. Sanctity of human life - no person should play God
      3. Undermines the value of a sick or disabled person
      4. Consequences are irreversible (i.e. if cure is developed)
      5. If it was lawful – you could overtly consider quality of life factors
         1. Difficulty to ensure appropriate safeguards - is it really voluntary
      6. Potential for abuse
      7. Slippery-slope argument
      8. Increased focus on supporting vulnerable – not killing them
         1. Euthanasia - easy option to take instead of supporting

Doctrine of Double Effect

\*\*This is actually quite difficult to prove – intent beyond reasonable doubt is hard – how do you show what is inside the doctors head

COMMON LAW

1. Step One: Intention
   1. The doctrine of double effect provides that it is lawful for a doctor to administer pain killing drugs which hasten a patient’s death provided the intent was to relieve pain and not cause or hasten death (*Bland; R v Adams).*
      1. “If the first purpose of medicine – the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.” (*R v Adams*)

**If the doctor intended to cause death the doctrine does not apply and they will be criminally liable.**

* 1. Some concerns
     1. Patients may be concerned that types/doses of palliative drugs to relieve pain may hasten death
     2. A doctors fear of attracting liability may result in conservative palliative care - do people die in pain?

1. Step Two: Elements
   1. The nature of the action must be morally good or indifferent
      1. There must be a lack of criminal intent – the action must be good or indifferent
   2. The good effect (relieving pain), not the bad effect (death), is the effect sincerely intended by the HCP
      1. A doctor cannot commit an offence as there is no criminal intent to unlawfully kill another (*Adams*)
      2. However it should be noted the focus is on the inevitable consequences of the doctors action – not the desired result (*R v Crabbe; see Grubbe p304 of Skene*)
   3. The good effect must not be produced by the bad effect
   4. There must be a proportionate reason for permitting foreseen bad effect to occur
   5. Death caused by underlying illness
      1. The doctor has not caused the death – the death is caused by the underlying condition (*Bland*)
      2. I.e. the removal of respirator tube is a ‘positive’ act as it does not constitute the act causing death (*Bland per Lord BW*)
   6. Is in the patients best interests
      1. The doctors act is lawful as it is care of the patient in their best interests (*Bland per Lord G*)
      2. A doctors duty to care for patient justifies the giving of pain relieving drugs even if they shorten life but does not equate to giving a lethal injection to end their agony (*Bland per Lord G*)
2. Step Three: Intention
   1. The critical element is that of intention which must be an intention to relieve pain and the doctor will therefore not be liable.
   2. Within the context of palliative care a doctor who provides pain relief treatment to a terminally ill patient yet foresees their death may be hastened is permitted to administer the treatment if the treatment is intended to relieve pain and not hasten death.
   3. Where the patient does die the doctor is said not to have intended that result even where the death was foreseeable (2004 (4) 1 QUTLJ @ p47).

***R v Adams (Bodkin) –NO INTENT***

* *1957: 81 year old patient*
* *A was doctor*
* *Evidence was giving her heroin, morphine and other drugs but there was also evidence saying the doctor wouldn’t do it in practice (i.e. denying he did it) but that some other doctor could*
* *Drugs weren’t that bad*
* *However he was a beneficiary under patients will*
* *Jury concluded he had no intention to kill – not guilty*
* *On receipt of not-guilty crown withdrew indictment of another patient*
* *When confronted with the fact had had possibly killed this patient his response was murder, can you prove it?*

***R v Cox - INTENT***

* *Patient was 70 years old – suffering from rheumatoid arthritis and at the end of life in agonising pain*
* *All other methods of alleviating pain failed*
* *Doctor treated patient for 13 years*
* *Doctor administered patient with a lethal dose of potassium chloride – which was not a pain killing drug*
* *Doctor said only way to relieve her pain was to answer her plea to end her life*
* *However doctor noted it in charts and a nurse discovered it and reported him*
* *Doctor was convicted of attempted murder (prosecution unsure if they could prove murder/intent to kill patient)*
* *However only received a suspended sentence*
  + *Note that if you do something knowing that something else is likely to happen then that is enough to form intent*

