LAW, AUTONOMY AND ADVANCE DIRECTIVES

Lindy Willmott,* Ben White* and Ben Mathews*

I. INTRODUCTION

At common law, advance directives regarding medical treatment are underpinned by the principle of autonomy. An advance directive provides a means by which a competent adult can determine the medical treatment that he or she wants to accept or refuse in the future if his or her decision-making competence is lost.1 While there are some conditions that need to be satisfied before a directive will be followed, for the most part, the common law requires a person’s refusal of treatment as expressed in an advance directive to be followed, even if it is unpopular with an individual’s family or friends, or is contrary to objective notions of good medical practice. In this way, the common law recognises autonomous choices about medical treatment made by a competent person. This right to refuse treatment has also been enshrined in statute. Legislation in most Australian jurisdictions permit a person with capacity to make an advance directive that refuses treatment.2 In recognising this common law right, the statutes too are then, at least implicitly, underpinned by autonomy.

This article considers whether the current reliance on autonomy by the law to recognise advance directives is appropriate. We begin by outlining, in Section II of the article, the common law that governs advance directives and, in Section III, we discuss the relevant Australian legislation that facilitate the making giving of such directives. In both sections, we examine the role that the principle of autonomy has played in recognising advance directives.

We then turn to consider whether autonomy can be justified as an appropriate normative framework. Section IV of the article examines the value accorded to this principle from three different perspectives, all of them being relevant to the context of advance directives. They range from broader perspectives that consider the role of regulation generally, through to a more specific examination of analogous situations.

Starting with the general, the first perspective considered is the value placed on autonomy in a liberal democracy. Most Western societies are liberal democracies and so regulation of human conduct, including the making and recognition of advance directives, should be consistent with theories of how such a society should function. Autonomy plays a significant role in these theories and so adds weight to the argument that the law should recognise a competent adult’s ability to refuse treatment in advance. One legal field that is becoming increasingly significant in liberal democracies is human rights. Unsurprisingly, human rights law places great weight on autonomy generally and some human rights legislation and instruments even expressly recognise the importance of autonomy in the context of refusing medical treatment.

---

1 This article only considers autonomy in the context of advance directives that refuse medical treatment. Advance directives that request treatment have not been recognised at law as involving a binding exercise of a person’s autonomy: R (Burke) v General Medical Council [2006] QB 273.

2 Consent to Medical Treatment and Palliative Care Act 1995 (SA); Guardianship and Administration Act 1990 (WA) pt 9B; Medical Treatment Act 1988 (Vic); Medical Treatment (Health Directions) Act 2006 (ACT); Natural Death Act 1989 (NT); Powers of Attorney Act 1998 (Qld) chap 3. See below at Section III.
The second perspective is that of medical ethics. Medical ethics and law are different disciplines, but there is an overlap and relationship between them so that the primacy given to autonomy in medical ethics adds weight to the use of autonomy in recognising advance directives as a matter of law. The third perspective is the closely analogous situation of refusals of life-sustaining treatment that are made contemporaneously. The very clear acceptance by the case law of autonomy in this context supports its acceptance in the case of refusals in advance.

In seeking to justify the current recognition of autonomy by the law governing advance directives, Section V of the article engages with the arguments as to why autonomy is not the appropriate framework to underpin advance directives. Firstly, global or philosophical objections to the appropriateness of autonomy in this context are considered. Secondly, concerns about the practical application of autonomy to advance directives are explored. As part of this examination, the merits of those arguments are critiqued and counter arguments raised.

Finally, we raise briefly a number of preliminary points concerning the scope of this article. The first relates to the meaning that we attribute to autonomy. There are many differing views about what is meant by the principle of autonomy, and it is beyond the scope of this article to engage in this debate. However, for the purpose of this article, Raanan Gillon’s definition of autonomy provides a helpful focus and encapsulates the principle of autonomy that is appropriate for our purposes:

“Autonomy (literally, self rule) is, in summary, the capacity to think, decide and act on the basis of such thought and decision freely and independently and without … hindrance.”

The second point to note is what is not considered in this article, and that is whether the law’s acceptance of the principle of autonomy is in fact reflected in the outcomes of judicially decided cases. While this is a related and significant issue, the purpose of this article instead is to argue that the law’s recognition that the principle of autonomy underpins advance directives is appropriate.

II. ADVANCE DIRECTIVES AND AUTONOMY AT COMMON LAW

4 This is noted by TL Beauchamp and JF Childress, Principles of Biomedical Ethics, 6th ed (New York: Oxford University Press, 2009) 99.
At common law, an advance directive that is valid and applicable to the relevant circumstances is legally binding and a doctor who does not follow it may be liable to both civil and criminal sanctions. In *Re AK (Medical Treatment: Consent)*, Hughes J stated:

It is… clearly the law that the doctors are not entitled so to act [provide treatment] if it is known that the patient, provided he was of sound mind and full capacity, has let it be known that he does not consent and that such treatment is against his wishes. To this extent an advance indication of the wishes of a patient of full capacity and sound mind are effective.

This section of the article outlines the common law that governs advance directives. It begins by examining the two conditions for an advance directive to be binding: that the directive is valid and applicable to the situation that has arisen. It then considers the legal authority for the proposition that autonomy underpins the law’s recognition of advance directives.

### A. Validity of advance directives

An advance directive will be valid at common law if two conditions are met. The first condition is that the person must be competent at the time the directive is given. A person will be competent if he or she has the necessary capacity to make the directive and is then able to communicate that decision. For a person to have capacity, he or she must have “…the ability, whether or not one chooses to use it, to function rationally: having the ability to understand, retain, believe and evaluate (ie, process) and weigh the information which is relevant to the subject matter.”

At common law, a person is presumed to have capacity to make a directive, so the onus of proving that there was a lack of capacity is on the person alleging it. The level of capacity needed to give an advance directive will depend on the nature of the decision being made. A decision with grave consequences, such as refusing life-sustaining treatment, will require a higher level of capacity than other decisions.

---


8 See, for example, *Re F* [1990] 2 AC 1, 73 (Lord Goff); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 117 (Butler-Sloss LJ) and *Airedale NHS Trust v Bland* [1993] AC 789, 866 (Lord Goff); *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, [40] (McDougall J). For a discussion of the damages available when there is a failure to follow an advance directive, see *S Michalowski, “Trial and Error at the End of Life – No Harm Done?”* (2007) 27 Oxford Journal of Legal Studies 257.


10 *R (Burke) v General Medical Council* [2005] QB 424, 440 (Munby J) (although note that, in overturning the decision, the Court of Appeal suggested caution in relying on aspects of Munby J’s judgment in future cases: *R (Burke) v General Medical Council* [2006] QB 273, 295 (Lord Phillips MR, Waller and Wall LJ)).

11 Ibid.


13 *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449, 472 (Butler-Sloss P); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113 (Lord Donaldson MR). For commentary about whether the high standard of capacity required in this context is consistent with notions of autonomy, see J Manning, “Autonomy and the Competent Patient’s Right to Refuse Life-Prolonging Medical Treatment — Again” (2002) 10 Journal of Law and Medicine 239. See also M Parker, “Judging Capacity: Paternalism and the Risk-Related Standard” (2004) 11 Journal of Law and Medicine 482, where he argues that there should be just the one standard for assessment of capacity, not a standard that alters with the gravity of the decision. He further argues that the latter “risk-related” assessment of capacity is paternalistic in that it imports medical values into determination of capacity: 489–490.
The second condition is that the person was free of undue influence at the time the directive was made. Not all influence will be regarded as undue. Provided the decision remains that of the person, it is legitimate for others, such as family, friends and doctors, to provide advice and even seek to persuade the person to change his or her mind.

It has been suggested that a third requirement must also be met before an advance directive can operate: a person must have been given sufficient information to found making a decision. While it is clearly desirable that decisions about medical treatment should be informed ones, the authors suggest that this requirement should not be part of the common law. Of significance is the often quoted passage from Lord Donaldson MR in Re T (Adult: Refusal of Treatment):

An adult patient who … suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered … This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.

These fundamental principles have been recognised across Western jurisdictions: in the United States Supreme Court, Cardozo J famously declared that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault’. To require as a matter of law that a person be provided with information before making a decision (whether contemporaneous or in advance) is inconsistent with this fundamental principle. It would permit, for example, the assault of a person to provide medical treatment against their wishes if he or she refused to hear information about prognosis. Accordingly, while informed decision-making is preferable, we argue that the common law does not require a person to have received relevant information before an advance directive can be binding. This view has now been accepted in Australia in the recent decision of the New South Wales Supreme Court.

Finally, there are no formality requirements for an advance directive to be valid, although a lack of formality may be relevant when seeking to establish the existence and scope of an advance directive. A directive is capable of being revoked by the person at any time they have the competence to do so.

