TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into end-of-life choices

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Necessary corrections to be notified to
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Prof. SKENE — My name is Loane Skene, and I am a professor of law in the Melbourne law school at the University of Melbourne.

The CHAIR — Professor, thank you very much for joining us this morning. I would like to welcome you here this morning and thank you for making yourself available.

I would also like to caution you that all evidence taken at this hearing this morning is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore, you are protected against any action for what you may say here today, but any comments made outside the hearing and not afforded such privilege. Today's evidence is being recorded. You will be provided with a proof version of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website.

Professor, we have allowed an hour for our session this morning, and I would invite you to make a short presentation, and thereafter committee members will have questions. Thank you again for being here.

Prof. SKENE — Thank you for inviting me. I would start by saying that I have listened to all of the presentation before mine, and I agree with everything that was said. I think what I am going on to talk about flows very well from that, because he called for regulation and that is what I am here to talk about. Obviously I am a lawyer, and I will be talking about the law.

Looking at the current law in Victoria, the first thing to remember is that somebody who expedites the death of another person or causes the death of another person can be charged with murder, and this is the most serious offence that we have. The person might also be charged with the statutory offence of aiding and abetting suicide, so although suicide itself is no longer a crime, it is still a crime to aid and abet or assist suicide. So any doctor who is helping a patient to die does risk being prosecuted. It is true that doctors are rarely prosecuted, but the fact is that this is an intentional act, and it makes no difference that the patient has requested it or even that the patient is in the process of dying. It is still a criminal offence.

Bearing that in mind as the sort of background against which doctors are making these difficult decisions, I think it is important, as the previous speaker said, to look at recent developments that have occurred. One major development was a recognition in the common law that sometimes it is futile to continue treatment, and treatment can be lawfully withheld or withdrawn. You notice I use the terms 'withheld' and 'withdrawn': I think those are interchangeable. It does not make any difference in this context.

This was first started and publicised in the English case in the House of Lords concerning a young man, Tony Bland, who went to the Hillsborough soccer stadium on the day there was a stampede into the stadium. People were caught on the cyclone wire fence. His chest was squeezed, he lost oxygen to the brain as a result of that and he was then taken to hospital. He was in a persistent vegetative state for three years. The area health authority in England, the parents and the treating doctors thought that treatment should be withdrawn. After a series of cases it ended up in the House of Lords, which is the top court in England, and all of the judges said that it would be lawful for the life-sustaining treatment to be withdrawn because it was futile to continue it and not in the patient's best interests.

That principle has been established in a number of recent cases, many of which are very well known. Terri Schiavo died in Florida, America, after the artificial breathing tube that kept her alive for many years was withdrawn. Twenty judges considered her case as it went through various reviews, and the overwhelming decision was that it was lawful to withdraw the treatment. One of the questions you have asked is about the rights and the views of people who hold sanctity of life views. I think it is interesting in this case that they pointed to antidiscrimination legislation and said that not to give the treatment further would be discriminating against this patient because she had a disability. It is true that she had a very serious disability in that she was being maintained on life support and could not exist without it; however, the argument was still that she could not have that discrimination against her. I think that is an interesting argument. Under our antidiscrimination legislation, what is prohibited is unlawful discrimination, and it is lawful to discriminate in certain circumstances, so I do not see that as such a problem here.

Closer to home, in Melbourne we have had Maria Korp, whom you will remember, and BWV, two cases in which the public advocate intervened in order to seek direction from VCAT with regard to what was an appropriate procedure to adopt. Again, there was a finding that it would be lawful to withhold the treatment. Those were cases where the patient was not able to make their own decision, and the circumstances were dire.

Looking at the next category of cases — and in Australia these were the cases that led to the Medical Treatment Act 1988 in Victoria — they are cases where the patient was able to refuse life-sustaining treatment themselves. The Victorian case was John McEwan, who was an Australian waterskiing champion, and he became a quadriplegic after a diving accident. He was on a ventilator, there was no chance that he could recover, and he said, as a competent adult patient, 'I don't want this treatment to continue'. At the time there was some uncertainty about his right to refuse the treatment. There were a number of cases in England that might have provided some guidance, but there was nothing in Australia.

