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ADVANCE DIRECTIVES TO WITHHOLD LIFE-SUSTAINING MEDICAL TREATMENT: ERODING AUTONOMY THROUGH STATUTORY REFORM

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I INTRODUCTION

How an adult's life comes to an end has been a topic of considerable public interest and scrutiny in recent times. In New South Wales, the Supreme Court refused to grant relief to the family of a 75 year old man, Isaac Messiha, who sought an order requiring the hospital to continue giving life support to him.[1] In Victoria, the Civil and Administrative Tribunal appointed the Public Advocate to be guardian of Maria Korp; the Advocate later making a decision to withdraw her life-support.[2] In the United States, after many years of legal dispute and, in the spotlight of the world media, life-support was withdrawn from Terri Schiavo.[3] All of these cases generated a high level of public interest and debate on the question of when it is appropriate to stop such treatment. These cases may have been resolved more simply and with less controversy if the adult had completed an

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1 *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061. The application was for the Supreme Court to exercise its *parens patriae* to act in the best interests of an individual who is unable to care for or make decisions for himself or herself. The Court was not satisfied that the treatment proposed by the hospital, namely the withdrawal of life-sustaining medical treatment, was not in the adult's best interests.

2 *Korp (Guardianship)* [2005] VCAT 779.

3 The order to terminate Terri Shiavo's life-prolonging medical procedures was ultimately made by a Guardianship Court: *In re Guardianship of Schiavo,* 780 So. 2d. 176 (Fla. 2nd DCA 2001). However, this decision was followed by various enactments and constitutional challenges of those enactments. For an overview of the legal issues that arose in the case, see Lindy Willmott, Ben White and Donna Cooper, 'The *Schiavo* Decision: Emotional, But Legally Controversial?' (2006) 18 *Bond Law Review* 132.

advance directive: a document indicating the treatment that he or she would have wanted in such circumstances.

A competent adult may refuse life-sustaining medical treatment.[4] However, the legal and ethical issues that surround refusal of treatment when an adult loses capacity to make decisions, are more complex. By the time an adult loses capacity to make a decision about medical treatment, he or she will be unable to advise health professionals of previously formed wishes. All jurisdictions in Australia facilitate the appointment of an individual to make a medical decision on behalf of an adult who lacks capacity.[5] However, a decision by that individual may not necessarily accord with the adult's previously expressed views or wishes.

The completion of an advance directive about life-sustaining medical treatment is another option that is available to a competent adult who wants to refuse particular medical treatment (or give consent to that treatment), at some later stage in the future, should he or she become no longer competent to make such decisions. The common law recognises the right of a competent adult to make such a directive, as does the legislation, at least in some circumstances, in five of the eight Australian States and Territories.[6] The common law continues to apply in the three jurisdictions that have not passed legislation.[7]

Individuals who complete an advance directive about life-sustaining treatment are likely to do so in the belief that such a directive will be complied with by their doctor if capacity to make a decision about medical treatment is lost. While this is generally the position at common law, it may not be necessarily the case under the statutes that operate throughout Australia. In some jurisdictions, statutes only allow an advance directive about withholding or withdrawing life-sustaining treatment to operate if the person is sufficiently ill. The position is even more regulated in Queensland, as a further limitation applies in relation to directives to withhold or withdraw artificial nutrition and hydration: such a direction will only be effective if it would be inconsistent with 'good medical practice' to provide that treatment.

The increasing importance to individuals in being able to make decisions about future medical treatment is reflected in the extent to which this topic has

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4 Treatment that is needed to sustain or prolong life is commonly referred to as 'life-sustaining medical treatment'. This sort of treatment includes procedures such as cardiopulmonary resuscitation, assisted ventilation and artificial nutrition and hydration. In Queensland, this treatment is referred to as a 'life-sustaining measure'. When considering the Queensland legislation, the term 'life-sustaining measure' is used in this article. In other contexts, the terms 'life-sustaining treatment' or 'life-sustaining medical treatment' will be used.

5 *Guardianship and Administration Act 1986* (Vic); *Guardianship Act 1987* (NSW); *Guardianship and Administration Act 2000* (Qld) ('*GAA*'); *Guardianship and Administration Act 2000* (WA); *Guardianship and Administration Act 1993* (SA); *Guardianship and Administration Act 1995* (Tas); *Guardianship and Management of Property Act 1991* (ACT); *Adult Guardianship Act* (NT).

6 *Medical Treatment Act 1988* (Vic); *Powers of Attorney Act 1998* (Qld); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Medical Treatment Act 1994* (ACT); *Natural Death Act 1988* (NT).

7 See 4C below for an examination of the continued application of the common law in the statutory jurisdictions.

been on the government agenda throughout Australia. The legal regimes and/or policy guidelines on advance directives have either been reviewed recently or are currently under review in six of the eight Australian States and Territories.[8] One of the challenges when contemplating statutory reform in relation to advance directives is the issue of what, if any, limits should be imposed on when they can operate. Subject to some limited conditions, the common law requires advance directives about medical treatment to be followed. Statutory schemes restrict the extent to which advance directives must be followed, by imposing conditions for validity, or operation. If these conditions are not met, health professionals are generally not required to comply with the directive. In developing a legislative regime about advance directives, law-makers must consider very complex and sensitive issues. An individual's autonomy and, therefore, his or her right to choose not to receive certain medical treatment in the future must be balanced against the need to ensure that treatment is not withheld or withdrawn from an individual in inappropriate circumstances. As will be seen in this article, different jurisdictions take different approaches to achieve this balance.