---

15 In Re T (Adult: Refusal of Treatment) where the English Court of Appeal found that a woman’s refusal of treatment was not binding on the treating team, Staughton LJ considered that influence will be undue only if there is ‘such a degree of external influence as to persuade the patient to depart from her own wishes’: [1993] Fam 95, 121.
16 Kennedy and Grubb, n 3 at 2037–2038.
18 Re T (Adult: Refusal of Treatment) [1993] Fam 95, 102. This passage is cited in Re MB (Medical Treatment) [1997] 2 FLR 426, 432 (Butler-Sloss LJ). See also Re B (Adult: Refusal of Medical Treatment) [2002] 2 All ER 449, 456 (Butler-Sloss P); Re T (Adult: Refusal of Treatment) [1993] Fam 95, 115 (Lord Donaldson MR), 116 (Butler-Sloss LJ), 120–121 (Staughton LJ); Airedale NHS Trust v Bland [1993] AC 789, 864 (Lord Goff), 891 (Lord Mustill); HE v A Hospital NHS Trust [2003] 2 FLR 408, 414; Nancy B v Hotel-Dieu de Quebec (1992) 86 DLR (4th) 385.
19 Schloendorff v Society of New York Hospital 105 NE 92 (1914), 93.
20 This point is argued at greater length in Willmott, White and Howard, n 17 at 220–221.
21 Although whether information was provided may, of course, be relevant to whether a person would have intended their directive to operate in the circumstances that have arisen.
B. Applicability of advance directives

In addition to being valid, an advance directive must also be applicable to the circumstances that have arisen for it to bind doctors. Applicability turns on whether the directive was intended by the person to operate in the relevant circumstances.25 Four categories where a directive may not reveal such an intention have been identified from the limited case law.26

The first category is where there has been a change in circumstances since the directive was made such that the person would not have intended it to govern the situation. In HE v A Hospital NHS Trust,27 a 24-year-old woman had executed an advance directive refusing blood transfusions or other blood products. She had initially been a Muslim but was raised as a Jehovah’s Witness by her mother. There was, however, evidence that she had agreed to revert to Islam because she was marrying a man of that faith, and that she had implemented that decision by no longer attending Jehovah’s Witness meetings and services. In these circumstances, Munby J held that the directive28 cannot have survived her deliberate, implemented, decision to abandon that faith and revert to being a Muslim. When the entire substratum has gone, when the very assumption on which the advance directive was based has been destroyed by subsequent events then … the refusal ceases to be effective.

The second category is where the terms of an advance directive are uncertain or ambiguous so that it cannot be said to apply to the circumstances that have arisen.29 An example commonly cited is where a directive refuses ‘heroic measures’ but does not articulate what sort of medical treatment that includes.30 An illustration of this category of advance directives not being applicable because of uncertainty or ambiguity is the decision of W Healthcare NHS Trust v H.31 This case involved a woman with multiple sclerosis who was being provided with artificial nutrition and hydration through a percutaneous endoscopic gastrostomy tube, which became dislodged. She had made a number of statements many years earlier about her future medical care. The English Court of Appeal accepted that some of her statements may have been sufficient to refuse some medical treatment, for example, her desire not to be kept alive on ‘life support machines’.32 However, other general statements that she wished to refuse treatment based on quality of life considerations were ‘not sufficiently clear’ to amount to an advance directive refusing artificial nutrition and hydration.33

The third category where an advance directive will not be applicable to the circumstances is where it is based on incorrect information or an incorrect assumption. In Re T (Adult: Refusal of Treatment),34 both Lord Donaldson MR and Butler-Sloss LJ indicated that a refusal based on an incorrect assumption would not be operative.35 They pointed to evidence that the patient, when

---

25 Re T (Adult: Refusal of Treatment) [1993] 3 Fam 95, 114 (Lord Donaldson MR).
27 [2003] 2 FLR 408.
28 Ibid 422.
31 [2005] 1 WLR 834. Compare Re AK (Medical Treatment: Consent) [2001] 1 FLR 129 where no issue of uncertainty arose, no doubt aided by the fact that the statements were given shortly before and in contemplation of the specific treatment that was being refused.
33 Ibid 840 (Brooke LJ).
34 [1993] Fam 95.
refusing blood products, was told that other effective alternative treatments were available and that a transfusion was not often needed in her circumstances.\textsuperscript{36}

The fourth category where an advance directive does not apply is where it does not make a decision about the circumstances that have arisen. The classic example cited is the American decision of \textit{Werth v Taylor}\.\textsuperscript{37} This case involved a written refusal of blood transfusions two months prior to the hospital admission which was reaffirmed verbally on arrival. The Michigan Court of Appeals concluded that because the directive was given at a time when the woman’s life was not in danger, she was not regarded as having made a decision to refuse blood transfusions in circumstances where her life was actually at risk.\textsuperscript{38}

\textbf{C. Autonomy underpinning legal recognition of advance directives}

The law concerning a competent adult’s right to refuse life-sustaining medical treatment highlights two important but conflicting principles, both of which are recognised by the common law. The first is that of personal autonomy, which dictates that an individual’s right to self-determination demands that he or she is able to refuse treatment, even if this results in the person’s death. The conflicting principle, the sanctity of life, recognises the State’s interest in ensuring the well-being of its citizens.

The courts have considered how these conflicting principles should be resolved in the context of refusals of life-sustaining medical treatment, and have uniformly concluded that the principle of autonomy should prevail over the sanctity of life. A famous (and frequently cited) pronouncement on the resolution of this conflict (albeit in the context of an incompetent adult who had not given an advance directive) is by Lord Goff in the landmark decision of \textit{Airedale NHS Trust v Bland}\.\textsuperscript{39}

First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so … To this extent, the principle of the sanctity of human life must yield to the principle of self-determination … Moreover the same principle applies where the patient’s refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it …

Similar statements were made in the English Court of Appeal in \textit{Re T (Adult: Refusal of Treatment)}\textsuperscript{40}, a case in which a woman lost consciousness after purporting to give a contemporaneous refusal of blood transfusions. The woman’s condition deteriorated to the extent that she needed to receive a blood transfusion to save her life. Lord Donaldson MR commented on the conflict of principles in the following way:\textsuperscript{41}

The situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient’s interest consists of his right to self-determination – his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society’s interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount.

\textsuperscript{36} Ibid 105 (Lord Donaldson MR), 120 (Butler-Sloss LJ).
\textsuperscript{37} 475 NW 2d 426 (1991).
\textsuperscript{38} Ibid 430 (Neef PJ).
\textsuperscript{39} [1993] AC 789, 864. These comments were referred to in \textit{Re AK (Medical Treatment: Consent)} [2001] FLR 129, 133-134 (Hughes J) and \textit{HE v A Hospital NHS Trust} [2003] 2 FLR 408, 416 (Munby J).
\textsuperscript{40} [1993] Fam 95.
\textsuperscript{41} Ibid 112.
A consistent position was taken by Martin CJ in the recent decision of the Western Australian Supreme Court in *Brightwater Care Group (Inc) v Rossiter*. The case involved a quadriplegic man who wished to stop receiving artificial hydration and nutrition through a percutaneous endoscopic gastrostomy tube. In deciding that it would be lawful for the man’s residential care facility to act on his instructions, Martin CJ observed that the right of autonomy or self-determination was ‘well established at common law’. His Honour continued that the right ‘of every human being of adult years and sound mind … to determine what shall be done with his own body’ formed part of the right of autonomy.

This position has also been adopted in cases involving advance directives, both in the United Kingdom and, more recently, in Australia. In *W Healthcare NHS Trust v H*, the above comments of Lord Donaldson were endorsed and Brooke LJ explained why the ‘important principle of personal autonomy’ underpinned the right to refuse treatment in advance. Similarly in *HE v Hospital NHS Trust*, Munby J also endorsed Lord Donaldson’s comments and described advance directives as ‘the embodiment of the patient’s autonomy and his right of self-determination’.

In the recent case of *Hunter and New England Area Health Service v A*, the New South Wales Supreme Court was asked to determine whether a refusal of dialysis that was contained in a document completed a year earlier should be followed. At the time the matter was heard by the Court, dialysis was necessary to keep the individual alive. McDougall J considered the ‘relevant but in some cases conflicting interests’ of ‘a competent adult’s right of autonomy or self-determination’ and ‘the interest of the State in protecting and preserving the lives and health of its citizens’. After reviewing how these competing principles had been considered in the case law in England, the United States and Canada, his Honour concluded that the principle of autonomy should prevail over the principle of sanctity of life. Because the Court considered the document to constitute a valid refusal of treatment, it held that it should be followed.

These extracts reflect the very strong and clear judicial support for autonomy being the basis upon which the common law recognises advance directives.

---

43 Ibid [24].
44 Ibid, quoting Justice Cardozo in *Schloendorff v Society of New York Hospital* 211 NY 125 (1914), 129. The right of a competent adult to refuse nutrition was subsequently endorsed by the Supreme Court of the Australian Capital Territory in *Australian Capital Territory v JT* [2009] ACTSC 105, [25]-[26]. In this case, however, the Court held that the adult who was refusing nutrition lacked capacity to make that decision.
45 [2005] 1 WLR 834.
46 Ibid 838 (Brooke LJ), with whom Clarke and Maurice Kay LJJ agreed (842).
47 [2003] 2 FLR 408.
48 Ibid 416.
49 Ibid 418 (original emphasis). This position was also endorsed by the Court of Appeal in *R (Burke) v General Medical Council* [2006] QB 273, 296 (Lord Phillips MR, Waller and Wall LJ).
50 (2009) 74 NSWLR 88.
52 Ibid.
53 Ibid.
54 Ibid [17]. It is interesting to observe that McDougall J had some reservations in accepting that the two principles were necessarily in conflict. His Honour did not necessarily accept that society’s interest in the preservation of life could be taken into account without recognising that, in a liberal democracy, concepts of ‘life’ must incorporate the right of autonomy or self-determination: *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, [16].
III. ADVANCE DIRECTIVES AND AUTONOMY UNDER STATUTE

A. The Australian legislation

Advance directive legislation which has been enacted in six of the eight Australian jurisdictions has enshrined the common law right to refuse medical treatment. Depending on the nature of the particular statutory scheme, a person may refuse treatment by giving an ‘anticipatory direction’, or making an ‘advance health directive’, a ‘refusal of treatment certificate’, a ‘health direction’, or a ‘direction’. Such ‘advance directions’ will operate at a future time when the person lacks capacity and, depending on the circumstances of the case, may be effective to refuse medical treatment.