Obviously that created a lot of publicity, and people said we should make it clear that patients are entitled to refuse treatment, even life-sustaining treatment. That is what led to the Medical Treatment Act in Victoria in 1988. When the Medical Treatment Act was first passed, it enabled the person to sign a refusal of medical treatment certificate, which we still have. When you are a competent adult, provided that you have a condition at that time which you can refuse treatment for, you can refuse any type of treatment, including all treatment.

That was later extended to enable a person to appoint an agent, which is still in the act, and that agent can refuse treatment on the patient's behalf. This is a very important point, because we heard from the last speaker that the main thing is: what does the patient want? What the patient wants might vary, and so he described different views that you might have. I am a person who, if I cannot have it all, I do not want it. But I can see that perhaps as time goes by and I start losing my faculties but life is still good for me I might change my mind. So if you can appoint an agent to make the decision for you, and you talk to that agent about how you are feeling all the time — you can now have an alternative agent as well, so there are two people, to make sure somebody is available — you can then make your views known and there is more flexibility in the situation. There have been a number of other developments with patients refusing life-sustaining treatment.

There is also the doctrine of double effect, which you will have heard about, where the law will support active measures, not only withdrawing or withholding treatment, provided that the intention of the doctor is to relieve pain and not to cause death or to hasten death. A lot has developed along these lines. The notion of terminal sedation, for example, would be part of this doctrine of double effect. What is the doctor trying to do? The doctor is trying to alleviate pain, keep the patient comfortable, make the dying process better and not kill the patient. Yet of course it is quite an artificial distinction, is it not? Because we have other case law that if you can see as a consequence of your act that something will occur, then you are deemed to have intended it. This principle was established in a case where a truck was driven into a hotel in the Northern Territory. The driver said, 'I didn't intend to kill anybody there', and the answer was, 'It was obvious that if you drove your great big truck into a hotel, people were at risk of dying'. So the foresight of those consequences was equivalent to an intention. The doctor can say, 'Double effect — I didn't intend this; I intended that', and yet if you give the patient increasing drugs, it is an inevitable consequence that that will happen.

That leads us to: who are the patients who are missing out? You have got the notion of futility, where the treatment can be withdrawn, you have got patients refusing treatment where the treatment can be withdrawn, and you have even got the doctors being able to give this pain relief on the doctrine of double effect. So who misses out? You can see that it is patients who have not got pain that has to be relieved by pain relief and patients who will not die if they refuse some sort of treatment. You have a whole lot of patients who can be helped, but you have still got these patients who need some sort of active intervention but who do not have pain that can be relieved in the same way as the doctrine of double effect.

Those are my opening comments. The question for you, it seems to me, is: what can you do about those patients? One of the other questions you are considering in the terms of reference — and I will let you ask questions about those, but I just thought I would mention this — is the difference between a refusal of treatment certificate and an advance care directive or advance care plan or something like that. The refusal of treatment certificate that we have in Victoria is quite limited. You have to have a current condition. I cannot go home and just say, 'If I am ever in pain, I don't want this'. I have to say, 'I have cancer. That is my current condition, and I don't want to have chemotherapy'. I can sign my certificate and get it witnessed by a medical practitioner and another person, and then that will stop me being given chemotherapy. In this way our Medical Treatment Act is a bit different.

I think there is greater flexibility if you appoint an agent, and there is greater flexibility if you set out what your views of life are. I am a person who likes reading and music and seeing the development of my grandchildren, and therefore for somebody like me I do not need to be able to climb mountains to be happy. That can be taken into account in deciding what should happen when my care decisions are being made.