1. SCOPE OF DOCTRINE
   1. Is consent of the patient required?
      1. No
      2. If intent is of correct type (to relieve pain) then consent is not an issue
   2. Does there need to be a terminal illness?
      1. If the primary purpose of doctor is to relieve pain (i.e. back pain) then it seems that there does not have to be a terminal illness
      2. However it would seem that passing pain, however extreme, will not be accepted as within the best interests of the patient to be provided life-shortening drugs (*Bland per Lord G*)
      3. Psychological pain also not referred to
   3. Procedures to be followed?
      1. There are no procedures to be followed – they need not seek other medical opinions, give time for patient to reconsider or document their decision – but these steps are ADVISED
2. STATUTE
   1. QUEENSLAND: Palliative care: s282A CC
      1. Prior to the enactment of s282A the position in Qld was unclear as s296 CC potentially had the effect of overriding the doctrine at common law by holding any person who hastens the death of a person who was terminally ill criminally liable for killing that person.
      2. However, the common law doctrine of double effect has now been given legislative force by the introduction of s282A into the CC. Under the legislative test, the basis of the doctrine has shifted from intention to whether the administration of the pain relieving medication was in accordance with “**good medical practice**”.
   2. A person is not criminally responsible for providing palliative care to another provided (s282A(1)):
      1. the person provides the palliative care in good faith and with reasonable care and skill; and
      2. the provision of the palliative care is reasonable, having regard to the other person's state at the time and all the circumstances of the case; and
      3. the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing
   3. This section applies even if an incidental effect of providing such care is to hasten the other persons death (s282A(2)). However, nothing in this section authorises, justifies or excuses (s282A(3)):
      1. an act done or omission made with intent to kill another person (i.e. euthanasia); or
      2. aiding another person to kill himself or herself (suicide).
   4. The doctrine of double effect is to be distinguished from mercy killing
      1. DE presents an intention to relieve pain – even if the dose is so high that it could do nothing other than hasten the patient’s death as pain relief will precede death (provided the dose is not high enough that it immediately causes death). Under the doctrine there always remains a distinction between an intended consequence and a merely foreseen one (2004 (4)1 QUTLJ @ p57).
      2. MK can be achieved by using drugs others than pain relieving drugs such as mercy killing and represents an intention to relieve pain by causing the death of another

**ELEMENTS**

Must establish all elements – any of these elements are not established beyond a reasonable doubt then the prosecution is able to succeed (2004 (4)1 QUTLJ @ 49).

* + 1. Palliative care
       1. Palliative care means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering (s282A(5)).
    2. Good faith and reasonable care and skill
       1. Standard provisions re duty
    3. Reasonable
       1. The treatment must be reasonable having regard to
          1. the other person's state at the time; and
          2. all the circumstances of the case; and
          3. Furthermore, palliative care is only reasonable in the context of **good medical practice** (s282A(4)). Good medical practice means good medical practice for the medical profession in Australia having regard to (sch2 GAA, 5B):

recognised medical standards, practices and procedures of the medical profession in Australia; and

recognised ethical standards of the medical profession in Australia

* + 1. By a doctor or confirmed in writing by doctor
       1. Criminal liability: person who is not doctor and the order isn’t confirmed in writing i.e. done over the phone i.e. nurse calls up doctor “Can I give them some more Doctor” “Yes go ahead”
       2. This can be a problem –
          1. Whether or not you go to jail (for not having writing) could depend on whether you have it in writing
          2. but has to be confirmed in 24 hours?

Common law v Statute – which would you rather?

Legislation

* 1. Greater certainty as a professional
  2. However is more onerous duty to discharge– more elements than mere intention

For common law

* 1. Only need to prove correct intention

Withholding life-sustaining medical treatment

1. Introduction
   1. A decision to withhold life sustaining medical treatment which will inevitably cause the death of another raises many complex moral, ethical and legal issues. Although the law is relatively clear where adults with capacity make such decisions the position is much more complex where adults lack capacity and in Queensland both the common law and statutory provisions are relevant.
2. Common Law
   1. In the appropriate circumstances the common law permits the withholding of LSM. There are two requirements for competence to make a decision to withdraw life sustaining measures:
      1. Capacity to make the decision; and
         1. An adult is presumed to have the capacity to make decisions about medical treatment however where consequences of decision are grave, capacity must be correspondingly high.
      2. Ability to communicate the decision in some way (*Burke per Munby J*)
   2. Is the adult competent?
      1. YES
         1. There is a rebuttable presumed that every adult has the capacity to make decisions for themselves (GP 1). Here [patient] will be considered competent where they are capable of (sch4 GAA):
            1. Understanding the nature and effect of the decision;
            2. Freely and voluntarily making the decision; and
            3. Communicating the decision in some way
         2. Where an adult is competent to make decisions of a medical nature they retain an absolute right to refuse life sustaining measures regardless of the reasons for making that choice are rational, irrational, unknown or even non-existent (Lord Donaldson in *Re T*). A provision of treatment in conflict with a desire to withdraw LSM is regarded as assault and trespass to the body.