In all of these jurisdictions, the person completing the advance direction must have capacity and, in most jurisdictions, he or she must not have completed the advance direction as the result of some vitiating factor. Generally, an advance direction must be made in writing, frequently in a prescribed form, and must comply with formality requirements regarding signature and witnessing. An additional requirement exists in Victoria, and the person completing the refusal of treatment certificate must first have received information about his or her condition.

Many of the legislative regimes differ from the common law in another important respect. There are sometimes restrictions imposed on when an advance direction that refuses treatment can be given, or when the direction can operate. In Victoria, treatment can only be refused through a refusal of treatment certificate if it relates to a ‘current condition’.

---

55 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7.
56 Guardianship and Administration Act 1990 (WA) s 110P; Powers of Attorney Act 1998 (Qld) s 35.
57 Medical Treatment Act 1988 (Vic) s 5.
58 Medical Treatment (Health Directions) Act 2006 (ACT) s 7.
59 Natural Death Act 1989 (NT) s 4.
60 For the purpose of this section of the article, the term ‘advance direction’ will be used to refer to statutory directives under the various statutes, unless the context requires the use of an alternative term.
61 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(1); Guardianship and Administration Act 1990 (WA) s 110P; Medical Treatment Act 1988 (Vic) s 5(1)(d); Medical Treatment (Health Directions) Act 2006 (ACT) s 7(3); Natural Death Act 1989 (NT) s 4(1); Powers of Attorney Act 1998 (Qld) s 42.
62 Guardianship and Administration Act 1990 (WA) s 110R; Medical Treatment Act 1988 (Vic) s 5(1)(b); Medical Treatment (Health Directions) Act 2006 (ACT) s 20; Powers of Attorney Act 1998 (Qld) sch 3 para (b) of the definition of ‘capacity’.
63 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(2); Guardianship and Administration Act 1990 (WA) s 110Q(1)(a); Medical Treatment Act 1988 (Vic) s 5(2); Natural Death Act 1989 (NT) s 4(1); Powers of Attorney Act 1998 (Qld), s 44(2). Compare the legislation in the Australian Capital Territory which allows a direction to be either in writing or oral: Medical Treatment (Health Directions) Act 2006 (ACT) s 7(2).
64 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(2); Guardianship and Administration Act 1990 (WA) s 110Q(1)(a); Medical Treatment Act 1988 (Vic) s 5(2); Natural Death Act 1989 (NT) s 4(1). If the direction made pursuant to the legislation in the Australian Capital Territory is in writing, it must be in the prescribed form: Medical Treatment (Health Directions) Act 2006 (ACT) ss 7(2) and 8 (Approved Form 2007 No 55). In Queensland, although a form is prescribed for the purpose of the legislation, a person is not required to use the prescribed form: Powers of Attorney Act 1998 (Qld), s 44(2).
65 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(2) and Consent to Medical Treatment and Palliative Care Regulations 2004 (SA) sch 1; Guardianship and Administration Act 1990 (WA) s 110Q(1)(c); Medical Treatment Act 1988 (Vic) s 5(2) and sch 1; Medical Treatment (Health Directions) Act 2006 (ACT) s 8(a); Natural Death Act 1989 (NT) and Natural Death Regulations 1989 (NT) sch. Powers of Attorney Act 1998 (Qld) s 44(3)(a).
66 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(1)(2)(b) and Consent to Medical Treatment and Palliative Care Regulations 2004 (SA) sch 1; Guardianship and Administration Act 1990 (WA) s 110Q(1)(d) and (e); Medical Treatment Act 1988 (Vic) s 5(1); Medical Treatment (Health Directions) Act 2006 (ACT) s 8(e); Natural Death Act 1989 (NT) s 4(2); Powers of Attorney Act 1998 (Qld) s 44(3), (4) and (6).
67 Medical Treatment Act 1988 (Vic) s 5(1)(b).
68 Medical Treatment Act 1988 (Vic) s 5(1).
be suffering from a medical condition before he or she can complete the certificate. Further, in South Australia, the Northern Territory and Queensland, the advance direction that refuses treatment can only operate if the person is sufficiently ill. In the Northern Territory, a direction can only operate if the person is suffering from a terminal illness,69 while in South Australia, the person must be in the terminal phase of a terminal illness or in a persistent vegetative state.70 The restrictions in Queensland are even more extensive and an advance health directive will only operate if the person has a terminal illness and the person is expected to die within a year, is in a persistent vegetative state, is permanently unconscious, or has an illness or injury of such severity that there is no reasonable prospect that he or she will recover to the extent that life-sustaining measures will not be needed.71

As at common law, a statutory advance direction must be applicable to the situation that has arisen. It will therefore not operate if the person has later evinced an intention not to be bound by it. The statutes recognise a number of situations in which this can occur: when the person intends to revoke the directive but has not yet done so, or has changed his or her mind about the direction;72 the circumstances have changed since the directive was made;73 or the advance health directive is uncertain.74

One final observation should be made about a provision in the Queensland legislation which is somewhat unique in the Australian legislative framework. A health professional is excused from following an advance health directive if he or she has reasonable grounds to believe that a directive is inconsistent with good medical practice.75

B. Autonomy underpinning statutory recognition of advance directives

As is the case with the common law, it is argued that the statutory recognition of advance directions in the Australian statutes is underpinned by an acceptance of the principle of autonomy. Although it has been observed that some legislative provisions accord autonomy less weight,76 the statutes

69 Natural Death Act 1988 (NT), s 4(1).
70 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(1)(a).
71 Powers of Attorney Act 1998 (Qld), s 36(2)(a). In addition to this requirement about the person’s health, the advance health directive cannot operate unless the person has no reasonable prospect of regaining the capacity needed to make decisions about his or her health (s 36(2)(c)). Further, if the treatment being refused is artificial nutrition and hydration, the commencement or continuation of that treatment must, in the circumstances, be contrary to good medical practice (s 36(2)(b)).
72 Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7(3); Guardianship and Administration Act 1990 (WA) s 110S(6); Medical Treatment Act 1988 (Vic) s 7(1); Medical Treatment (Health Directions) Act 2006 (ACT) ss 10(1) and 12; Natural Death Act 1989 (NT) s 4(3)(a).
73 As described above, in South Australia, the Northern Territory, Queensland and Victoria, the advance direction will only apply if the person has a condition or illness as set out in the various statutes. If the person no longer suffers from the condition or illness, therefore, the advance direction will not apply. In addition, in Western Australia and Queensland, the legislation specifically provides for the advance health directive not to apply if circumstances have changed, and this would have caused a reasonable person to have changed his or her mind (Western Australia: Guardianship and Administration Act 1990 (WA) s 110S(3)), or would have caused a medical professional to believe that the terms of the directive are inappropriate (Queensland: Powers of Attorney Act 1998 (Qld) s 103).
74 Powers of Attorney Act 1998 (Qld) s 103. For a consideration of the situation in the other statutory jurisdictions if the advance direction is ambiguous or uncertain, see Willmott, White and Howard, n 17 at 233.
75 Powers of Attorney Act 1998 (Qld) s 103. The term ‘good medical practice’ is defined by having regard to the recognised medical standards, practices and procedures of the medical profession in Australia, and the recognised ethical standards of the medical profession in Australia: Powers of Attorney Act 1998 (Qld), sch 2 s 5B.
broadly purport to give effect to the common law. For example, when the *Medical Treatment and Palliative Care Bill 1995* (SA) was introduced into Parliament, the Hon SJ Baker commented that the legislation “confirms the common law right to refuse treatment”. Similar comments were made in other jurisdictions when introducing the Bills into Parliament. If the primacy of autonomy is recognised in the common law, then the enactment into statute of those common law principles also accepts, at least implicitly, the appropriateness of autonomy as underpinning advance decisions.

**IV. AUTONOMY JUSTIFIES LEGAL RECOGNITION OF ADVANCE DIRECTIVES**

Having established that autonomy is the basis upon which advance directives are recognised as a matter of law, this section of the article makes some observations about why this reliance on autonomy is appropriate from a theoretical perspective. We explore three arguments in support of this position: the necessity of autonomy in a liberal democracy, the primacy of autonomy in medical ethics, and the role of autonomy in contemporaneous refusals of medical treatment.

**A. The necessity of autonomy in a liberal democracy**

*Liberal democracies, liberty and autonomy*

While it is impossible to define and has many manifestations, ‘liberal’ thought is the most influential ideology underpinning law and social policy in modern Western liberal democracies. The central motivation of liberal thought is the idea of individual liberty: that the individual should be free to formulate and pursue their own ends, and that in this pursuit the individual should be free from unjustified interference by the State and others. Liberal thought therefore places the individual at the centre of society, prioritising individual liberty and rights wherever possible. In 1859, John Stuart Mill captured the core element of liberty in liberal thought, and both the rightful and unwarranted exercise of State or other power in interfering with individual liberty. Mill declared that:

> the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection…the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others.