This article will focus on the Queensland legislation that regulates an advance directive to withhold or withdraw life-sustaining medical treatment. This jurisdiction is analysed in particular detail, because it imposes more restrictions on an individual's ability to complete a binding and operative advance directive than any other Australian jurisdiction. As such, this law brings into sharp focus the tension between the principle of individual autonomy and the right to refuse medical treatment and, the state's interest in preserving the life of its citizens. It is

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8 Legislation facilitating completion of advance directives does not exist in New South Wales, so the common law governs issues of validity and scope of operation. In 2004, the New South Wales Department of Health developed a document entitled 'Using Advance Care Directives' which is designed to 'provide advice to health professionals on the best practice use of advance care directives within an advance care planning process': This document is available at: http://www.health.nsw.gov.au/pubs/2004/ pdf/adcare_directive.pdf. Legislation also does not exist in Tasmania, but in 2005, a private member's Bill, *Directions for Medical Treatment Bill,* was introduced into the Tasmanian Parliament. This Bill was not passed at the second reading speech stage on 21 June 2005 and has now lapsed. Western Australia does not yet have legislation about statutory advance directives. However, in May 2005, the Attorney-General and Minister for Health in Western Australia, Jim McGinty, published a Discussion Paper 'Medical Treatment for the Dying' that called for public submissions on an appropriate legal regime for advance directives. The *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) has been drafted as a result of that review. This Bill was read for the second time in the Legislative Council on 6 December 2006. Review of existing statutes is also occurring in South Australia and the Northern Territory. In South Australia, an Advance Directives Review Issues Paper is currently being drafted and a Review Committee is being established by the South Australian Government. In March 2005, the Northern Territory, the Department of Health and Community Services released a Discussion Paper entitled 'Review of Adult Guardianship within the Northern Territory': http://www.nt.gov.au/health/org_supp/performance_audit/adult_guard/nt_guardianship_review_discussion.doc [last accessed 15 December 2006]. The Paper considers the role of advance directives within the broader context of decision-making for individuals who lack capacity. In Queensland, the laws are being reviewed by the Queensland Law Reform Commission. The operation of advance directives is also of interest to many peak organisations. For example, in May 2006, Alzheimer's Australia published Discussion Paper 8, 'Decision making in advance: Reducing barriers and improving access to advance directives for people with dementia', authored by Dr Margaret Brown, Research Fellow, Hawke Research Institute, University of South Australia.

also the only jurisdiction in which the laws are currently being reviewed by a Law Reform Commission. A reference to review existing guardianship laws was given to the Commission by the then Attorney-General, Linda Lavarch, in 2005. One aspect of the review is 'the law relating to the withholding and withdrawal of life-sustaining measures'. This will require, among other things, a consideration of advance directives and their operation within the context of withholding or withdrawing treatment.

The article will compare the legal frameworks both at common law and under the State and Territory legislation. The proposals for change being contemplated by the Western Australian government will also be considered. The article critiques the Queensland legislation and suggests that its restrictions on the operation of an advance directive unjustifiably infringe a competent adult's right to determine medical treatment and that the Queensland Law Reform Commission ('QLRC') should recommend reform to abolish many of those restrictions. Conclusions reached in this article about the appropriate balance between autonomy on the one hand and, sanctity of life, on the other, in the context of the Queensland legislation, are equally relevant to the numerous reviews on this issue occurring throughout Australia.

II ADVANCE HEALTH DIRECTIVES IN QUEENSLAND

In Queensland, an adult may complete an advance health directive ('AHD') about the health care that he or she wants or does not want to receive at some time in the future if he or she loses capacity to make such decisions.[9] The *Powers of Attorney Act 1998* (Qld) governs the requisite capacity that an adult must possess to complete an AHD, formal requirements with which an AHD must comply and, the circumstances in which an AHD that relates to withholding or withdrawing life-sustaining measures, can operate. The legislation also addresses whether the common law regime regarding advance directives will continue to operate alongside the statutory regime.

9 A variety of terms is used to describe the instructions about health care that are given by an adult in advance of his or her loss of capacity and intended to operate after capacity is lost. The term used in the Queensland legislation is 'advance health directive': *Powers of Attorney Act 1998* (Qld) ch 3 pt 3. This is also the term proposed under the *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) pt 9B. Other terms used include 'refusal of treatment certificate': *Medical Treatment Act 1988* (Vic) s 5, a 'direction' (to refuse or for the withdrawal of medical treatment): *Medical Treatment Act 1994* (ACT) s 3 and pt 2 div 2.1 and *Natural Death Act 1988* (NT) or an 'anticipatory direction' (to grant or refuse consent to medical treatment): *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ss 4 and 7.

A When is an AHD to Withdraw or Withhold a Life-Sustaining Measure Valid?