The CHAIR — Professor, thank you for your opening comments. If I could perhaps ask the first question and just take you back to that case of the truck that went into the hotel and the doctrine of foreseeable consequences, are you saying that as a result of that the doctrine of double effect is unclear or the legal basis of it — —

Prof. SKENE — It does seem to be somewhat illogical, and it has certainly been criticised in the literature.

The CHAIR — Okay. We heard from our first witness, as you would have as well, that that has yet to be formally tested in Australia.

Prof. SKENE — That is right. This doctrine goes back a long way to an English case. It is widely cited and talked about, but it has not arisen specifically for legal analysis.

Ms PATTEN — I have a couple of questions. I noted in one of your papers that you said patients cannot refuse palliative care — did I misread that?

Prof. SKENE — That is not quite right. They can refuse anything at common law. What that would have referred to is a refusal of treatment certificate. When you sign a refusal of treatment certificate, you can refuse all treatments except for palliative care — the reasonable provision of food and water and palliative care. That means that if you sign the refusal of treatment certificate, it does not cover those things — you can be given those things. But if you are awake at the time and competent, you could say, ‘No, I do not want anything; I do not want any pain relief’. This might be quite a reasonable decision to take. You might think, ‘I would rather suffer the pain and be aware and able to say goodbye to my relatives and have a meaningful death; I do not want to be out of it’.

Ms PATTEN — Do you have a concept of what sort of legislative changes you would like to see us pursue to possibly confirm this illogical position on double effect and also whether we can be more proactive in our advance directives?

Prof. SKENE — It is extremely difficult to draft suitable legislation. In Australia the only time this has succeeded, despite numerous private bills in various state parliaments, was in the Northern Territory, with the Rights of the Terminally Ill Act. If you were to draft something like that, I think there would be a lot of hostility, particularly from the medical profession, because it was very difficult to administer. If a doctor saw a patient who was seeking that sort of treatment, there were two processes. You had to explain it all to the patient and get informed consent, and then there was a waiting period. Then you had to get a second medical opinion, another waiting period, and then after the death there were requirements to make a report to the coroner. You think, ‘Why did they have all this?’. The answer is obvious: because not all of these sorts of proceedings are going to go forward without disputes, and family members may be out to pursue their own ends.

It is difficult to have protections in the legislation, which you might think that people would want to have, and yet at the same time give the doctors sufficient flexibility to make the decisions. I think it is very unfortunate that we talk all the time about euthanasia, assisted suicide, assisting death and things like that; we should be looking at the total care of the patient. We should be supporting doctors who want to help patients and also have services known to be available where doctors will not have a conscientious objection and that sort of thing, which can also be an issue in the legislation. I think the legislative scheme that you might recommend is by far your most difficult issue.

Ms PATTEN — Yes. Thank you, Professor.

Mr MULINO — To go back to the first issue, just to clarify, I think you said you were broadly supportive of what had been put forward in the earlier submissions.

Prof. SKENE — Yes.

Mr MULINO — Does that mean that, notwithstanding some of the potential conceptual difficulties with double effect, you would be supportive of a simple legislative provision that codified, arguably, what is going on along the lines that Professor Komesaroff put forward, with those four elements? Would you think that those four elements would be workable?

Prof. SKENE — I think that there is a general tendency in the law to this view. One case that I have not mentioned is the recent Canadian case of *Carter v. Canada* and the view of the Canadian Supreme Court that the right to patient autonomy should override, basically, the sanctity of life. This goes right back to Tony Bland's case in the House of Lords — that you should look at putting the patient at the centre of your decision-making. In the Supreme Court they said the autonomy of the patient is the predominant factor. The Supreme Court directed that the provinces and the federal government within a year — the grace period — should prepare some scheme to help patients, which might not be a legislative scheme. It might be some other device to deal with patients who are in this position — terminally ill with pain they cannot deal with.