Mill’s statement then continued to articulate the idea of autonomy, a closely related and equally necessary element in liberal thought. ‘In the part [of a person’s conduct] which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.’ This injunction encapsulates the idea of autonomy: the right of self-government. As with liberty, the preference given to autonomy does not mean that it is treated as an absolute value that can never be overridden, but it does mean that where possible it will be preferred. Some public health measures, such as the mandatory screening of individuals where there are concerns involving infectious disease, exemplify a situation where an overriding public good outweighs an individual’s autonomy.

These notions of liberty and autonomy are closely related, and are also connected to the concept of individual rights. Conceptualised simply, rights can be viewed as rights to some things that are

---

78 For a review of relevant parliamentary debates in the statutory jurisdictions, see Willmott, ‘Advance Directives and the Promotion of Autonomy: a Comparative Australian Statutory Analysis’, n 76 at 559-561.
80 Ibid 69.
deemed desirable in the liberal worldview (what may be called positive liberty), and rights against some things seen as undesirable (negative liberty).\textsuperscript{82} Positive liberty includes the rights to life, liberty and security of the person, the right to equality, the right of participation in society, and the rights to freedom of speech, movement, thought, conscience and assembly. Positive liberty can be discerned as being a condition for a person’s autonomy, or self-rule. As Berlin conceived it, positive liberty is the ‘wish to be an instrument of my own, not other men’s acts of will…deciding, not being decided for, self-directed and not acted upon [by others as though incapable] of conceiving goals and policies of my own and realizing them.’\textsuperscript{83} Alongside these positive rights, there are negative rights, which include the rights to be free from arbitrary arrest, torture, and discrimination. Whereas positive liberty closely equates with autonomy, negative liberty can be seen as an even closer embodiment of liberty in the sense of freedom from external interference.

There is no doubt that liberty and ‘autonomy’ are very similar concepts, and that a breach of a person’s liberty will often and even usually also involve an infringement of their autonomy. However, as Gerald Dworkin has pointed out, the two concepts are distinct. The clearest example of this is that a person may wish to be restricted in some way, for example by joining a monastic order,\textsuperscript{84} or by donating a body part, or, in the case of an apotemnophiliac, having a healthy limb amputated.\textsuperscript{85} Such a wish, if granted, would result in a practical restriction of liberty in the sense of a limitation on the ability to move, function or act in a certain way. But, fulfilment of this wish would not restrict the person’s autonomy (self-rule); rather, it would respect and secure it. For Dworkin, autonomy is therefore ‘a richer notion than liberty’,\textsuperscript{86} being an essential part of personhood because it is concerned with the individual’s ‘construction of meaning in his life’.\textsuperscript{87} One can possess autonomy and choose for one’s liberty to be restricted or curtailed; but one cannot lack autonomy and possess liberty.

\textit{Autonomy, rights to autonomy, and legal instruments}

In Sections II and III, we saw that the law has evolved to place the concept of autonomy as the privileged value in how law regulates a person’s ability to refuse medical treatment. In light of the development of liberal democracy over several centuries, the preference afforded to autonomy can be seen as an entirely logical and coherent approach. It would be at odds with the dominant societal ideology if, in the legal and social context of medical treatment, autonomy had been supplanted by a competing value which did not advance the goals of liberal society.

Given the centrality of the rich notion of autonomy in liberal democracy, it is not surprising that Western liberal democracies have not only embedded autonomy within the common law and statute, but have also positioned it as a driving force within legal instruments containing their most aspirational socio-legal objectives. The concept of human rights is a core feature of liberal democracy, and a range of human rights are the impetus behind legislation and other human rights instruments at provincial, national and international levels. For some decades now, Western liberal democracies have manifested the concern to promote and protect the ideals of liberty and autonomy by enshrining rights in legislation; in this context, rights are used as tools to secure autonomy. Examples of the legislative protection of autonomy in the context of refusal of medical treatment

\textsuperscript{82} See further Isaiah Berlin’s exploration of ‘positive liberty’ and ‘negative liberty’: \textit{Four essays on Liberty} (Oxford: Oxford University Press, 1969) 165.
\textsuperscript{83} Ibid 131. This is also discussed in Gerald Dworkin, \textit{The Theory and Practice of Autonomy} (Cambridge: Cambridge University Press, 1988) 13.
\textsuperscript{84} Gerald Dworkin, n 83 at 18.
\textsuperscript{85} We take this example from I Kerridge, M Lowe and C Stewart, \textit{Ethics and law for the health professions}, 3\textsuperscript{rd} ed (Sydney: The Federation Press, 2009) 84.
\textsuperscript{86} Gerald Dworkin, n 83 at 107.
\textsuperscript{87} Gerald Dworkin, n 83 at 110.
can be found in the United Kingdom, the USA, New Zealand, and Australia, and in international human rights instruments. In some cases, this is framed explicitly as a right to refuse medical treatment, which implicitly promotes autonomy; in others, autonomy is a consequence of the recognition of a right to personal security or privacy.

In the United Kingdom, the principal human rights instrument is the European Convention on Human Rights. The relevant provision is Article 8, which provides for a right to respect for ‘private and family life’. It has been held that ‘personal autonomy is an important principle underlying the interpretation’ of Article 8. Although subject to qualification, the expression of autonomy embedded in this right includes not only how a person lives his or her life, but also the way in which a person spends his or her final moments before death. The role of Article 8 in the context of refusals of medical treatment was commented on by the European Court of Human Rights in *Pretty v United Kingdom*:

> In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention. As recognised in domestic case-law, a person may claim to exercise a choice to die by declining to consent to treatment which might have the effect of prolonging his life …

In the USA, the Supreme Court has recognised that the right to refuse life-sustaining medical treatment is an aspect of the liberty interest protected by the Fourteenth Amendment to the Constitution. The Fourteenth Amendment provides for citizenship rights, including the right that ‘nor shall any State deprive any person of life, liberty, or property, without due process of law’. Under this due process clause, a competent person has a liberty-based interest in refusing unwanted medical treatment, and a constitutionally protected right to refuse lifesaving hydration and nutrition. In addition, at state level, courts have typically identified a right to refuse treatment derived from the common law right to informed consent, or on a combination of this right to refuse treatment and a constitutional right to privacy.

New Zealand and two Australian States provide for autonomy in their human rights legislation through the explicit recognition of a right to refuse medical treatment. In New Zealand, section 11 of the *New Zealand Bill of Rights Act 1990* (NZ) includes as a civil right the right to refuse medical

---


90 *European Convention on Human Rights*, art 8(2).

91 *R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department Intervening)*, [2002] 1 AC 800, 846 (Lord Hope of Craighead) which is referred to with approval in *Pretty v United Kingdom*, (2002) 35 EHRR 1, 36-37 and *R (on the application of Purdy) v Director of Public Prosecutions*, [2009] 3 WLR 403, 416-417 (Lord Hope of Craighead). See also *R (on the application of Purdy) v Director of Public Prosecutions*, [2009] 3 WLR 403, 424 (Baroness Hale of Richmond), 427 (Lord Brown of Eaton-Under-Heywood).

92 (2002) 35 EHRR 1, 36. See also *R (on the application of Purdy) v Director of Public Prosecutions*, [2009] 3 WLR 403, 424 (Baroness Hale of Richmond). Note, however, that both decisions arose in the context of assisted suicide rather than refusals of medical treatment.


94 The United States Supreme Court has also found that the equal protection clause of the Federal Constitution’s Fourteenth Amendment, which requires that no State shall deny to any person the equal protection of the laws, was not infringed by New York state laws which outlawed assisted suicide but which permitted patients to refuse medical treatment: *Vacco (Attorney-General of New York) v Quill*, 521 US 793 (1997).

95 *In re Storar*, 52 NY 2d 363.

96 *Superintendent of Belchertown State School v Sakewicz*, 373 Mass 728.
treatment. This is not an absolute right, but section 5 states that any legal limit on this right will be permissible only if it can be ‘demonstrably justified in a free and democratic society’.

In the Australian State of Victoria, section 10(c) of the Charter of Human Rights and Responsibilities 2006 (Vic) protects people from the imposition of medical treatment without ‘full, free and informed consent’. Similarly, in the Australian Capital Territory, section 10(2) of the Human Rights Act 2004 (ACT) protects people from the imposition of medical treatment without ‘free consent’. The Victorian provision has been judicially commented on as providing ‘protection of personal autonomy and integrity of the highest order [which addresses] the subject better than the comparable provisions internationally’.

There are also a number of international instruments that promote autonomy in this area. The most recent instrument to promote autonomy explicitly in the context of medical treatment is the Universal Declaration on Bioethics and Human Rights. Article 5 states that the autonomy of persons to make decisions is to be respected, and article 6 provides that any medical intervention is only to be performed with prior free and informed consent. Earlier international instruments also recognised autonomy, or rights to personal security, including the International Covenant on Civil and Political Rights 1966 (for example, articles 7 and 9) and the Universal Declaration of Human Rights 1948 (for example, article 3). More recently, in Europe, article 5 of the Council of Europe’s Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine requires free and informed consent to medical procedures. More specifically, relevant to the context of advance directives, article 9 provides that ‘previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account’.