For an AHD to be valid, the adult must have capacity at the time it is executed and, the relevant provisions regarding formality, must be complied with. The position regarding capacity is complex. First, the adult must possess the requisite capacity. A person is regarded as having capacity for a matter if he or she is capable of understanding the nature and effect of decisions, can freely and voluntarily make decisions and can communicate the decision in some way.[10] This definition relates to matters generally under the legislation. The second relevant provision specifically addresses the capacity that an adult must have to complete an AHD. Pursuant to s 42, an adult can make an AHD only if he or she understands the following matters:

(a) the nature and likely effects of each direction in the advance health directive;

(b) a direction operates only while the principal has impaired capacity for the matter covered by the direction;

(c) the principal may revoke a direction at any time the principal has capacity for the matter covered by the direction;

(d) at any time the principal is not capable of revoking a direction, the principal is unable to effectively oversee the implementation of the direction.[11]

The Queensland legislation is not entirely clear about how this provision interrelates with the definition of 'capacity' in schedule 3. It is submitted that s 42 sets out a non-exhaustive list of matters that an adult must be able to understand to meet the test of 'capacity' that is set out in the schedule 3 definition.[12]

In addition to having the requisite capacity, the AHD must satisfy the formal requirements of the legislation. The AHD must be in writing and may be in the approved form.[13] It must be signed by the adult[14] and signed and dated by an eligible witness.[15] The witness must certify that the AHD was signed in the witness's presence and, at the time the adult signed, he or she appeared to have the capacity necessary to make the AHD.[16] An AHD must also include a certificate that is signed and dated by a doctor; the certificate attesting to the fact that, at the

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10 *Powers of Attorney Act 1998* (Qld) sch 3 definition of 'capacity'.

11 If the adult also uses the AHD to appoint an attorney to make health care decisions on the adult's behalf, then he or she must also have the necessary capacity to complete an enduring power of attorney: *Powers of Attorney Act 1998* (Qld) ss 42(2), 41.

12 For further discussion of this point, see Lindy Willmott, Ben White and Michelle Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211.

13 *Powers of Attorney Act 1998* (Qld) s 44(2).

14 *Powers of Attorney Act 1998* (Qld) s 44(3)(a)(i). Note that if the adult is unable to sign the document, the legislation makes provision for the AHD to be signed by an 'eligible signer' under the instruction of the adult: *Powers of Attorney Act 1998* (Qld) s 44(3)(a)(ii).

15 *Powers of Attorney Act 1998* (Qld) s 44(3)(b).

16 *Powers of Attorney Act 1998* (Qld) s 44(4).

time the adult made the AHD, he or she appeared to the doctor to have the necessary capacity to complete the document.[17]

B *When Can an AHD about Withholding or Withdrawing a Life-Sustaining Measure Operate?*

The *Powers of Attorney Act 1998* (Qld) provides that an adult may give directions about 'health matters' and 'special health matters' in an AHD.[18] A 'health matter' is defined to be 'a matter relating to health care, other than special health care' of the adult.[19] The legislation then defines health care in very broad terms.[20] Part of that definition deals specifically with life-sustaining measures:

> (2) Health care … includes withholding or withdrawal of a life-sustaining measure for the principal if the commencement or continuation of the measure for the principal would be inconsistent with good medical practice.[21]

This means that a direction in an AHD can include a direction about withholding or withdrawing a life-sustaining measure. For example, an adult may direct in such a document that he or she does not wish to receive cardiopulmonary resuscitation even if such a measure may be required to keep the adult alive.

Generally speaking, an AHD that complies with the formal requirements of the legislation and is completed by an adult with the requisite capacity must be followed. Thus the health professional must follow a direction set out in an AHD, or risk committing an offence under the legislation.[22]

However, where a direction in an AHD relates to the withholding or withdrawing of a life-sustaining measure, the legislation imposes restrictions on its operation. The *Powers of Attorney Act 1998* (Qld) provides that such a direction cannot operate unless two or three conditions are met, depending on the circumstances.[23] The first condition is that the adult's health must be sufficiently poor and the legislation requires the adult to fall within one of four categories. The adult must:

- have a terminal illness (or a condition that is incurable or irreversible) from which the adult is expected to die within a year;

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17 *Powers of Attorney Act 1998* (Qld) s 44(6).

18 *Powers of Attorney Act 1998* (Qld) s 35(1)(a).

19 *Powers of Attorney Act 1998* (Qld) sch 2 s 4. 'Special health care' is defined in *Powers of Attorney Act 1998* (Qld) sch 2 s 7 as health care of the following types: (a) removal of tissue for donation to someone else; (b) sterilisation; (c) termination of pregnancy; (d) participation in special medical research or experimental health care; (e) electroconvulsive therapy or psychosurgery; and (f) prescribed health care.

20 *Powers of Attorney Act 1998* (Qld) sch 2 s 5(1).

21 *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2).

22 *GAA* ss 79 and 66. Note, however, there are excuses under s 103 *Powers of Attorney Act 1998* (Qld) that are available to health professionals who do not comply with an AHD. For a detailed examination of these excuses and excuses that apply at common law and in other Australian jurisdictions, see Willmott, White and Howard, above n 12.

23 *Powers of Attorney Act 1998* (Qld) s 36(2).

- be in a persistent vegetative state;
- be permanently unconscious; or
- have an illness or injury of such severity that there is no reasonable prospect that the adult will recover to an extent that life-sustaining measures will not be needed.

The second condition is that the AHD can only apply if the adult has no reasonable prospect of regaining the capacity needed to make decisions about his or her health.

