LEGAL AND ETHICAL RAMIFICATIONS OF WITHDRAWAL OF LIFE SUPPORT SYSTEMS FROM INCOMPETENT PATIENTS

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Introduction

Developments in medical technology and medical science have revolutionised modern medical practice of the past two decades and have created novel ethical and legal dilemmas for medical practitioners. This paper will discuss one of the most contentious legal issues associated with medically indicated withdrawal of life sustaining treatment from incompetent patients, where such discontinuance will inevitably bring about death, namely, the question of criminal responsibility of doctors who decide to undertake such termination. Critical to the doctors' legal liability is the attribution of the cause of death. If the patient's death in such circumstances is legally attributed to the underlying condition, then, in the absence of negligent conduct on the part of the treating personnel, no legal liability will follow. If, however, the cause of death is legally attributed to the doctor's conduct in disconnecting life support system, the possibility of criminal sanctions will arise.

In Australia at present, withdrawal of life support systems is governed partly by common law and partly by statute in South Australia, (Natural Death Act (SA) 1983), Northern Territory (Natural Death Act (NT) 1988; Natural Death Regulations (NT) 1989), and Victoria, (Medical Treatment Act (Vic) 1988). Common law alone governs withdrawal of treatment in all other states as well as in the Australian Capital Territory. Statutory provisions will be discussed first, and then the common law. (For a more extensive discussion of the statutory provisions see Mendelson D: Medico-legal aspects of the "right to die" legislation in Australia. Melbourne University Law Review 1993).

Statutory Provisions

In 1983 of South Australia enacted the Natural Death Act 1983 (No 121) 1983 South Australia, whereby terminally ill patients have been enabled, in certain circumstances, to direct the doctor to discontinue life supports. The NDA applies only to persons who suffer from "terminal illness", that is, to those patients whose medical condition is incurable and irreversible, and where the application of extraordinary measures would only serve to prolong the process of dying. In these circumstances, the NDA empowers a terminally ill person "of sound mind" to direct, in the prescribed form, completed either before the patient goes to the hospital, or while he is in hospital, that he or she should not be subjected to any "extraordinary measures" for prolonging life (s. 4). The phrase "extraordinary measures" is defined as:

Medical or surgical measures that prolong life, or are intended to prolong life, 
by supplanting or maintaining the operation of bodily functions that are 
temporarily or permanently incapable of independent operation (s. 3).

Application of artificial ventilation, intravenous hydration or alimentation, dialysis to overcome the effect of renal failure, an artificial heart, and transplants of such vital organs as heart and liver would probably be included among the "extraordinary measures" covered by the definition.

The patient has to be of sound mind at the time of direction, but he or she need not be competent at the time when the direction is being acted upon. Thus, a patient's direction under the NDA is a variant of what is known as a "living will". A living will is a document which enables a competent person to advise medical personnel that treatment be withheld or withdrawn in case of some future medical contingency when he or she becomes unconscious.

Under the Natural Death Act, non-application or withdrawal of "extraordinary measures" from a person suffering from a terminal illness following a valid direction is deemed not to constitute
a cause of death. This means that a medical practitioner who acts in compliance with the patient's direction, as a result of which the patient dies, is not liable at law for causing the patient's death, even where by the time the direction is acted upon the patient has become incompetent (s. 6). Provisions similar to the South Australian NDA exist in the Northern Territory.

The Victorian legislature has taken a different approach towards the issue of withholding and withdrawal of medical treatment. The Medical Treatment Act (Vic) 1988 (No. 41/1988) incorporating Medical Treatment (Enduring Power of Attorney) Act 1990 (No 7) 1990 Victoria as amended by Medical Treatment (Agents) Act (No 26) 1992. In order to avoid repetitive use of the full titles of these statutes, the Natural Death Act 1983 as the NDA and to the Medical Treatment 1988 shall be referred to as the MTA. The MTA applies not only to terminally ill patients but to all competent adult persons under medical care. At the same time, the refusal of treatment certificate executed by a competent person under the MTA is valid solely in respect of the current medical condition from which the person is suffering. This means that although a competent person in Victoria can direct doctors to switch off the life supports, where these are utilised in response to his or her current condition, such patient cannot validly execute a living will in anticipation of his or her incompetency.