***Re B***

*Woman had serious illness and became tetraplegic – tried to refuse treatment (ventilator) – hospital kept providing – woman went to court and held that hospital had to stop treating her if she wants it*

* 1. **Advance Health Directives – Common law**
     1. A person also has the right to refuse LSM prior to a medical situation arising where they lose capacity – known as an advance health directive. For an AHD to be effective at common law it must:
        1. Be made by a competent adult
        2. Directly relate to the situation which has arisen
        3. Be given free of undue influence
        4. Have been made with all relevant information at the time
     2. Provided these are established it is likely Australian courts would uphold a common law advance directive
     3. Limitations of operation re: advanced health directive
        1. Cannot come into operation until the following are met:
           1. Sufficient ill health:

Terminal illness (expected to die within a year)

Persistent vegetative state

Permanently unconscious

Such severity that always need them

* + - 1. No reasonable prospect of regaining capacity
      2. Only for artificial nutrition and hydration
         1. Commence or continue life sustaining measures is inconsistent with good medical practice

***Re T***

* *Woman signed form refusing blood transfusion*
* *However it was not contemplated that a transfusion would be needed to save her life – woman understood that non-blood products could be used*
* ***HELD:*** *The advance refusal did not cover the situation that ultimately arose*
* *It was lawful for doctors to provide treatment considered in her best interests.*
  1. Not competent & PVS (Permanent vegetive state)
     1. Where the adult is NOT competent to make a decision to withhold LSM i.e. an adult is not competent is one who suffers from a sever mental disability or is in a persistent vegetative state, the position is much more complex – who is entitled to make the decision and under what criteria must the decision be made?
     2. The landmark case dealing with these issues is *Bland* whereby a 17yr old boy was left in a persistent vegetative state for three years after the Hillsborough football disaster. The House of Lords ultimately determined it was in the best interests of B who was in a PVS that LSM be withdrawn and he be allowed to die with dignity.

1. **Who makes the decision? (NOTE: this links back to consent)**
   1. Under the common law either the doctor or the courts are deemed to be the appropriate decision makers where the adult concerned lacks capacity to make decisions themselves.
      1. Doctors
         1. The general principle is that a doctor or other health care professional cannot provide LSM or medical treatment without the consent of the patient. In the context of withdrawal of LSM health care professionals are able to provide necessary treatment to patients who lack capacity (*in re F*) provided it is in the best interests of the patient (*Bland*). Therefore, where LSM are not considered to be in the patients best interests consent of the patient is not required for the doctor to withhold LSM.
      2. Courts
         1. Although a decision to withhold LSM is a medical decision at first instance (*Northridge v CSAHS*) the courts are also entitled to make decisions on behalf of adults lacking capacity under the *parens patriae* jurisdiction. Where a court order is made to withhold LSM the doctor/HCP is effectively doing so with the consent of the adult (*Re G*).
         2. Intervention by the courts is generally only required where there is some dispute as to the assessment of the patients condition or the doctor wishes to obtain court approval/direction before proceeding (which is highly advisable).

***Re G***

* *Suffered serious injuries whilst riding motorcycle*
* *Whilst getting resuscitated he had a heart attack which caused brain damage = PVS*
* *Wife supported the withdrawal of feeding but his mother opposed*
* *Family views were held not able to prevail against the best interests for the patient*

1. **Criterion for making the decision**
   1. In making a decision to withdraw or withhold LSM the decision maker must have primary regard to the best interests of the patient (*Bland*).
   2. Things to consider (*Bland*)
      1. Responsible medical opinion i.e. is it appropriate to continue treatment from a medical perspective
      2. What the patient would have wanted
      3. Views of the family
      4. the lack of dignity for him to continue to be subjected to such invasive measures
      5. the ordeal that the treatment involved for his family