The third condition applies only if the AHD is being relied upon to refrain from providing artificial nutrition and hydration. In these circumstances, the directive will only operate if the commencement or continuation of this treatment would be inconsistent with good medical practice.

C *Preservation of the Common Law Regime*

Five Australian jurisdictions have enacted legislation that facilitates an adult completing an advance directive for health care. In most of these jurisdictions, the common law regime regarding advance directives, continues to apply.[24] This means that a two-tier system will operate. An adult can choose to give an advance directive which, if valid at common law, will govern future treatment. Alternatively, the adult may choose to comply with the formal requirements of the relevant legislative regime so that his or her instructions will be regulated by statute.

As outlined above, the Queensland legislation establishes a comprehensive process whereby the adult makes decisions about the treatment that he or she may wish to receive or not receive at some future time. Although the legislation establishes a comprehensive statutory regime, the *Powers of Attorney Act 1998* (Qld) specifically recognises the common law scheme governing advance directives. Section 39 of the *Powers of Attorney Act 1998* (Qld) states: '[t]his Act does not affect common law recognition of instructions about health care given by an adult that are not given in an advance health directive.'

Despite the clear attempt to retain this aspect of the common law, it is suggested that s 66 of the *Guardianship and Administration Act 2000* (Qld) ('*GAA*') precludes its recognition. Section 66(1) of the *GAA* states: '[i]f an adult has impaired capacity for a health matter, the matter *may only be dealt with* under the first of the following subsections to apply (emphasis added).'

24 *Medical Treatment Act 1988* (Vic) s 4; *Medical Treatment Act 1994* (ACT) s 5; *Natural Death Act 1988* (NT) s 5. The South Australian legislation is silent about the effect of the legislation on the common law, but in the absence of a provision to the contrary, the common law rights would continue to apply. This proposition is supported by C Stewart in 'The Australian Experience of Advance Directives and Possible Future Directions' (2005) 24 Special Supplement Edition of the *Australasian Journal on Ageing* s 25.

The subsections that follow do not include directives that are recognised at common law. The words 'may only be dealt with' are absolutely clear: the sources of decision-making in relation to health care are to be found *only* in this section. Instructions about health care given previously by the adult that would be recognised as binding at common law are not mentioned in s 66, so while they may be relevant in guiding decision-makers, they cannot compel a particular outcome.[25] It could be argued that the specific words of s 39 might prevail over the more general words of s 66. However, s 8 of the *GAA* and s 6A(4) of the *Powers of Attorney Act 1998* (Qld) specifically provide that, in the case of inconsistency between the two Acts, the *GAA* should prevail. The result is that a common law advance directive given by an adult in Queensland will not be binding on health professionals. The significant implications of this exclusion are considered in Section V of the article.

III ADVANCE DIRECTIVES AT COMMON LAW

This section of the article examines the status of advance directives at common law. Although there is a relative dearth of case law that directly considers this issue, the common law, both in Australia and overseas, seems to recognise the right of an adult to refuse life-sustaining measures in advance of losing capacity.

For a common law advance directive to withdraw or withhold a life-sustaining measure to operate, it must be valid and the adult must have intended it to apply to the situation that ultimately arose. On the rare occasions that such cases are judicially considered, it is clear that the courts are rigorous in their efforts to ensure both the validity of the directive and the adult's intention that it would operate in specific circumstances.

A *Recognition of Advance Directives to Withdraw or Withhold Life-Sustaining Medical Treatment*

The common law recognises that, in some circumstances, an adult can complete an advance directive that will operate at a future time when the adult no longer has capacity to make decisions about health care. Further, that directive may relate to life-sustaining medical treatment.

This right has been acknowledged on a number of occasions and the law is now regarded as settled in many common law jurisdictions.[26] While no Australian

25 For a more detailed examination of why common law directives will not apply following the enactment of the Queensland statutes, see Ben White and Lindy Willmott, 'Will You Do As I Ask?' (2004) 4 *Queensland University of Technology Law and Justice Journal* 77.

26 *R (on the application of Burke) v The General Medical Council* [2004] EWHC 1879 (Admin) (although note that the Court of Appeal suggested caution in relying on aspects of Munby J's judgment in future cases: [2005] EWCA Civ 1003 [24]); *HE v A Hospital NHS Trust* [2003]

case has directly ruled on whether an advance directive is an effective legal tool for giving advance consent to, or refusal of, treatment, it is generally thought that this would be the case. This assertion can be made for a number of reasons. First, Australian statutes that create a statutory regime for refusing treatment in advance, generally assume this to be the case.[27] Secondly, although not forming part of the *ratio decidendi* of the decision, the Victorian Court of Appeal in 1998 seemed to accept that a common law advance directive would be binding on health professionals.[28] Thirdly, academic and other literature in Australia assume the effectiveness of advance directives as a mechanism to direct future treatment.[29]

B *When Will an Advance Directive to Withdraw or Withhold Life-Sustaining Medical Treatment be Valid?*

There are only two requirements for an advance directive to be valid at common law: firstly the adult must be competent to give the directive and second, the adult must have acted without undue influence in giving or making that directive.[30] These requirements also apply to directives about life-sustaining medical treatment.