Taking into consideration the desire by some individuals to exercise some measure of control over medical treatment choices when they become incompetent, the MTA also enables an adult person of sound mind to appoint an agent or an alternate agent (s.5B. Guardians appointed under the Guardianship and Administration Board Act (Vic) 1986 are granted the same powers to refuse medical treatment on behalf of the represented persons as agents appointed under the Enduring Power of Attorney) who can refuse medical treatment, including a refusal to continue administration of life support systems on behalf of the patient, when he or she becomes incompetent. At common law a person of sound mind has the right to appoint another person to manage his or her affairs, however the power of attorney lapses after the donor becomes legally incompetent. The legislation, however, explicitly excludes from the statutory ambit the right to refuse palliative care. Neither the patient nor the agent can refuse "palliative care" (Purpose (2); Schedule 1 Note; Schedule 3 Note) which under the MTA includes:

(a) the provision of reasonable medical procedures for relief of pain, suffering and discomfort; or
(b) the reasonable provision of food and water." (ibid).

Palliative care has been defined as treatment which increases the well-being of the patient by relieving symptoms of disease or illness without effecting cure (Maddocks 1990). The phrase, "reasonable provision of food and water" clearly encompasses such life-saving medical procedures as intubation for the purposes of nutrition and hydration. Artificial feeding can be administered either through of a tube inserted to the functioning gastrointestinal tract for the purpose of improving hydration and electrolyte balance, or through an intravenous feeding line inserted into one of the major veins of the chest for the purpose of intravenous alimentation.

As it stands at present, the MTA protects doctors who in good faith and in reliance on a refusal of treatment certificate discontinue medical treatment from "being guilty of an offence", (ss 9(1)(b)) but the legislation, by definition, does not grant similar immunity to medical practitioners who withdraw from the patient "reasonable provision of food and water". Withdrawal of hydration, and nutrition from patients who are permanently unconscious and who are unable to sense anything, could be defended on the grounds that the result probably would not be unreasonably distressing, and that such treatment in any case is not of life-saving kind, but is merely life-sustaining. This indeed was the argument of the treating doctors in the case of Anthony Bland which will be discussed later. However, the issue of withdrawal of nutrition and hydration is a very serious one and needs to be treated with particular caution. The Victorian exception is not unique; in 20 of the 39 American states which have legislated in favour of living wills, the legislation specifically excludes termination of life by the withdrawal of nourishment and hydration (per Lord Mustill in Airedale NHS Trust v Bland [1993] 2 WLR 316 at 392).

To summarise, in South Australia and Northern Territory patients with diagnosed terminal illness have a statutory right to direct that extraordinary means for keeping them biologically
alive be withheld or terminated. In Victoria any adult person of sound mind has the right to appoint an agent with powers of attorney (medical treatment) to give consent to the withdrawal of life sustaining measures from the incompetent patient-donor. How many persons avail themselves of these statutory rights?

The South Australian Parliamentary report on Care of Terminally Ill Patients: General Practitioners' Views and Experience, (Australian Parliamentary Select Committee on the Law and Practice Relating to Death and Dying November, 1991; Ashley & Wakefield 1993) which analysed responses of 117 general practitioners in South Australia about the awareness and use of the NDA reported that whereas 63.2 per cent of the respondents indicated familiarity with the legislation, only 19.4 per cent related that at least one of their patients signed a living will (ibid p. 7). There has not been any published research on the number of persons who have appointed an agent under the MTA, but anecdotal evidence suggests that very few patients elect to avail themselves of these provisions. Therefore, in the great majority of cases, withdrawal of life-sustaining measures from incompetent patients is governed by common law.

There are two broad groups of patients where the issue of withdrawal of life support systems poses particular problems. The first group comprises patients who, while conscious and mentally competent, have given consent to treatment but then due to disease or medical misadventure have lapsed into a sudden coma. The second group are persons who have become comatose as a result of traffic or other accidents.

Whereas, in the past, administering medical treatment to a patient who has lapsed into a deep coma was not undertaken because the comatose patient had very little chance of survival, today patients who become unconscious due to a disease or an accidental injury can be treated, often effectively, in the sense that many of them will return to sapient life. Therefore, initially, every person who has lost consciousness tends to be treated as an emergency, in accordance with the ethical principles of beneficence and the sanctity of life supported by the legal doctrine of medical necessity.