**Autonomy as a sound underpinning value for the law on advance directives**

Within Western liberal societies then, there is a broad base of support for autonomy as the appropriate normative framework for the context of administration of medical treatment, including refusal of life-sustaining treatment and advance directives. This alone informs a strong argument that it is appropriate that the notion of autonomy motivates the law about advance directives. It is not the purpose of this article to explore every possible alternative organising principle, or even to engage in an extended defence of autonomy against its critics, but we do seek to make some brief observations about the question of whether autonomy appears in general to be a normatively justifiable framework. In doing so, we examine the appropriateness of autonomy in this context from a theoretical perspective and, having regard to the fact that the law must generally be consistent and coherent, from a broader legal perspective. We conclude that recognising autonomy as the normative framework motivating the law on advance directives produces a conclusion that it is, at the very least, a coherent and sound approach in these respects.

---

97 See also Firmin v Attorney-General, [2007] NZHC 50.
101 Universal Declaration of Human Rights (10 December 1948).
**Theory**

Theoretically, the notion of positive liberty, which as we have seen is a condition for securing autonomy, and particularly the right to security of the person, is at the core of the context of refusal of medical treatment. Imposition of medical treatment against a person’s wishes not only interferes with the person’s liberty, but infringes on their autonomy.\(^{103}\) Such intrusion is a direct infringement on the individual’s security of the person, hence infringing their positive liberty and their autonomy.

Within the framework of a modern liberal democracy, which seeks to protect and promote the individual’s freedom from personal violation and the right to choose how his or her body is treated, it is difficult to divine how any framework other than autonomy could be appropriate in this area of law, both in logic and philosophical preference. In the medical context in general, the requirement that a patient provide informed consent to treatment, which is necessary to avoid an interference with liberty, is a classical embodiment of liberalism’s concern to protect and promote the individual’s rights and to counter unwarranted paternalism by either State or individual. The most prominent competing preference, of sanctity of life, is incompatible with a framework which elevates as the supreme value the individual’s positive liberty to personal security and autonomy. Preferring autonomy is logically and philosophically consistent, whereas to prefer sanctity of life would be illogical and inconsistent.

For Gerald Dworkin, autonomy is particularly essential in the context of decisions about health care because one’s goals are unavoidably connected to one’s body. Decisions about medical treatment are not technical decisions for experts, but rather are inherently concerned with an autonomous patient because the patient’s body is irreplaceable, inescapable, and is the patient. These qualities lead Dworkin to the conclusion that ‘failure to respect my wishes concerning my body is a particularly insulting denial of autonomy’.\(^{104}\) Dworkin accepts that because the body is so important, then if paternalistic provision of treatment against one’s wishes will produce beneficial results, then that would seem to strengthen its claim to override a contrary autonomous refusal. However, he argues that the only exceptions to complying with patients’ autonomous decisions are in cases of emergency, decisions made by incompetent patients, patient waiver and therapeutic privilege; none of which apply to the case of advance directives.\(^{105}\)

Suppose a person who had made an advance directive in a situation where her family, relatives and friends, and even relevant cultural groups such as church or ethnic communities of which she was closely involved, were unhappy with her decision. On Mill’s conception, one who has made an advance directive would be entitled to do so, and no individual or collective, including the State, possesses a justified power in invalidating it. While the ‘harm’ concept is slippery, it would not be so broad as to embrace feelings of sadness or loss that the woman’s family or friends may experience. The act would properly be seen as self-regarding, and hence within the woman’s private sphere of liberty and a matter for her autonomous decision; it is not a violation in any sense of ‘a distinct and assignable obligation to any other person’ sufficient to take it outside the class of self-regarding acts.\(^{106}\) Acts can still be self-regarding even if they cause ‘pain or loss to others’.\(^{107}\) Thus, there is no argument to prevent her decision based on it causing harm to others. For Mill, her family, friends and others are perfectly entitled to try and persuade her to take a different course of action;\(^{108}\) but no sufficient evil is being done to justify another actor compelling her to do otherwise.

---

\(^{103}\) See Gerald Dworkin, n 83 at 14.

\(^{104}\) Ibid 113.

\(^{105}\) Ibid 115-120.

\(^{106}\) Mill, n 79 at 148.

\(^{107}\) Ibid 163.

\(^{108}\) Ibid 68.
Law
The emphasis on the right to security of the person and hence autonomy is also consistent with the broader legal framework, demonstrating that these principles are consistent with the general law, and are not outliers with unsound conceptual foundations. Beyond the context of medical treatment, one of the most fundamental rights long recognised by the common law is the individual’s broad right to be free from interference with one’s body: this is the principle of personal inviolability.\(^\text{109}\) The common law is broadly informed by, and places great weight on, the principle of autonomy.\(^\text{110}\) This can be seen particularly clearly in the law of tort, which gives causes of action in assault, battery and negligence for positive infringements of bodily integrity.\(^\text{111}\)

A subspecies of this protection in the general law is the right to refuse medical treatment. This right is so robust that an expectant mother is entitled to refuse treatment when to do so jeopardises the life of the foetus; hence, despite a crude utilitarian calculus demonstrating the likely gain, the preservation of the life of an unborn child cannot be preferred to infringing the woman’s autonomy.\(^\text{112}\) In our context, a further extension of that application is found in the right to give in advance a direction that certain medical treatment not be administered to one’s body.

Opposing views
This is not to say that the liberal worldview is the only one, or that different organising principles would not promote different values as being appropriate to guide the law in this area. Beyond the framework of liberal thought, other conceptions of the good might produce a different result. In a society where neither law nor social policy is predicated on notions of individual liberty and autonomy, the preference given in theory and law to other values may lead to different outcomes. A hunger strike may be ended by force-feeding; life-saving treatment may be provided in a case where a patient is refusing only out of what others perceive to be ‘irrational fear’. Such measures may be justified under a society which has as its dominant philosophy, manifested in its law, a preference at least in some cases, to preserve life rather than adhere to the individual’s stated wishes.\(^\text{113}\) However, in societies privileging liberalism and notions of liberty and autonomy, then autonomy does seem to be the appropriate normative framework in the context of advance directives.

B. Autonomy in medical ethics

Primacy of autonomy in medical ethics generally
We argue that it is appropriate for autonomy to underpin legal recognition of advance directives because within the broader medical ethics discourse, autonomy is generally regarded as the dominant ethical principle.\(^\text{114}\) The increased emphasis on autonomy has evolved in recent decades


\(^{110}\) For a very recent discussion of the influence of autonomy in developing the common law, see Stuart v Kirkland-Veenstra, (2009) 237 CLR 215, 248-251 (Gummow, Hayne and Heydon JJ).


\(^{112}\) St George’s Healthcare NHS Trust v S, [1999] Fam 26; and see discussion in B v Responsible Medical Officer, Broadmoor Hospital, [2005] EWHC 1936 (Admin), [34]-[37].

\(^{113}\) Examples from Israel and India are provided in S Glick, “Unlimited Human Autonomy — A Cultural Bias?” (1997) 336;13 New England Journal of Medicine 954-956.

and this is likely to have occurred in response to the medical paternalism which had earlier characterised the doctor/patient relationship. Whereas in the past, doctors tended to advise patients about which treatment option should be selected, the more recent trend has been for patients to exercise greater self-determination as to treatment choices.115

In addition to the principle of autonomy being important in its own right, it is also a central component of the ‘four-principles’ approach to medical ethics developed by Beauchamp and Childress.116 Under this approach, there are four principles that should guide conduct: autonomy, non-maleficence (doing no harm), beneficence (act of doing good), and justice (people should be treated fairly).117 In the abstract, no principle is regarded as being more important than the others. On a given set of facts, though, the ‘right’ outcome may be achieved by one principle overriding the others, or alternatively by balancing the different principles. For example, where a competent adult seeks medical advice, he or she is not required to accept the treatment that is recommended by the doctor. From an ethical perspective, there is consensus that autonomy (the patient’s choice to refuse treatment) prevails over beneficence (the doctor’s recommendation that medical treatment is required to improve the patient’s health).118

It is acknowledged, however, that there are many who are critical of the primacy that autonomy has assumed in modern times. For example, English and others argue that the dominance of autonomy is not helpful in resolving complex and controversial issues in emerging areas such as genetic testing and sharing of information that may arise from such testing, where issues about the health of others may be in direct conflict with an individual’s right to privacy.119 Further, even supporters of the principle of autonomy or the four-principles approach recognise its limitations. Childress notes that the principle of autonomy will not always prevail.120 An example given is mandatory screening to manage the spread of infectious diseases. In such cases, an individual’s right to refuse treatment (the principle of autonomy) may need to be overridden for the communal good.121 When considering the balancing of principles, Kerridge and others also postulate whether justice will, or should, overtake autonomy as the predominant principle in the 21st Century. They point to increasing concerns about health care being provided to the rich at the expense of the less affluent, and the increasing disparity between health care provided to those in poor and rich countries.122