The requirement of competence has two limbs: the adult must have capacity at the time the directive is given; and must be able to communicate that directive in some way.[31] In making an assessment about capacity in the context of decisions about medical treatment, the level of capacity that must be demonstrated depends

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EWHC 1017 (Fam); *Re AK (medical treatment: consent)* [2001] 1 FLR 129; *Re C (adult: refusal of medical treatment)* [1994] 1 All ER 819; *Airedale NHS Trust v Bland* [1993] AC 789, 860, 866, 892; *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 653, 662-663, 665-666, 669; *Malette v Shulman* (1990) 67 DLR (4th) 321; *Werth v Taylor* (1991) 475 NW 2d 426.

27 *Powers of Attorney Act 1998* (Qld) s 39, *Medical Treatment Act 1988* (Vic) s 4, *Medical Treatment Act 1994* (ACT) s 5, *Natural Death Act 1988* (NT) s 5.

28 *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 (the High Court refusing special leave to appeal (*Qumsieh v Pilgrim* M98/1998 (29 October 1999, 11 February 2000)). For a discussion of this case, see Cameron Stewart, 'Qumsieh's Case, Civil Liability and the Right to Refuse Medical Treatment' (2000) 8 *Journal of Law and Medicine* 56.

29 Authors of health law texts and scholarly articles frequently look to the common law on advance directives in overseas jurisdictions as representative of the likely position in Australia and tend to assume that the common law on advance directives would apply: see, for example, Ian Kerridge, Michael Lowe and John McPhee, *Ethics and law for the Health Professionals* (2nd ed, 2005) 191, 199; Loane Skene, *Law and Medical Practice* (2nd ed, 2004) 107, 157; Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-Making by and for People with a Decision-Making Disability,* Report No 49 (1996) Volume 1, 348, 357; 'Medical Treatment for the Dying' Discussion Paper issued by the Western Australian Attorney-General and Minister for Health, May 2005, p 4.

30 Some authors suggest that, in addition, the adult must also have intended the directive to apply to the situation that ultimately took place, and that the directive given must be based on sufficient information: Ian Kennedy and Andrew Grubb, *Medical Law* (3rd ed, 2000) 2037. It is submitted, however, that the former requirement relates to operation of the directive rather than validity, and that validity of an advance directive at common law does not turn on the sufficiency of information that the adult had before making the directive. For a more detailed discussion of the latter point, see Willmott, White and Howard, above n 12, 220–21.

31 *R (on the application of Burke) v The General Medical Council* [2004] EWHC 1879 (Admin) at [41].

on the treatment. If the consequences of the decision are grave, such as a decision to withhold or withdraw a life-sustaining measure, the level of competence required is commensurately high.[32] The same principles apply when considering an adult's capacity to make a directive in advance of treatment being necessary.

'Capacity' has recently been defined as follows: Essentially capacity is dependent upon having 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.[33]

Secondly, the directive must have been the result of an independent exercise of the adult's free will. If the directive was given as a result of undue influence being exerted on the adult by someone else, the directive would be invalid.[34] In such cases, the adult will be regarded as not having made a decision and, at common law, the health professional is legally able to make a decision about the adult's medical treatment based on his or her view of the best interests of the patient.[35]

C *When Will an Advance Directive Operate?*

Validity is not the only condition for an advance directive to operate. A directive will only govern the medical treatment to be given if the adult intended the directive to apply in the circumstances that ultimately arose.[36] For example, if an adult indicated to a health professional that he or she did not want to be kept alive by extraordinary measures if he or she were in the end stages of a terminal illness, that directive would not prevent cardiopulmonary resuscitation being given to the same adult who did not have a terminal illness but suffered a heart attack. In the example given, the adult would not have intended the directive to operate in these circumstances and, as such, although legally valid (because the adult was

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32 *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449, 472 and *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 661. In the former case, it was held that the woman had sufficient capacity to make the decision to withdraw artificial ventilation. For comment about the standard of capacity required for such decisions, 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 and M Parker, 'Judging Capacity: Paternalism and The Risk-Related Standard' (2004) 11 *Journal Law of Medicine* 482.

33 *R (on the application of Burke) v The General Medical Council* [2004] EWHC 1879 (Admin). For other judicial pronouncements on this test, see also *Re C (adult: refusal of medial treatment)* [1994] 1 All ER 819, *Re MB (Medical Treatment)* [1997] 2 FLR 426 and *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449.

34 *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649. In this case, the English Court of Appeal held that undue influence had been exerted on a woman who was 34 weeks pregnant and made an advance directive refusing a blood transfusion by her mother. In the course of his judgment, Straughton LJ distinguished between legitimate influence that is commonly exerted on adults by family members with 'undue' influence which effectively persuades the adult to depart from his or her own will: [1992] 4 All ER 649, 669.

35 *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 664.

36 See, for example, *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 662-663 (Donaldson MR), 668 (Butler-Sloss LJ) and 669 (Staughton LJ).

competent and there was no undue influence), the directive would not have been operative in the legal sense.