Then you say, 'What are the possible alternatives to legislation?'. You could have prosecution guidelines, which is one of the things that has been tried in the UK, or you could have wider publicity for doctors on what they can do and more discussion in the wider community. As the previous speaker said, this is something that comes from a committee like this. I would like to see the legal issues referred to the law reform commission to assess them, because looking at what happened with the law of abortion, we had a good method of examining all of the alternatives and recommendations being made, which were then taken up by the Parliament.

Ms FITZHERBERT — Do you think there is a need to have any safeguards to protect the vulnerable? Should that be a finding of this committee?

Prof. SKENE — We have the public advocate, and the public advocate is able to intervene on behalf of a patient. I gave examples of Maria Korp and BWV, two high-profile cases in which that happened. I think that does give some safeguard in a contentious case where the relatives may not agree on what should happen. But the best protection we have really is the doctors. The doctors have the ultimate responsibility for their decisions, and, as I have said, they can be prosecuted. There are precedents for at least one case that springs to mind where a doctor has been prosecuted for assisting a patient to die in the UK — the case of Dr Cox. If you have procedures within the hospital where the doctor can consult others in the process and have records of discussions that have taken place, I think I would be satisfied with those sorts of safeguards.

Ms FITZHERBERT — As a follow-up of sorts, from what I am hearing from the evidence you have given, I am wondering if you are broadly satisfied with the system we have at the moment or whether you think it needs to be changed.

Prof. SKENE — I think it works quite well in practice, but of course I am not a doctor who is at risk of prosecution. We saw the issues for doctors who were undertaking late-term abortions, which really led to the law reform commission report and the amendments to the law of abortion. While anybody is at risk of criminal proceedings when they are doing their best in their everyday professional life, then the situation would seem to be unsatisfactory. I think you have to think: how can we make doctors feel more protected so that they can confidently help patients in these circumstances?

If there is a great body of opinion and procedure within the hospital on how these decisions are going to be taken, you could have a process where the patient is assessed, as they will have been in any event, and you call in the family and you have a family meeting and there are records kept of that if necessary — if there is any dispute in the family members — and you could get extra medical opinion on what is the best outcome. You would have patient's plan, hopefully prepared in advance, telling you what sort of person they are and what they would have wanted. Then the decision could be made, and you could have a policy that the doctor would not be prosecuted in such circumstances, which I think is very unlikely to happen.

Ms FITZHERBERT — If I could just follow up on that one: if I understand you correctly, you are saying we have a system that largely works at the moment but there is a danger in that system in that we are relying on a quite ancient doctrine to protect the practice — but it has never been tested here. If it were, it might take the law and therefore future medical practice in a direction that is undesirable, and we have an opportunity to head that off. Is that what you are saying?

Prof. SKENE — I think it is unlikely that the doctrine of double effect would not be accepted. In the case in which the doctor was prosecuted and convicted in the UK, the doctor had used a drug that would kill the patient straightaway rather than a drug that looked as if it might be alleviating the patient's pain. He said, 'Well, I had thought of other drugs, but I did not think anything else would work. I have had this patient for a long time, she has got a lot of pain, we have tried other sorts of drugs, they did not work and I thought the only way to help her was to give her this drug that would kill her straightaway. That is what she wanted, and the chaplain was involved in the decision as well'. It really tested the fact of whether you can say that that was something done to relieve pain or something to cause death. That doctor was actually sent off for counselling on better methods of dealing with patients who were dying, and now there are better drugs and there is more to do — but it does not deal with everything. You have patients who are gasping for breath or have other sorts of conditions that are extremely distressing for them and cannot be dealt with by the drugs, and it is those sorts of patients whom you have to think whether the law needs to be changed to help them.

Mr MELHEM — On that point, the patients who actually do not have pain.

Prof. SKENE — They have distress.

Mr MELHEM — Yes, what we do with them — the things we can put in place. Following on from that is: what sort of legislation can the state put in place? How would that sit with the commonwealth? The commonwealth might have some issues with the constitutional challenges.