116 Beauchamp and Childress, n 4. This approach is an example of ‘principle-based’ ethics, a method of analysis which sets out a number of important principles that should guide decision-making. This approach does not necessarily dictate the ‘right’ outcome in a particular situation, but sets out a framework in which a decision can be made.
117 For a discussion of these four principles, see Kerridge et al, n 85, chap 5.
118 See, for example, Devereux, n 114 at 8. For a more detailed examination of the principles of autonomy and beneficence and their interrelationship, see A Maclean, Autonomy, Informed Consent and Medical Law (Cambridge: Cambridge University Press, 2009). Maclean comments that ‘the healthcare professional’s duty of beneficence incorporates an obligation to avoid or to prevent an infringement of the patient’s autonomy’: 49. See also Sade, n 115; Mason, McCall Smith and Laurie, n 114 at 6-10.
119 English et al, n 114.
120 Childress, n 4.
121 Ibid.
122 Kerridge et al, n 85 at 80 referring to an editorial by R Gillon in “After 20 Years, Some Reflections and Farewell” (2001) 27 Journal of Medical Ethics 75.
Primacy of autonomy in medical ethics about advance directives

Autonomy is also the dominant principle in medical ethics discourse on advance directives. If a competent adult’s advance directive refuses treatment (including life-sustaining treatment), then the principle of autonomy would support the notion that this refusal should be respected. However, the principle of beneficence could also be relevant to the extent that a doctor may consider it to be in the person’s medical best interest to receive that treatment. Where such conflict of principles exists, there is broad ethical consensus that the individual’s right of self-determination flowing from the principle of autonomy should prevail over the more indirect interest of the doctor in providing his or her perception of appropriate treatment.123

While this is the prevailing view of how these ethical principles should be applied, there is not universal acceptance of this position. Dresser, for example, protests the dominance of autonomy on the basis that, in some contexts of refusing life-sustaining treatment, it can lead to patient harm and, therefore, conflicts with the principles of beneficence and non-maleficence.124 She argues that in cases where a directive forbids treatment that would relieve a person’s pain or discomfort, or would allow the person to continue an apparently valuable life, it should not be followed. Dresser prioritises other principles over autonomy in these cases.125

Writing in the context of end-of-life care generally, Burt suggests that while autonomy remains important, the principles guiding end-of-life care should shift away from autonomy as the central feature.126 He argues that the autonomy framework “does not fit the facts” in this context.127 Burt’s hypothesis is that individuals do not want to confront and plan for the reality of their own death and, therefore, we should turn to an alternative framework for deciding treatment.128

Despite these (and the earlier) objections raised by commentators, the prevailing view remains that autonomy is the dominant principle in medical ethics generally and in relation to advance directives. It is acknowledged that the principle of autonomy is not absolute and, in some health care contexts, other principles may need to prevail. Nevertheless, autonomy remains central to any consideration of the medical ethics involved in an advance directive made by a competent person refusing treatment. Accordingly, we argue that the law’s reliance on autonomy in grounding its recognition of advance directives is appropriate.

---

123 See n 114.
125 Dresser’s view that autonomy plays too great a role in the context of advance directives is shared by other commentators. See, for example, C Jordens, M Little, I Kerridge, J McPhee, “From Advance Directives to Advance Care Planning: Current Legal Status, Ethical Rationales and a New Research Agenda” (2005) 35(9) Internal Medicine Journal 563 where the authors suggest that there are other ethical considerations that are relevant when providing treatment to an individual who has completed an advance directive; K Schaefer, U Eibach, D Roy, “The Advance Directive: An Expression of Autonomy, But Also of Care” (2002) 18 Ethics and Medicine 15 where the authors describe empirical research which they interpret as suggesting that it is the care of the patient rather then the patient’s autonomy that was (and needed to be) the centre of ethical considerations in end-of-life treatment. See also S Ikonomidis and PA Singer, “Autonomy, Liberalism and Advance Care Planning” (1999) 25 Journal of Medical Ethics 522 who justify autonomy (largely) as an appropriate theory to underpin advance care planning.
127 Ibid.
128 For other criticisms of autonomy as a framework for medical decision-making either generally or in the end-of-life context, see also the following: G Winzelberg, L Hanson and J Tulsky, n 5; JS Taylor, “Autonomy and Informed Consent: a Much Misunderstood Relationship” (2004) 38 Journal of Value Inquiry 383 where the author argues that patient well-being rather than patient autonomy is the pre-eminent value of medical treatment; L Emanuel and Ezekiel Emanuel, “Decisions at the End of Life: Guided by Communities of Patients” (1993) 23(5) The Hastings Center Report 6 where they argue that the preferences of the relevant ‘community of patients’ should be used as a guideline to end-of-life care.
C. Autonomy in contemporaneous refusals of treatment

The final argument in support of autonomy as the appropriate source for legal recognition of advance directives is that autonomy is the basis upon which the law regards contemporaneous refusals of treatment as binding. The law is very clear in its acceptance that a competent adult is entitled to refuse medical treatment, even if it is clearly in the person’s medical best interest, and even if it is needed to keep the person alive. The basis for this right is the principle of autonomy. As was discussed above, this principle trumps the sanctity of life in circumstances where a competent person refuses treatment.129 This is well illustrated in the decision of Re B (Adult: Refusal of Medical Treatment),130 which involved a refusal of treatment by B, a tetraplegic who was being kept alive by a ventilator. In this case, B’s request to have the ventilator removed was not followed by medical staff over a period of time. Butler-Sloss P noted the conflict between the principles of autonomy and the sanctity of life and concluded that “the right of the competent patient to request cessation of treatment must prevail over the natural desire of the medical and nursing profession to try to keep her alive”.131 A declaration was made that the continued treatment of B was unlawful.

The law governing the contemporaneous refusal of treatment described in the previous paragraph was recently endorsed as representing the common law in Australia. The facts of Brightwater Care Group (Inc) v Rossiter,132 a case involving the request of Mr Rossiter, a quadriplegic, to have his percutaneous endoscopic gastrostomy tube removed, were rehearsed earlier. Declaratory relief was sought both by Mr Rossiter and his residential care facility about their respective entitlements and legal obligations. The Western Australian Supreme Court held that Mr Rossiter was competent to make a decision about receiving artificial nutrition. Accordingly, he had the right to refuse such treatment, although that would result in his death.133 This position was endorsed soon afterwards in a case involving an individual who had decided to fast. In Australian Capital Territory v JT,134 the Supreme Court opined that a competent adult was entitled to refuse nutrition even if that resulted in his death.135 On the facts of the case, however, Higgins CJ held that the individual lacked capacity to make this decision.

In a liberal democracy, the legal position just described is the only sustainable one to adopt. A competent adult cannot be required to receive medical treatment against his or her will because, for example, that treatment is indicated by an objectively determined assessment of medical best interests. We are unaware of any commentator who advances this as a defensible position.

If the current law in relation to contemporaneous refusals is accepted, there is no principled basis for different law to apply simply because the refusal of treatment occurs in advance. The application of the principle of autonomy remains the same – a competent adult must be able to

---

129 See Section II(C). In particular, see the quote extracted from Lord Donaldson MR in Re T (Adult: Refusal of Treatment), [1993] Fam 95, 102 as this case involved a purported contemporaneous refusal by an adult before losing consciousness.

130 [2002] 2 All ER 449.

131 Ibid 457.


133 Note, however, that the declaration of the Court was that the artificial nutrition and hydration could lawfully cease only if Mr Rossiter requested this to occur after receiving advice from a medical practitioner about the consequences of having the tube removed. It is suggested, however, that the right to refuse treatment should not depend on the provision of information for the reasons discussed above: see Section II(A). It is argued that the Court fell into error by converting the duty of the residential care facility to provide information to Mr Rossiter into a condition that he receive that information before he was able to refuse treatment: B White and L Willmott, “Contemporaneous Refusals of Life-Sustaining Treatment Lawful” (2009) 29 The Queensland Lawyer 290.


135 Ibid [25]-[26].
refuse treatment they do not wish to receive. The only difference is one of timing. We do concede that there are practical consequences of an advance directive that do not arise when treatment is refused contemporaneously, and that these issues must inform the development and design of the law. However, as a matter of principle, these concerns do not justify departing from an established legal position when the refusal is question is made in advance.

V. RESPONDING TO CRITIQUES OF AUTONOMY AND ADVANCE DIRECTIVES

A. Global objections to the appropriateness of autonomy

In the previous section, we have argued why it is appropriate for the law to ground its recognition of advance directives in autonomy. This is not, however, a universally accepted position. Some argue, from philosophical or other perspectives, that the principle of autonomy does not justify recognising advance directives. We begin by considering some of the global objections to the appropriateness of autonomy in this context and respond to those objections. Two main themes can be drawn from the literature: advance directives lack of moral authority, and frameworks other than autonomy better meet the needs of incompetent adults.

Lack of moral authority of an advance directive made by a competent adult

Individuals who suffer from some kinds of degenerative disease or illness, such as dementia, will undergo changes in their personal characteristics, often to a significant degree. For example, a woman who previously worked as a heath professional in a large teaching hospital with no desire for, or interest in, leisure activities may subsequently receive enjoyment out of simple things such as strolling in the garden. The illness may have, in effect, transformed her very essence.

The notion that an individual’s identity can change over time is consistent with Parfit’s reductionist view of identity. When considering identity, Parfit uses the concepts of psychological continuity and connectedness. If continuity or connectedness does not exist between a person at time 1 and the same person at time 2, the person may be regarded as a different entity. Some commentators apply Parfit’s concept of identity to advance directives, and claim that there is an insufficient connection between the competent and incompetent adult to regard the previous directions given when competent as morally binding on the incompetent adult.

Take the above example of the health professional. Assume she made a decision that she did not want to receive life-sustaining treatment once her decision-making capacity was lost because, as a competent adult, working as a health professional was of the greatest significance to her. She did not want to continue to live if the only activities in which she could engage were simple leisure activities such as walking in the garden. But as a dementia-affected individual, she receives much pleasure from these kinds of activities and, in her present state, would certainly wish to receive treatment if it was needed to stay alive so that she could continue to enjoy them.