***Airedale v Bland (UK)***

* *B was 17 year old boy – seriously injured in Hillsborough football disaster – lungs severely crushed and punctured – lost supply of oxygen to the brain causing irreversible brain damage*
* *Was left in a PVS for three years – no hope for recovery*
* *B had never indicated his wishes were this to happen – father gave evidence his son would not want to be left like that*
* *Family, doctor and independent medical advice sought declaration that they may lawfully withdraw LSM to allow him to die peacefully with dignity and no pain, suffering or distress*
* *HELD - unanimous*
* *The object of medical treatment is to benefit the patient however since a large body of medical opinion was of the view that a PVS was not beneficial to the patient and the sanctity of life was not violated by withdrawing LSM even though the patient had not consented*
* *The doctors were not under a duty to continue such medical care*
* *The patient had no further interest in being kept alive*
* *This was not about euthanasia (i.e. that taking of positive steps to end the life of someone) but was about whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done the patient will shortly thereafter die*
* *This wasn’t in Bland’s best interests and treatment was stopped – decided to withdraw treatment*
* *1. Act/omission distinction: withdrawing withholding is an omission not an act*
* *2. Best interests*
* *3. Criminal liability arises if there is a duty to provide the treatment*
* *4. No duty to treat: Here there is no duty as it is not in his best interests therefore there is no duty to treat and lawful to stop*

***Re PVM***

* *Mr M had severe fall – caused traumatic brain and spinal cord injury*
* *Had difficulty communicating*
* *Mrs M claimed her husband had communicated he did not want to be put on life support – wanted it pulled*
* *Issue: did Mr M have capacity to make these decisions?*
* *Intensive care specialists, mother, wife and his 2 sisters believed he did*
* *Independent psychiatrists did not believe he had capacity*
* *Tribunal more persuaded by confidence in wife, mother and ICS who dealt with him on day-to-day basis – psychiatrists were not entirely sure*

***Re B***

* *B was 41 year old woman – tetraplegic and suffered paralysis from neck down*
* *Wanted to be taken off LSM but hospital would not agree*
* *Applied for declaratory relief that hospitals actions constituted assault – treating her without her consent*
* *Held: she had capacity to make decision*

***Re T***

* *T was young woman in accident – needed a blood transfusion*
* *After talking to her mother ( a Jehovah’s witness) T declined treatment involving blood products*
* *Held: T’s decision was not her own – overborne by mother – mothers undue influence meant T lacked capacity to decide*

1. If you get to the stage where you are considering withholding life saving measures for people without capacity – go through hand written diagram in consent notes

**NOTE: NEW CASE STUDIES FROM 2009**

***Hunter and New England Area Health Service v A***

*JH witness man had lost capacity and he had what was an advanced directive hospital didn’t know whether to act on it – not to give dialysis – goes before the court and the court said that it should not be – the court said that this was a valid directive and it was sufficient to refuse treatment – what happens if it wasn’t signed? Then it wouldn’t be valid –in NSW there is no leg that governs advance health directive – here it was in NSW and it wasn’t signed, but it was in his handwriting – the court said – maybe look at this intention in filling it out – does it express an intention – question of evidence – what are the two arguments pushing against each other*

1. *Sanctity of life*
2. *Exercise of autonomy –this trumps sanctity of life*

***Brightwater Care Group v Rossiter***

*The patient was a quadriplegic was not terminally ill but decided that he didn’t wanna live – he was dying – but he wanted the food and hydration that he was being force fed to be removed – the care group that was providing care asked the court if they were obliged to follow this and what conduct after this would be legal – the court said the guy had capcity and he was entitled to say that he didn’t want the treatment and it had to be witheld – interesting thing was the questions that came about how much he knew about how long his death would take from that point – the judge made the point that it would only come into effect if he received a certain amount of information about this point – again sanctity of life and autonomy are the issues and again, autonomy trumps*

*He had tried to previously commit but he was still found to have capacity in this interest – does his interest deprive him of capacity to make the decision but they said no – is someone suffering firm depression deprived of capacity*

***ACT v JT***

*ACT guy has paranoia, schizophrenia believed that by fasting he would get closer to god but that god would prevent him from dying – says that he doesn’t want treatment – ACT health said that we are happy not to provide treatment – outcome= concerns about capacity – so he was not of capacity and so his wishes were not followed*