Under the doctrine of medical necessity, in cases of an unconscious patient whose life is in danger, and whose wishes are unknown, and where no legally authorised representative is available, consent to life-saving procedures is implied either under common law (per McHugh J in Secretary, Department of Health & Community Services (NT) v JWB and SMB (1992) 66 ALJR 300 (Re Marion) at 337) or under statute (Medical Act (Qld) 1939 s.52; Voluntary Aid and Emergency Act (Qld) 1973 s.3; Conse and Dental Procedures Act (SA) 1985; Emergency Medical Operations Act (NT) 1973 s.3). In these circumstances, the doctors' primary obligation is to save life. Depending on the severity of the patient's condition, the life saving treatment may involve administration of intravenous fluids, intubation and assisted respiration, as well as medications to control cardiac arrhythmia. Only when it is realised that the patient has irreversibly lost consciousness, or has developed a condition known as a persistent vegetative state (PVS) (Schneiderman, Jecker, Johnsen 1990), that the issue of withdrawal of treatment will arise, and with it the concerns of medical ethics and the law.

The question in what circumstances can a medical practitioner lawfully discontinue life sustaining treatment - including nutrition and hydration as well as ventilation - from patients with severe brain damage was originally examined in several cases in the USA, (Raffin 1989) notably in the case of Karen Quinlan.4 There have been no reported cases on this issue in Australia, but this paper shall examine the issue of possible criminal responsibility based upon attribution of the cause of death faced by doctors who withdraw life supports from otherwise terminal incompetent patients, in two recent cases, one by the House of Lords in the UK, and the other by Mr Justice Thomas in New Zealand.

The case of Airedale NHS Trust v Bland [1993] 2 WLR 316 concerned a patient, Anthony David Bland who, at the age of 17, was one of the victims of the Hillsborough football ground disaster in April 1989. Anthony sustained what later transpired to be a catastrophic and an irreversible damage to the higher centres of his brain which had left him in a persistent vegetative state (PVS). Although his body could breathe and react in a reflex manner to painful stimuli, there was no awareness on his part of anything that was taking place around him. When
medical specialists reached unanimous diagnosis of PVS, with no hope of improvement, let alone recovery, they felt that it would be appropriate to cease further treatment. In this conclusion they were fully supported by Anthony Bland's family.

Termination of treatment meant the withdrawal of artificial feeding through a nasogastric tube, and withholding antibiotic treatment if and when infection occurred, while at the same time instituting appropriate palliative care. The lack of sustenance would bring an end to the physical functioning of the body within 10 to 14 days (Though his father, firmly believed that his son would not want to be left like he is', Anthony himself did not at any time before the disaster indicate his wishes if he should find himself in such a condition. Airedale NHS Trust v Bland [1993] 2 WLR 316 at 324).

The hospital sought a declaration that physicians caring for Anthony Bland may lawfully proceed in good faith with the outlined course of action; and that when death occurred following the discontinuance of life supports, the cause of death should be attributed to the natural causes of the patient's condition, and thus should not give rise to any civil or criminal liability on the part of the treating medical personnel.

The Official Solicitor of the English Supreme Court, as guardian ad litem for Anthony Bland opposed the hospital's declaration, contending that if the action proposed by the medical practitioners and the hospital were to be implemented it would in terms amount in law to at least the crime of manslaughter, at most to murder, because by withdrawing the feeding tubes the doctors would be taking active steps to bring about Anthony's death.

The Official Solicitor's argument was based on the statement of Ognall J in Reg v Cox (September 1992 (unreported)), who, when directing the jury said that there is an absolute prohibition on a doctor purposefully taking life as opposed to saving it'. Dr Nigel Cox, a consultant physician, was convicted of attempted murder on the charge of injecting a terminally ill patient with potassium chloride. The House of Lords reiterated the principle that it is the intent to kill or cause grievous bodily harm which constitutes the mens rea of murder, and that the reason for which the intent was formed is irrelevant to the substantive law of murder (per Lord Mustill in Airedale NHS Trust v Bland [1993] 2 WLR 316 at 394; Lord Keith of Kinkel at 362. According to Lord Browne-Wilkinson, 'it is undoubtedly the law ... that doing of a positive act with the intention of ending life is and remains murder.' Airedale NHS Trust v Bland [1993] 2 WLR 316 at 387). The House of Lords, however distinguished Reg v Cox, and a similar cases of Reg v Adams [1957] Crim LR 365 and Reg v Arthur (5 November 1981 (unreported)) as precedents, on the grounds that in these cases, the respective medical practitioners administered lethal drugs with an intent to actively bring about death of their patients.