D *Judicial Approach to Advance Directives about Withholding and Withdrawing Life-Sustaining Measures*

Although the law recognises an adult's right to self-determination, in the context of an adult's desire to refuse a life-sustaining measure, the judiciary frequently comments on the tension between this right and society's legitimate interest in the sanctity of life and the need to preserve life wherever possible. This tension was graphically illustrated in *Re B (adult: refusal of medical treatment)*[37] where a 41 year old tetraplegic woman wanted to refuse artificial ventilation. Her medical team disagreed as they wanted her to try other treatment options and so refused to follow her direction. Although Butler-Sloss P found that the refusal to follow the directions of Ms B was unlawful and that treatment should have been stopped, the President noted the tension between the principle of autonomy and the concerns raised by society and the medical profession to guard the 'equally fundamental principle of the sanctity of life'.[38] Despite this tension, it is clearly established that an adult's right to self-determination prevails over the principle of sanctity of life.[39]

That said, the judiciary is very cautious before it concludes that an advance directive to withhold or withdraw a life-sustaining measure will operate.[40] This caution is evidenced in two ways. First, a court is cautious in its assessment of the validity of an advance directive,[41] whether it was intended to extend to the situation that occurred,[42] and whether it continues to operate.[43] In determining

37 [2002] 2 All ER 449.

38 *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449, 456.

39 *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449, 457 citing Lord Mustill in *Airedale NHS Trust v Bland* [1993] AC 789, 891 and Lord Donaldson in *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 661.

40 For a further discussion of judicial approaches to proof in the context, see also Willmott, White and Howard, above n 12, 236–37.

41 See, for example, the decision of the Court of Appeal in *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649. Despite relatively clear declarations by the adult that she did not want to be treated with blood products, and the fact that such a directive was consistent with her upbringing by her mother who was a Jehovah's Witness, the Court held that the adult did not have capacity at the time she made the directive. At the time, the adult's will was held to be overborne by that of her mother's.

42 Again, *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649 is illustrative. The case was decided on the basis that the adult's refusal was not valid as she was subject to undue influence. Two of the Justices also indicated that the *scope* of the refusal may not have operated to provide an effective refusal: [1992] 4 All ER 649, 662-63 (Donaldson MR), 668 (Butler-Sloss LJ). As there was evidence that there may have been a satisfactory alternative to blood products, any refusal of blood products by the adult may be limited to a case where there was a satisfactory alternative treatment. See also *Werth v Taylor* (1991) 475 NW 2d 426 where the Michigan Court of Appeals held that a 'Refusal to Permit Blood Transfusion' form was completed in contemplation of routine elective surgery rather then in the context of life-threatening circumstances. As such, it did not represent a refusal that was binding on health professionals. Compare, however, *Malette v Shulman* (1990) 67 DLR (4th) 321.

these matters, the court will err on the side of caution and any doubt will be resolved 'in favour of the preservation of life'[44] by not upholding the advance directive. If the public interest in preserving the sanctity of life is to be overridden, the direction must be in clear terms.[45]

Secondly, the Family Division of the English High Court has recently taken an interesting approach to the issue of 'onus of proof' which, from a practical perspective, may limit the extent to which an advance directive refusing life-sustaining treatment is likely to be accepted by courts as representing the current views of the adult. *HE v A Hospital Trust*[46] involved a 24 year old woman who was born and brought up a Muslim, but who later became a Jehovah's Witness. The woman completed an advance directive stating that she did not want to receive blood or primary blood components. The advance directive also provided that it could only be directly revoked in writing. Just over two years later, the woman became ill and needed a blood transfusion to save her life. Since completing the advance directive, the woman had become betrothed to a Muslim man, had stated that she would become a Muslim again and had stopped attending Jehovah's Witness meetings. Munby J held that the advance directive had ceased to operate as the woman would not have intended it to apply in the changed circumstances. Also, the provision limiting the way in which the directive could be altered was void as it was contrary to public policy. This decision is not surprising as circumstances had changed since the time the advance directive was completed. What is surprising, is Munby J's comment about the onus and burden of proof. In his view, the burden of proving the existence, continuing validity and applicability of an advance directive lies with those seeking to rely on it. Further, the standard of proof must be 'clear and convincing proof'.

If an adult takes the necessary steps to complete an advance directive that details the treatment that he or she does not want to receive, it is difficult to find a rational basis to require another individual to provide clear and convincing proof that such a directive continues to be in existence and is still valid and applicable. The adult prepared the advance directive to provide just that proof. If the advance directive appears on its face to be valid and to apply to the situation that arose, a more sensible approach would be for the onus of proof to shift to those individuals who claim that the directive is no longer valid or applicable. This approach would be more consistent with accepted views about self-determination and autonomy.

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43 See, for example, Lord Goff in *Airedale NHS Trust v Bland* [1993] AC 789, 864 where he commented that 'especial care may be necessary to ensure that the prior refusal or consent is still properly to be regarded as applicable in the circumstances which have subsequently arisen'.

44 *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam), [47]; *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 661.

45 *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 661.

46 [2003] EWHC 1017 (Fam).

IV ADVANCE DIRECTIVES IN OTHER STATUTORY JURISDICTIONS

Queensland is one of five jurisdictions in Australia that regulate directives about future health care. Legislation also exists in Victoria,[47] South Australia,[48] the Australian Capital Territory[49] and the Northern Territory.[50] The Western Australian Government is also reviewing the law on medical treatment for the dying and is considering whether the right to make an advance directive should be statutorily enshrined.[51] A Bill has been drafted and awaits enactment.[52] A Bill, largely modelled on the South Australian legislation, was introduced into the Tasmanian Parliament in 2005 but has since lapsed.[53] The statutes (and proposed statutes) vary significantly in their scope and operation, but all allow an adult, at least in some circumstances, to complete a directive refusing life-sustaining medical treatment at a future time when that adult no longer has the capacity to make decisions.