This view posits that as the dementia affected-person is so different from the competent person, the latter lacks the moral authority to decide on treatment that the dementia-affected person should receive or not receive. It is argued that one person should not be able to decide treatment for another when they have different interests, priorities and life goals.

Our response

It is acknowledged that an individual who has been suffering from dementia for an extended period of time can be a very different person from who he or she was before the illness took effect. The damage to the brain can affect that person’s nature and behaviour. That individual may receive pleasure in activities that were of no interest when he or she had competence.

However, this is not a justification for not following the directions that have been previously expressed by the competent adult. An important factor overlooked in this debate is that the dementia-affected person lacks decision-making ability. The implications of this are, and should be, significant. As that person lacks competence to make decisions, we, as a society, have mechanisms in place so that a decision can be made in some other way. This means, for example, that if an incompetent adult has been suffering from pneumonia but insists on taking his or her usual hour walk in the garden on a cold winter’s night, it is unlikely that he or she would be permitted to do so. The fact that the person believes that he or she will enjoy this activity (and, at some level, may enjoy it) does not mean that this view will prevail. Instead, another decision will be made for him or her.

The same logic must apply to medical treatment. The view of the person with dementia will not, and should not, necessarily prevail. We are of the view that if the individual made a decision refusing treatment while competent, that choice should be respected. In this regard, we are persuaded by Ronald Dworkin’s analysis of the famous and challenging situation of Margo, a woman with Alzheimer’s disease. Her illness was such that when reading a book, she appeared to select where she read at random and without regard to what parts of the book she has previously read. Likewise, she listened to the same piece of music repeatedly and painted the same picture each day, apparently unaware of this repetition. Margo was, however, very happy. She appeared to derive a great deal of joy from these activities and was untroubled by her mental state.

Ronald Dworkin presents the challenge of how Margo should be treated if she had executed a document refusing all medical treatment should she develop Alzheimer’s disease. His analysis leads to a conclusion that honours Margo’s pre-dementia advance directive, by three planks: the integrity view of autonomy (as the more powerful aspect of autonomy than the evidentiary view of autonomy); a perception of life as a single unified narrative; and the elevation of critical interests as having higher moral value — that is, the aims and hopes which provide authentic meaning to the individual’s life, including the person’s desire about how his or her life is to end — over simpler experiential interests such as Margo’s enjoyment of sensate pleasures like music, art and reading. Even in the challenging situation of Margo, Dworkin’s analysis and reliance on the integrity view of autonomy appears to leave autonomy intact as a justifiable normative framework.

It may be important to an individual that his or her life not be extended if, for example, that person has lost his or her ability for high-level thinking and interaction. For that person, the fact that he or

---

138 Margo’s case was described by a medical student in AD Firlik, “Margo’s Logo” (1991) 265 Journal of American Medical Association 201.
140 Dworkin’s notions of the ‘integrity view of autonomy’ and the ‘evidentiary view of autonomy’ are explored by Dresser, n 137. As explained by Dresser, the integrity view of autonomy requires us to allow people to live their lives in the way that they choose, even if that conflicts with their best interests. The evidentiary view of autonomy, on the other hand, is a reference to the choices that a person makes as being the best evidence of decisions that would protect their welfare: n 137 at 33.
141 Ronald Dworkin, n 139, chap 8.
142 For further discussion of some of Ronald Dworkin’s critics and possible responses, see J Herring, “Entering the Fog: On the Borderlines of Mental Capacity” (2008) 83 Indiana Law Journal 1619, 1638-1641.
she comes to enjoy leisurely pursuits and does not seem concerned about the lack of intellectual activities is irrelevant. In this context, it is difficult to sustain that a competent person, having been diagnosed with dementia and fully researched the disease including its potential effect on him or her, lacks the moral authority to make future treatment choices. It is of fundamental importance for some people to plan for a time when they can no longer make decisions. The planning may extend to such things as appointing someone to look after their finances, seeking a place to be cared for as well as the medical treatment they may want or not want. Of all of these matters, arguably medical treatment they do not want to receive, which affects how they may die, is the most fundamental decision of all. Decisions about such treatment should not be disregarded as soon as the anticipated event, decision-making incompetence, occurs.

**Frameworks other than autonomy are better suited to determine treatment for incompetent adults**

The autonomy framework prioritises previously expressed directions of the now incompetent adult. Some argue that, even leaving aside what they regard as inherent flaws in the autonomy framework, other models are better suited to caring for incompetent adults. Dresser believes that a broader based model is required, one that considers the person’s condition and prognosis, the views of loved ones and the concerns of the larger community to which the person belongs.\(^{143}\) Drawing on her views that the incompetent adult is a different person as a result of the illness, she argues that emphasis should be placed on his or her subjective perspective, as well as an objective consideration of his or her welfare. In Dresser’s view, adherence to the autonomy model results in a lack of compassion, care and protection of an incompetent (and therefore vulnerable) adult. A broader model, based on what she describes as a ‘revised best-interest’ principle, is needed.

Maclean is also concerned about the moral authority of advance directives, and therefore advocates another decision-making model. While he does not reject the authority of the advance directive outright, Maclean advocates limits on its power.\(^{144}\) Those limits, he suggests, should be akin to the limits on the decision-making power that a parent has in relation to decisions about medical treatment for his or her child. In that context, a prima facie right exists for a parent to make decisions for a child, but that right is subject to challenge if the decision is not in the best interests of the child. Maclean applies this model to advance directives and argues that a directive given by a competent adult should be prima facie binding, except if following it would be inconsistent with that now incompetent person’s best interests.

**Our response**

The substance of our response is that to rely on a model other than autonomy would effectively result in a return to paternalism. Under the model proposed by Dresser, an individual’s right to decide on treatment that is consistent with his or her own values and philosophies is compromised. An individual is not obliged to make an advance directive and if he or she does not, a decision-making model based largely on that proposed by Dresser is likely to operate. However, if a person has made an autonomous choice as to treatment they do not want in the future and thereby rejected that alternative model for decision-making, that should not be disregarded. By not recognising advance directives and instead requiring all decisions to be made through this alternative regime, decisions that a person has specifically sought to avoid through their directive may be imposed upon them.

\(^{143}\) Dresser, n 124. See also A Donchin, “Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethical Principles” (2001) 26(4) *Journal of Medicine and Philosophy* 365 where Donchin, while recognising the importance of autonomy within bioethical theory, argued the need to reformulate autonomy to encompass relationship experiences.

\(^{144}\) Maclean, n 137. A similar view is found in Herring, n 142 at 1645. The model proposed there involves following an incompetent person’s current views unless doing so would cause serious harm, and relying on advance directives where the person does not currently have strong views about their treatment. See also J Herring, “Losing it? Losing what? The Law and Dementia” (2009) 21 *Child and Family Law Quarterly* 3.
Similar criticisms of paternalism can be made of Maclean’s argument. While purporting to accept the authority of advance directives, that acceptance is conditional upon the directive being in the best interests of the person. It is argued that this deprives advance directives of their utility in the circumstances in which they are most likely to be needed, namely where a person’s particular views about how they wish to live their life may not coincide with societal (or medical) notions of what is in their best interests. A failure to give effect to an autonomous decision simply because it does not accord with more objective notions of a person’s well-being cannot be sustained.

B. Specific or practical objections to the application of autonomy to advance directives

Having considered some global concerns about the appropriateness of autonomy in justifying advance directives, we turn now to examine specific or practical objections that have been raised about the utility of autonomy in this context.

Lack of information on which to base an advance directive

A common concern raised about following an advance directive is that the decision may not be an informed one, and therefore does not represent the autonomous choice of the person who is refusing treatment. This is particularly likely to be so where an advance directive is given before a person suffers from the condition or illness for which a treatment decision ultimately needs to be made. The onset of dementia is often given to illustrate this concern.

Consider the following example: Angela, while well and before being diagnosed with dementia, completes an advance directive refusing any form of life-sustaining medical treatment should she be diagnosed with dementia and then later lose competence. She now has dementia and is unable to make her own health care decisions. However, she still leads a very active life and has considerable contact with her family, which she enjoys. Angela becomes ill and a decision needs to be made whether to treat her with antibiotics to control an infection that is threatening her life.

The concern is that her refusal in the advance directive may have been made without any understanding of the complexity of dementia, the different ways it can affect people, the different stages of deterioration, and the different treatment pathways. In the above case, for example, a course of antibiotics may quickly control Angela’s infection and allow her to continue living for many years in good physical health. Angela may not have had this scenario in mind when she made an advance directive refusing life-sustaining medical treatment. She may have (wrongly in her case) assumed that by the time her decision-making competence was lost, she would be unable to receive any enjoyment out of life, and would rather not continue living.

Our response

This argument for not adhering to the prior advance directive is persuasive and perhaps shared by some members of the general public. It is clearly desirable that decisions about medical treatment should be informed ones. However, the issue is not whether this is desirable but whether the objection is sufficient to preclude the recognition of advance directives as a means for making decisions about medical treatment. We do not consider this objection sufficient for two reasons.