According to the House of Lords, as summarised by Lord Mustill, doctors may, under the existing law, and independently of the intervention of the court, lawfully discontinue nasogastric feeding and other treatment which sustains life of a person in the position of Anthony Bland, in the following circumstances:

Where the cessation of nourishment and hydration is an omission, and not an act (see also Lord Goff of Chieveley at 375-376). This is because, once taken out of the category positive act, termination will not be regarded as a criminal conduct unless it is shown that doctors were under a duty to continue the treatment.

In the case of Anthony Bland, when he came unconscious into the care of the doctors, he was unable to make decisions about his care. Non-consensual decisions had to be made for him on the principle of necessity in his best interests. Since the possibility that he might recover still existed, his best interests required that he should be supported by mechanical and biochemical means in the hope that this would happen. The question of Anthony's best interests had to be inquired into again after all hope of his recovery was abandoned.

At this point, it became clear that although, on the one hand, the termination of life supports did not further the best interests of a person in the position of Anthony Bland, on the other hand, his interests in being kept alive have also disappeared, taking with them the justification for the non-consensual medical regime, and the co-relative duty to keep the treatment in being. In such circumstances, there was no longer a duty to provide nourishment and hydration, and therefore a
failure to do so could not constitute a criminal offence (Airedale NHS Trust v Bland [1993] 2 WLR 316 at 398).

The practical conclusion reached by the House of Lords accords with medical ethics and commonsense. It rests, however, upon a contentious legal premise, namely, that the withdrawal of life-sustaining systems and procedures is an omission rather than a positive conduct in law. Lord Mustill recognised as much when he said that ‘this chain of reasoning makes an unpromising start by transferring the morally and intellectually dubious distinction between acts and omissions into a context where the ethical foundations of the law are already open to question.’ Airedale NHS Trust v Bland [1993] 2 WLR 316 at 399. Nevertheless, His Lordship determined that withdrawal of life sustaining treatment was so near the borderline of the category of omissions that it should be classified as such.

Lord Goff of Chieveley also wrestled with the incongruity of a notion that an active withdrawal of life supports should be categorised as an omission. His Lordship chose to rely upon the explanation for treating such withdrawal as an omission provided by Professor Glanville Williams who said that what the doctor does when he switches off a life support machine "is in substance not an act but an omission to struggle" (Williams 1983 p.282) and that such "omission is not a breach of duty by the doctor, because he is not obliged to continue a hopeless case" (p. 282). Without further arguments to substantiate the first assertion, the categorisation of an act of discontinuance as an omission is difficult to accept.

Since, in the United Kingdom, the whole edifice of legality of medical decision-making in respect of withdrawal of life sustaining treatment depends upon the court's categorisation of the doctor's conduct in each particular case, the law is no more certain now than it was before the Bland case. Lord Browne-Wilkinson acknowledged the failure of the decision to live up in practice to its stated goal of enabling doctors under the existing law, to make decisions in respect of withdrawal of treatment independently of the intervention of the court, when he said that:

for the foreseeable future, doctors would be well advised in each case to apply to the court for a declaration as to the legality of any proposed discontinuance of life support where there has been no valid consent by or on behalf of the patient to such discontinuance (Airedale NHS Trust v Bland [1993] 2 WLR 316 at 387; see also Lord Keith of Kinkel at 363 and Lord Goff of Chieveley at 376).

The approach of the House of Lords can be contrasted with that of Mr Justice Thomas of the High Court of New Zealand. The case Auckland Area Health Board v Attorney-General, [1993] 1 NZLR 235 like the Bland case involved an application for a declaratory judgment. Doctors working in the intensive care unit of the Auckland Area Hospital applied for a declaration clarifying whether in law they would be guilty of culpable homicide under the New Zealand Crimes Act, if they withdrew the ventilatory support system which maintained the breathing and heartbeat of a 59 year old patient, Mr L, who suffered an extreme case of Guillain-Barre syndrome. Some 12 months before the court application, disease destroyed conductivity of nerves in the Mr L's nervous system between his brain and his body. As a result, Mr L's brain, though still living was entirely disengaged from his body.