A *When is an Advance Directive to Withdraw or Withhold Life-Sustaining Medical Treatment Valid?*

The statutes in the other statutory jurisdictions have equivalent validity requirements to those that exist in Queensland. First, the adult must be of sound mind at the time the advance directive is completed.[54] Second, the adult must have completed the advance directive in the absence of undue influence or other vitiating factors.[55] The various statutes approach these requirements in different ways. The Victorian legislation requires the witness to an advance directive to attest that the adult completed the directive 'voluntarily and without inducement or compulsion',[56] while the Australian Capital Territory statute provides that an advance directive will be void if it is obtained through the use of 'violence, threats,

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47 *Medical Treatment Act 1988* (Vic).

48 *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

49 *Medical Treatment Act 1994* (ACT).

50 *Natural Death Act 1988* (NT).

51 'Medical Treatment for the Dying' Discussion Paper issued by the Attorney-General and Minister for Health, May 2005.

52 *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA).

53 *Directions for Medical Treatment Bill 2005* (Tas). As this Bill has now lapsed, it will not be considered in this review of Australian legislation.

54 *Medical Treatment Act 1988* (Vic) s 5(1)(d); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1); *Medical Treatment Act 1994* (ACT) s 6; *Natural Death Act 1988* (NT) s 4(1). The Western Australian Bill requires the adult to have 'full legal capacity: the *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) s 11 inserting s 110Q into the *Guardianship and Administration Act 1990*.

55 This can be compared with the Queensland approach where the ability of the adult to make a directive 'freely and voluntarily' was a limb of the definition of capacity, rather than a separate requirement for validity of the directive: *Powers of Attorney Act 1998* (Qld) sch 3 definition of capacity.

56 *Medical Treatment Act 1988* (Vic) s 5(1)(b).

intimidation, or a person otherwise hinders or interferes with the adult for the purpose of obtaining a directive'.[57] The Western Australian Bill requires the treatment decision in the directive to be made voluntarily and not as a result of inducement or coercion.[58] The legislative provisions in South Australia and the Northern Territory are silent on the effect of an advance directive completed as a result of undue influence. In those jurisdictions, it is likely that common law principles will apply and that such an advance directive would not be regarded as being valid. In addition, the advance directive would need to comply with the relevant formality requirements such as signing the document by the adult and witnesses. In some jurisdictions, the witness needs to attest to the fact that the adult possessed the requisite capacity to sign the advance directive,[59] while in others, the attestation relates only to the fact that the adult signed the document.[60]

B *When Will an Advance Directive about Withholding or Withdrawing a Life-Sustaining Measure Operate?*

In most of these jurisdictions, there are some restrictions about when an advance directive that refuses life-sustaining medical treatment can be made, or will operate. In broad terms, the statutes set out two kinds of restrictions regarding advance refusal of treatment. The first restriction is that a directive to refuse life-sustaining treatment will only operate if the adult is suffering from a particular condition (Victoria),[61] or is sufficiently ill (South Australia[62] and the Northern Territory)[63]. This restriction exists in all of the statutory jurisdictions except the Australian Capital Territory (and the legislation proposed in Western Australia), and is similar to that described as applying in Queensland.

The second restriction exists only in Victoria. In that State, the adult must be suffering from a particular condition or illness before he or she can complete a certificate refusing specified treatment.[64]

57 *Medical Treatment Act 1994* (ACT) s 19(2).

58 *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) s 11 inserting s 110R(1) into the *Guardianship and Administration Act 1990*.

59 Victoria: *Medical Treatment Act 1988* (Vic) s 5(1) and South Australia: *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(2) and *Consent to Medical Treatment and Palliative Regulation 2004* (SA) sch 1.

60 Australian Capital Territory: *Medical Treatment Act 1994* (ACT) s 7(c)-(d) and sch 1 form 1; Northern Territory: *Natural Death Act 1988* (NT) s 4(2) and *Natural Death Regulations* (NT) reg 2 and sch; Western Australia: *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) s 11 inserting s 110Q(1) into the *Guardianship and Administration Act 1990*.

61 *Medical Treatment Act 1988* (Vic) s 5(1).

62 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(1).

63 *Natural Death Act 1988* (NT) s (4)(1).

64 *Medical Treatment Act 1988* (Vic) s 5(1).

C *Preservation of the Common Law Regime*

The statutory regimes in Victoria, South Australia, the Australian Capital Territory, the Northern Territory and that proposed in Western Australia differ from Queensland's statute in an important respect. The common law regime regarding advance directives continues to apply notwithstanding the enactment of a statutory regime for the advance refusal of medical treatment. This is expressly stated to be the case in Victoria,[65] the Australian Capital Territory,[66] the Northern Territory[67] and Western Australia.[68] Although the South Australian legislation is silent on this point, it is submitted that the rights that existed at common law prior to the enactment of the legislation, namely the right to complete a binding advance directive, would remain unless that right were expressly abolished.[69]

This means that a two-tier system operates in these jurisdictions. An adult can choose to give an advance directive which, if valid at common law, will govern future treatment. Alternatively, the adult may choose to comply with the formal requirements of the relevant legislative regime so that his or her instructions will be regulated by statute.