Prof. SKENE — These are very complex questions. You will have to ask the medicos about what to do with them, but one option is terminal sedation. You can keep them sort of just below unconsciousness so that they do not have the feeling of gasping for air or something like that, which may accelerate death, but you would argue on the basis of double effect that you are acting to relieve their suffering. Suffering and pain — what is the difference?

With regard to the constitutional issue, one of the things you will be thinking of there, I expect, is that the Rights of the Terminally Ill Act in the Northern Territory was repealed by a commonwealth law, even though it was a Territory law. The commonwealth was able to do this under the territories' power because the Northern Territory is a territory. I think it is extremely unlikely that that would happen with a Victorian law. You would have to go to a constitutional lawyer to get more details on this. There is not an immediate head of power for the commonwealth — that would be one — but also states have a different constitutional nature from the territories. But there might be other ways. The commonwealth might be able to withhold funding for health facilities or something like that and be able to control what the state does in other ways.

Mr MELHEM — Just to follow on from that, let us say a doctor made a decision. Should we have some sort of system where doctors need to get legal advice as part of the decision-making process?

Prof. SKENE — I think we have to think of how many patients there are in this situation. Again we heard that from the previous speaker. It is going to increase. We have an ageing population, we have chronic diseases, but people have better medical procedures, so people can be kept alive for a long time. The thought that every time the doctor is making what should be a medical decision they would have to go and get legal advice — —

Mr MELHEM — I am talking about the terminally ill, to use the term I have used earlier. If a doctor is about to make a decision to turn the lights off, at that point should the doctor consult or seek a legal opinion to have compliance?

Prof. SKENE — It is interesting. After Tony Bland's case the judge was really saying that in cases where this happens in future there should be a court application and the court should decide. But that is not the case any longer; it is accepted that in cases of futility you can withdraw treatment without a court order, and I think that is what would happen here.

The CHAIR — Professor, you mentioned the role of the agent and the opportunity to have an alternative agent as well. Could you perhaps give a bit more background to the legal standing of the agent and what roles and functions the agent can perform?

Prof. SKENE — Yes. The agent virtually steps into the shoes of the patient. In order to have the agent the patient has to appoint the agent using the form in the act and the procedures in the act — it has to be witnessed and all that sort of thing — and then after the agent is appointed, when the patient has a current condition the agent can then sign a refusal of treatment certificate as the agent of the patient.

If you look at the way that the refusal of treatment certificate can be challenged and the agent's refusal of treatment certificate can be challenged, there is a difference there. If a person has signed the valid refusal of treatment certificate and it has been properly witnessed, then it is very difficult for a doctor not to follow it, and there is no procedure where it can be reviewed and struck out unless there is some error on the face of it, say, in the way it has been witnessed. You cannot go back and say, 'This patient has changed his mind and they would not have made the same decision now'. With the procedure by the agent, that can be challenged to VCAT. If there is evidence that the person has changed their mind, for example, I think that that could be one of the grounds of challenge, and then the public advocate would be appointed and the public advocate would go ahead and make the decision.

The CHAIR — Does that challenge happen very frequently? You cited two situations.

Prof. SKENE — Yes. I do not personally know of any, but I have not looked for them. However, you can imagine that might happen if there was a dispute in the family, one person has been appointed as the agent and that person says, 'This is what he or she would have wanted, therefore I am going to follow that', and someone says, 'You haven't been around for the last month and I have'.

The CHAIR — Do you believe the current legal framework with regard to agents is satisfactory or needs review or should be changed?

Prof. SKENE — I have not got any personal knowledge of how it works. The fact that I have not seen this appearing in the case law maybe is significant.

Ms PATTEN — In looking at those people who are not covered — and with an ageing population this may become significant — generally an advance directive is just a refusal of treatment. I am wanting your opinion about a more proactive advance directive that says, 'If I am not capable of doing this, then my directive is that I do not necessarily want to continue with my life'.