Mr L did not suffer brain damage, though apparently, his consciousness was clouded, he was totally unable to move or communicate, and there was no prospect of recovery. The medical team of eight specialists who had examined Mr L were unanimous that the ventilatory support of the patient could not be medically justified. It was agreed that when the life-support system was withdrawn, death would be instantaneous and painless. The medical team had the support of Mr L's wife, and the approval of the hospital ethics committee.

In his determination, Mr Justice Thomas took a different approach to that of the House of Lords. Unlike the Law Lords, His Honour's stated aim was
This aim could only be fulfilled by clarification of the law in respect of the legal attribution of the cause of death following medically indicated cessation of life-sustaining treatment. Like the House of Lords, Mr Justice Thomas examined the parameters of the medical duty to continue treatment. His Honour’s approach to this issue, however, was based upon different conceptual precepts of which one involved the medical duty of care based upon good practice, and the other the concept of a lawful excuse (ibid p. 254).

When defining the ambit of medical duty of care, His Honour utilised the legal concept of ‘necessaries of life’ (goods and services which are essential requirements of a person subject to incapacity). The provision of artificial life supports such as a ventilator may be regarded as a ‘necessary of life’ where it is required to prevent, cure or alleviate a disease that endangers the health or life of a patient (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 at 249). Where, however, the patient is surviving only by virtue of mechanical or biochemical means and is otherwise beyond recovery, the provision of such life-supports should not be legally construed as a necessary of life.

To require the continuation of a life-support system when it serves no other purpose than to prolong his or her non-cognitive biological life is to act contrary to the primary purpose of medicine which is to preserve and promote health, and to alleviate suffering. In such circumstances, the continuation of the artificial means of life support may be lawful, but it does not make the termination of the support systems unlawful, providing the discontinuance accords with good medical practice (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 at 250).

Thomas J outlined the judicial view of what constitutes good medical practice. Within the doctor-patient relationship, doctors have a duty to treat patients in accordance with their own best clinical judgment, and should not be required to act contrary to this fundamental duty (in setting out these principles, Thomas J relied upon the judgment of Lord Donaldson in *Re J (a minor)* [1992] TLR 290). Since neither law nor medical ethics require doctors to treat the dying as if they were curable, a doctor is under no legal duty to prolong life - or to defer death - in cases where there is no reasonable possibility of the patient emerging from his or her unconscious condition to a cognitive, sapient state (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 at 251). Consequently, the treating doctors have lawful excuse to discontinue life support systems when there is no medical nor legal justification for continuing that form of medical assistance.

His Honour concluded that the cause of death, as a matter of law, will be attributed to the underlying condition of the patient rather than to medical conduct only when the doctors have followed the following relevant principles of good medical practice:

1. They have made a bona fide consultative decision as to what, in their judgment, is in the best interests of the patient.
2. The decision was made in accordance with the prevailing medical standards, practices, procedures and traditions which command general approval within medical profession.
3. The appropriate ethics committee has been consulted, and the proposed course of action was arrived at with informed concurrence of the patient's family and/or guardians.

Thus, in New Zealand, doctors acting in accordance with these guidelines will be deemed to have acted with a lawful excuse and thus will not be liable to any criminal sanction.

**Conclusion**

The decision of the House of Lords in the *Bland* case, while specifically supportive of the concept of patient's autonomy, is implicitly mistrustful of the professional autonomy of medical personnel. Mistrust was the reason why the House of Lords in order to justify its conclusion - the only workable one in the circumstances - resorted to a dubious, and ultimately ineffective,
categorisation of conduct involved in withdrawal of treatment as an omission rather than a positive act. Lord Lowery articulated the Law Lords' unwillingness to relinquish judicial supervision of medical decision-making when he said that:

> in the absence of an application [for a judicial declaration], the doctor who proposes the cessation of life-supporting care and treatment on the ground that their continuance would not be in the patient's best interests will have reached that conclusion himself and will be judge in his own cause unless and until his chosen course of action is challenged in criminal or civil proceedings (Airedale NHS Trust v Bland [1993] 2 WLR 316 at 378).