The first is that the likelihood that some people may not take steps to ensure their decision is an informed one is not sufficient to deprive others of an ability to make an autonomous decision to...
refuse medical treatment. For the reasons discussed above, liberal societies do not displace such rights lightly, particularly when to do so would result in unauthorised interference with a person’s bodily integrity.

The second reason is that to accept this objection would lead to an unjustified inconsistency with the law in relation to a competent adult contemporaneously refusing treatment. For example, a person diagnosed with terminal cancer may choose not to receive chemotherapy or other treatment. That refusal is not conditional upon the patient receiving advice or information about the likely progression of the cancer if treated or untreated, or of the various treatment options. There is no principled basis for imposing additional requirements on a competent person refusing treatment simply because they are doing so in advance.

**Instability of treatment choice**

A number of commentators are also concerned that a decision recorded in an advance directive, and possibly made when a person is well, may not reflect the same person’s treatment choice at a later time.\(^{146}\) Accordingly, the earlier direction could not be regarded as the autonomous choice of the individual at that later stage. There may be a number of reasons for a person’s change of treatment choice. His or her view about treatment may simply evolve through personal experience and maturity. Some also suggest that a person’s treatment choice is likely to change when he or she becomes ill and is closer to death.\(^{147}\) Even in cases where death is not imminent, a person may have successfully adjusted to the illness and no longer wish to refuse treatment should the need for it arise. In a similar vein, others suggest that a person’s treatment setting may affect choices. There is empirical evidence that people who are hospitalised are more likely to opt for medical intervention than those in the community.\(^{148}\) So, once hospitalised, a person who has earlier made an advance directive refusing treatment, may now want to receive medical intervention.

This apparent inability to predict treatment choices accurately, it is argued, undermines the integrity of advance directives. It is difficult for doctors to have confidence that an advance directive made at an earlier time, possibly in a different context, and perhaps when the person was well, still reflects a current treatment choice.

**Our response**

There are a number of responses to these concerns. First, in a number of the contexts postulated above, the person is likely to have retained decision-making competence. As such, their current views rather than previously expressed instructions in an advance directive will govern treatment. Secondly, even if the person no longer has the ability to make decisions about health care, the advance directive will not govern treatment if the circumstances, including the altered views expressed by the person when he or she still had competence, indicate that the person would no longer intend to be bound by the prior refusal of treatment.\(^{149}\) Thirdly, if the views of the person only changed after his or her decision-making capacity was lost, it is not appropriate for reasons already discussed}\(^{150}\) for the views of the incompetent adult to govern treatment.

The more challenging issue for those supporting the integrity of advance directives, arises where a person might have made different treatment choices in an advance directive had he or she

---

\(^{146}\) Dresser, n 145; Ryan, n 145; Dresser, n 137.

\(^{147}\) Ryan, n 145.


\(^{149}\) See above at Sections II(B) and III(A).

\(^{150}\) See above at Section V(A). Compare Herring, n 142 and Herring, n 144.
experienced ill-health at the time of making it, but there is now an inability to change those instructions due to a lack of competence. It is conceivable that such a ‘lived experience’, if it occurred before making the advance directive, would have resulted in acceptance rather than refusal of treatment.

Our response to this objection is that in a liberal democracy, a person should not be prevented from making a bad decision. As reflected in the words of Lord Donaldson MR, provided a person is competent at the relevant time, the ‘right of choice is not limited to decisions which others might regard as sensible’. Making any decision in advance of it arising carries with it a risk that it will not be appropriate for the circumstances that eventuate. This is a risk that autonomous individuals accept when choosing to make an advance directive. Those concerned about this possibility need not make an advance directive and could instead provide guidelines or preferences to support others making the decision of their behalf when the time comes. The risk that treatment preferences will change over time (a risk which is assumed by those making an advance directive) is not sufficient to displace the right to make an autonomous decision to refuse medical treatment.

**Advance directive is not a true reflection of a person’s wishes**

Critics of advance directives argue that the recorded directive may not necessarily reflect the views of the person, and point to empirical evidence to support this claim. Dresser relies on one study which indicates that two-thirds of those who completed an advance directive about whether they wanted to receive dialysis if they developed Alzheimer’s disease, wanted family and friends to retain some discretion about treatment, despite the directive they had given. Fagerlin and Schneider refer to a significant body of evidence that suggests that the responses a person gives will be shaped by the way the questions are asked. In the context of advance directives, these authors contend that a person may give a different directive depending on how the question about treatment is conveyed (in a negative or positive light) or how the treatment is described. Similarly, people sometimes insert inconsistent statements into an advance directive. Clearly one of these statements could not represent the person’s view.

If an advance directive does not truly represent a person’s wishes about treatment, it is argued that the directive cannot be regarded as promoting or advancing that person’s autonomous choice.

**Our response**

The empirical research referred to above reveals some worrying data. It is concerning that a percentage of individuals who draft advance directives refusing treatment do so with some unarticulated qualifications about that refusal in mind. However, what is also clear from that same research, is that some individuals do complete advance directives in the expectation that their directive will be followed closely. It would be wrong, in principle, to deprive those people of the opportunity to refuse treatment in advance because others are less responsible with their

---

151 Luttrell and Sommerville express similar views, commenting that respect for autonomy requires adults to be able to make risky decisions: S Luttrell, A Sommerville, “Limiting Risks by Curtailing Rights: a Response to Dr Ryan” (1996) 22 Journal of Medical Ethics 100.

152 Re T (Adult: Refusal of Treatment), [1993] Fam 95, 102.

153 Compare the practical response from Ryan who shares the concerns about instability of choice. He advocates that legislation governing advance directives should require the person to be informed that patient decisions are likely to change over time: Ryan, n 145.

154 Dresser, n 145.

155 Fagerlin and Schneider, n 145.

156 Dresser, for example, refers to research where 10 out of 29 people agreed to inconsistent statements being included in their advance directive. The first statement was that the person would never want to be on a respirator in an intensive care unit. The second statement was that the person would want to receive extreme intensive medical care for a short period if it could return the person to near-normal condition: Dresser, n 137, referring to L Forrow, E Gogel, E Thomas, “Advance Directives for Medical Care” (letter) (1991) 325 New England Journal for Medical Care 1255.
instructions. The preferable approach is not to deprive competent adults the right to decide their future treatment, but to address these concerns through education or the creation of legislative safeguards so that those who complete advance directives have a better understanding of their effect.

It is beyond the scope of this article to consider measures that could achieve this outcome. However, possible strategies could include warnings in the document itself that advance directives will bind health professionals, family and friends in relation to treatment, combined with a legislative requirement that a directive be completed in consultation with a doctor.157 These steps would instil greater confidence that the advance directive reflects a person’s true wishes, and that complying with such a directive would be giving effect to that person’s autonomous choice.

**Advance directives rarely provide doctors with meaningful information**

Opponents of advance directives frequently criticise the quality of the instructions conveyed by them. Concerns have been raised about the difficulty in articulating with sufficient clarity the kind of treatment a person wants to receive or refuse. Fagerlin and Schneider, for example, observe that many adults are ‘functionally illiterate, and most of the literate cannot express themselves in writing’.158 Standard forms that facilitate completing advance directives have been developed, no doubt to assist people in this difficult process. However, these forms have also been criticised both as being too general or superficial and, at the same time, too narrow, so that meaningful information about treatment is not conveyed to doctors.159

**Our response**

These issues, while practically relevant and should be addressed, do not raise philosophical concerns about the desirability of advance directives and the appropriateness of relying on autonomy to respect these choices. Under existing legal principles, a doctor is not at risk for not following an advance directive that is unclear or uncertain.160 In other words, opponents of advance directives who object to their use for this reason need not be concerned as a directive that does not convey meaningful information will not determine treatment decisions.

Even if it is thought that this objection might have some merit, the point made earlier on a number of occasions about a liberal society also applies here. Denying a person the ability to determine his or her future treatment simply because others may give directives that lack clear guidance is unsustainable. To do so would be an unprincipled interference with a competent adult’s autonomous choice to refuse medical treatment.

**VI. CONCLUSION**

Both common law and statute recognise that a person may make an advance directive refusing medical treatment, even if that would result in the person’s death. Underpinning this right to refuse treatment is autonomy. We have sought to argue in this article that this position is appropriate, desirable and defensible.

157 See for example, Law Reform Commission of Ireland, *Bioethics: Advance Care Directives*, LRC CP 51 (2008), which provisionally recommends that consultation with a medical professional should be encouraged when making an advance directive, and be mandatory if the directive is refusing life-sustaining medical treatment: 73.
159 Dresser, n 145; Dresser, n 137.
160 See above at Sections II(B) and III(A).
We suggested that the acceptance of autonomy as an appropriate normative framework for such decisions is clearly justifiable in a liberal democracy. Further, the dominant role of autonomy in medical ethics generally, and specifically in relation to advance directives, lends further weight to the current position. Finally, we argued that the clear endorsement of autonomy in cases involving contemporaneous refusals of medical treatment favours acceptance of this principle when making these same decisions in advance.

We also examined the views of those who argue against recognising autonomy as an appropriate normative framework to govern advance directives. Some objections raised were global ones, for example, suggesting that other models were better suited to decision-making in this context. However, those objections, in turn, raise further problems such as allowing for a return to medical paternalism. Other objections were more practical in nature, but again many of the difficulties that were claimed to exist could be addressed through education or legislative adjustment. Although acknowledging these contrary views, we conclude that autonomy remains an appropriate and defensible normative framework to underpin the law governing advance directives.