Prof. SKENE — I am pleased that you have asked this question, because it was something I should have said at the beginning. In cases dealing with medical procedures generally we have a growing emphasis on patient autonomy, and this has gone with the rise of the doctrine of informed consent. Patients have to be told what is involved, including material risks, and be given the opportunity to decide, but what they decide is not something that they can demand positively. They can refuse treatment, but they can only choose one of the options that is available to them, and if the doctor is not prepared to provide that option, then they are not entitled to demand that they have some positive step.

In thinking about the answer to your question, you have to bear in mind that background. You could say that a patient might be able to say, 'If it were available, I would want to be given a lethal dose of a drug and end my life', but it would then be for the doctor to decide whether that is clinically appropriate. Then the doctor of course bears the responsibility for it, so the doctor has to be confident that the patient is terminally ill, is of sound mind when they say that, is not being coerced, is adult — we have not looked at neonates and young children at all, where different issues arise — and that in all the circumstances of the case it is in the patient's best interests and that proper procedures have been followed. I have suggested some of the recording procedures that might reinforce confidence that the doctor could make those decisions.

Ms PATTEN — Do you think it would be acceptable to include in an advance directive a person's desire that 'If I got to this point, if available, this is what I would like', rather than what seems to be traditional, which is, 'This is what I don't want'?

Prof. SKENE — The 'Don't want' will be legally enforceable and the 'I want the positive dose' will not.

The CHAIR — I will ask one final question, Professor. In the case of Dr Cox in the United Kingdom, which you referred to, can you refer to information about the judgement and what penalty was applied?

Prof. SKENE — He was convicted. My recollection is he received a one-year suspended sentence. There was an investigation by the General Medical Council, which is like the medical board, and, as I said, he was disciplined and he had to have training in end-of-life drugs and other care. He was also subjected to ongoing publicity in the press, as you can imagine, and the stress and worry of it all. It was a dreadful experience for him.

The CHAIR — No doubt.

Ms FITZHERBERT — I assume the charge was murder or manslaughter for Dr Cox. What was the charge?

Prof. SKENE — He was originally charged with murder and that was changed to manslaughter later. I believe the reason for that was the Crown was not sure that it would be able to prove that the drug he had given caused the death and not the patient's underlying condition.

You have not asked me anything about causation. I think that is an interesting issue, too — what causes the patient's death if you withdraw treatment? Is it the doctor withdrawing treatment or is it the patient's underlying condition that goes on? I think that is an interesting issue.

The CHAIR — Has that been considered by the courts?

Prof. SKENE — There is case law on it, but I cannot bring it to mind just at this moment.

Ms SYMES — Would that not play in part into the whole concept of ongoing treatment being futile? Would that not almost imply that the underlying illness is what actually causes the death?

Prof. SKENE — Yes. That was the case with Tony Bland. He had his lungs squashed. He had very severe brain damage. It was said in the judgement that his brain was reduced to a watery mass. In the case of Terri Schiavo, when you look at her brain in the post-mortem, it is absolutely apparent that nobody could have continued to live unaided with these conditions. What caused Tony Bland's death? It was the underlying conditions. This issue of what causes the death was in fact considered a lot in Tony Bland's case. It was said in that case that the cause of death was the underlying condition. When a doctor turned off the life-support, that was lawful; but if an interloper had come in the night, to use the words in the judgement, and switched off the switch, that interloper would have been the person who caused the death. You can see the inconsistencies and difficulties of the law.

Ms FITZHERBERT — I am reminded of criticisms that are made sometimes in these circumstances, that what actually kills some quite fragile patients is that they starve to death or they die because they are not receiving hydration. Are you addressing those sorts of circumstances in your comments about causation?

Prof. SKENE — Yes. You can say: what causes the death there? People lose their desire for food and even water as they are dying, and you could say if that is part of their condition, what causes their death — those may be proximate causes — is really the fact that they have an underlying condition from which they are dying.