Mr Justice Thomas' judgment exemplifies a balance between respect for the rights of patients, and the respect for autonomy of the ethical integrity of medicine and the medical professional judgment in regard to the diagnosis of the patient's condition, its prognosis and treatment. His Honour's judicial guidelines confine the decision-making process to the parties who are professionally or emotionally involved with the care of the incompetent patient, while excluding the necessity for determination by the courts, so long as proper procedures are followed.

As pointed out before, the Australian courts have not judicially examined the issue of withdrawal of life support systems from terminally ill incompetent patients. Court process, especially in relation to such emotionally charged issue as termination of life, is always a harrowing experience both for the medical personnel and the family of the person involved. Therefore it would be preferable for the state and territorial Parliaments of Australia to draw guidelines on the management of incompetent patients with an otherwise terminal illness with an aim of legislatively attributing the cause of death in such cases to natural causes, as was done in the South Australian Natural Death Act. Comprehensive guidelines issued in March 1993 by the New South Wales Department of Health (1993) could serve as a model for such legislation.

In the absence of uniform legislation, I would suggest, that in Australia, the great majority of, if not all, doctors working in critical care units follow procedures similar to those which Mr Justice Thomas described as good medical practice. Therefore, should a case of withdrawal of life-saving treatment from an incompetent terminally ill patient come before Australian courts, the better view would be for the judiciary to adopt the New Zealand rather than the United Kingdom precedent. Though, it should be noted that the majority judgment in Re Marion Secretary, Department of Health & Community Services (NT) v JWB and SMB (1992) 66 ALJR 300 (Re Marion) in which the High Court of Australia held that in cases of incompetent female minors the decision whether or not sterilisation operation should be performed requires authorisation by the appropriate court, because of the invasiveness and irreversability of such medical procedures, suggests that a similar requirement may be imposed in cases of withdrawal of treatment from incompetent terminally ill patients, death being the ultimate irrevocable condition.

Footnote

1. This presentation will not examine the law pertaining to competent patients requesting withdrawal of medically provided life-supports, and to minors.

2. Natural Death Act 1983, s. 3 gives the following definition: "Any illness, injury or degeneration of mental or physical faculties (a) such that death would, if extraordinary measures were not undertaken, be imminent; and (b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken."

3. The NDA does not specify whether to be valid, the direction to refuse "extraordinary measures" should be given before or after the diagnosis of terminal illness has been made. Lanham D, Fehlberg B: Living wills and the right to die with dignity. Melbourne University Law Review 1991; 18: 329-349.

persistent vegetative state. The father also sought an express power to authorise the hospital to
discontinue "all extraordinary procedures for sustaining daughter's vital processes." This case, like
the most of the "right to die" cases in the USA, tend to argue an important constitutional issue of the
state interest in the preservation of life as enshrined in the American Declaration of Independence and
the 1947 Constitution of the US. In Australia, the state interest in preservation of life does not have
constitutional foundation.

5. The English law, as set out in In re F [1990] 2 AC and approved in Bland, provides that in the case of
incompetent patients, the doctors must make treatment decisions which are in the person's best
interests.

6. The question which has to be asked in respect of PVS patients is whether the interests of the patient are
best served through the continuation of life-sustaining treatment, not whether the termination of life is
in the best interests of such person. By ending a life of a person in PVS one cannot not be acting in that
person's best interests, for he or she has none. Per Lord Mustill in Airedale NHS Trust v Bland [1993]
2 WLR 316 at 398.

7. Mr L was originally admitted to the hospital suffering from numbness in his hands. Shortly afterwards,
and following a diagnosis of Guillain-Barre syndrome, his condition deteriorated to the point that he
needed to be connected to an artificial ventilator, though at this point he was still conscious and able to
communicate. Within ten days, however, Mr L became totally paralysed; even his eyeball muscles
became inert. Mr L's brain was described as being in drowsy, semi-working state and had no responses
and displayed no awareness to anything happening to him.

8. The concurrence of family members is desirable for socio-psychological reasons, but it is not critical
to the validity of medical decision.

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