Mr MULINO — I just want to go back to the complexities of double effect. You have referred to the Northern Territory case, where you drive a truck into a building and there are significant consequences that were not necessarily your primary motivation. Do you think that that kind of artificiality could be limited if you imposed a reasonableness and a necessary test to the action, that reasonableness would mean that the other effects would, in a sense, not be so disproportionate and unrelated to what it is that you are doing?

Prof. SKENE — I think it would be better to acknowledge that doctors, who are acting in the best interests of their patient from a medical perspective, are not covered by the same sort of principle. I think if you try to say that the 'reasonable foresight of consequences' argument should apply to doctors — I mean it would apply if you had your appendix out; there is a possibility that you will die as a result of that operation. It may be a remote possibility, but it is still something that you can foresee as a possibility. Obviously it is not like the firm likelihood, or reality, that if you drive a truck into a hotel, then people will be killed, assuming there are people in there. I am sorry, I am not putting this very well. I think that the doctor should be in a different category.

Mr MULINO — I am just going back to Denning's case. I am not talking so much about what is reasonably foreseeable but whether the practice itself is reasonable — as in: is the action that you are undertaking in prescribing pain relief consistent with reasonable medical practice? I would have thought that could provide some kind of constraint on what actually might be captured by the — —

Prof. SKENE — I think the way that you have put it — 'What is consistent with reasonable medical practice?' — should be our guide. That is why I think if the doctors get together, and the family is present, they talk and give the family time to grieve and agree and then have a procedure where, if there is not agreement, the family can go to the public advocate and it can be heard by VCAT to determine it, then you have broad agreement and you have records that back up the decision-making process that can be looked at later if there is a dispute by the coroner if necessary. If we have all of that in the background, I think that is probably the best line forward.

The CHAIR — Professor, perhaps at a higher level, could I ask you to give some commentary on how Victoria operates as a jurisdiction compared to other jurisdictions in Australia or other comparable jurisdictions around the world and whether there are opportunities for us to improve the way we do things, drawing on the experiences of other comparable jurisdictions?

Prof. SKENE — Yes. In Queensland there has been a lot of discussion about advance care directives and appointing somebody to make decisions for you when you are no longer competent. In South Australia they have had legislation for much longer. There they protect decisions that are made refusing treatment, and the decision does not have to be made when you have a current condition, so to that extent the Victorian act is more limited than the South Australian legislation. Obviously the legislation is only one place for the law, and in New South Wales I think there has probably been greater emphasis on common law. There was a recent case — it is not so recent now — in the Hunter Valley — I think it involved the Hunter Valley health authority — in which a judge set out a detailed statement acknowledging that patients can make decisions refusing treatment at common law. The patient in that case had kidney disease. He was on dialysis and he wanted to refuse dialysis continuing. He wrote that down when he was admitted to hospital, but it was a common-law directive, and the judge said that that directive could be followed by the area health authority and they did not have to give him dialysis when he said that he did not want it. It sets out the procedure to be followed in some detail in the judgement. I think that has been the approach there.

I have said a few things about the English law. In England and also in Canada they have human rights legislation. We have our human rights state act but we do not have a constitutional provision protecting human rights, but if you do, as happened in the *Carter v. Canada* case, you can say that the person's rights to autonomy should outweigh all other factors, and I think that has been a general trend in litigation in a court review in England and, as I said earlier with regard to informed consent, it has been a trend in Australian cases as well.

The CHAIR — Could you provide more information about what Queensland has done in relation to advance care directives?

Prof. SKENE — They have done a great deal of research in thinking how they can be set out and what the traps are and that sort of thing, particularly at Queensland University of Technology. Lindy Willmott and Ben White are the two names that you might like to look at. I have not looked at them for a while so I would rather not say more about that.

The CHAIR — Professor, the committee thanks you very much for your presentation this morning, for your answers to our questions and for giving us some pointers to further areas of research that we can look at.

Prof. SKENE — Thank you again for inviting me. I hope all will go well with your deliberations in this difficult area.

The CHAIR — Thank you, Professor.

Witness withdrew.