V CRITIQUE OF LEGISLATIVE REGULATION OF ADVANCE DIRECTIVES: A STATUTORY CASE STUDY

The introduction of a legislative regime of advance directives necessarily imposes limitations on an individual's ability to refuse future treatment. At common law, an individual is entitled to make any directive about future treatment. In the absence of vitiating factors, that directive must be followed by a health professional if the contemplated medical situation later arises. A legislative regime limits an individual's right to make a binding directive. At the very least, a statute prescribes formality obligations about signing, witnessing and, in some cases, the use of prescribed forms. Most jurisdictions also impose conditions about when the directive can operate.

There are also advantages in a legislative regime. First, the formality obligations provide a degree of certainty for health professionals who are relying on the directive to guide treatment decisions. A document that is signed by the adult and witnessed by another person, at least, provides evidence that the

65 *Medical Treatment Act 1988* (Vic) s 4.

66 *Medical Treatment Act 1994* (ACT) s 5.

67 *Natural Death Act 1988* (NT) s 5.

68 *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) s 11 inserting s 110ZB into the *Guardianship and Administration Act 1990.*

69 See above, n 24.

directive was given by the adult. In some jurisdictions, witnesses also attest to the capacity of the adult. Where the directive relates to withholding or withdrawing a life-sustaining measure, it is crucial for health professionals to be confident that the directive represented the views of the adult and, that the adult had capacity, when making the directive. This certainty is more likely to be achieved where there are signing and witnessing requirements.

Secondly, a formal advance directive regime encourages an individual to consciously focus on the medical decisions that may need to be made in the future. This is particularly so in those jurisdictions that have prescribed forms that may or must be used and which detail what type of medical decisions might need to be considered. By contrast, common law directives may simply be oral statements made by the adult and not necessarily in the context of a serious discussion about medical treatments that the adult wanted to receive or not receive in specified future circumstances.

Thirdly, formal directives may provide comfort to family and friends of the adult, when the adult no longer has capacity to make medical decisions and, a decision needs to be made, about a life-sustaining treatment. Knowing that the adult had given treatment decisions careful consideration may relieve loved ones of some pressure during a period of crisis. They are aware of the treatment that the adult wants to receive or wants to refuse. In the absence of a formal directive, family and friends may be required to relay previous utterances of the adult to health professionals. An assessment would then have to be made about the certainty and reliability of previous statements. This difficult process could be avoided if the adult's wishes were expressed in a more formal way.

When governments consider whether to introduce a statutory regime to replace or supplement the common law, they must balance these advantages against the disadvantages, namely, the restrictions imposed by legislation that affect both validity and operation of the directive. Some legislative restrictions may be desirable. The formality requirements are designed to ensure that the directive was indeed given by the adult and represented his or her wishes at the time. The restrictions about when an advance directive can operate, however, are different in nature and cannot be justified on these grounds. These restrictions effectively impinge on an individual's previously held common law right to refuse treatment in any circumstance. They are imposed because state interest in preserving life, and in ensuring medical treatment is only withheld in situations that might be regarded as appropriate by the community, such as when an adult is in the terminal phase of an illness.

Queensland's restricted treatment of advance directives raises significant issues. Additional criteria to the widely endorsed requirements of capacity and formality compliance — a sufficiently poor state of health, lack of prospects of recovering capacity and, inconsistency with good medical practice — mark Queensland's legislation as the most restrictive in Australia.

Although the *Powers of Attorney Act 1998* (Qld) is largely based on recommendations made by the QLRC in its final report,[70] the Commission abstained from making a recommendation about how decisions regarding life-sustaining treatment should be made. While concluding that the 'state of the law in this area is unsatisfactory and should be comprehensively reviewed',[71] the Commission also stated that this issue involved much wider moral and ethical dilemmas and required extensive public consultation and debate. As such, no recommendations were made. The restrictions therefore are not based on recommendations of the QLRC. Further, the original Bill that was introduced into Parliament in 1997 did not contain the current limitations set out in the legislation and discussed in this article. These amendments were introduced into the Bill at the Committee stage in 1998. It appears the Bill was amended as a result of pressure exerted from lobby groups. The problem is that there is no examination of these restrictions in the explanatory memorandum to the Bill and very little in the Parliamentary debate as recorded in Hansard.[72] When discussing the amendments during the Parliamentary debate, the then Attorney-General, Mr Beanland, stated the following: '[a]n advance health directive enables a person to make the same sort of decisions in advance of his or her losing capacity that he or she could have made previously.'

In the context of a directive about withholding and withdrawing a life-sustaining measure, this statement is misleading. The amendments made at the Committee stage significantly restrict the previously held right of a person to dictate future treatment. The Attorney-General did not acknowledge that an AHD could only operate in more limited circumstances than dictated at common law, nor explain why the amendments to insert the limitations, were necessary[73]

This section of the article critiques the legislation in Queensland. This jurisdiction was chosen because it contains the greatest restrictions on when an advance directive to withhold or withdraw life-sustaining medical treatment can operate. The analysis that follows is of the kind that will need to be undertaken by the QLRC when reviewing the Queensland law. As we have seen, the law in many other jurisdictions is currently being reviewed in this area. Many of the issues raised are ones that will have to be grappled with by all of the reviews in the other Australian States and Territories.

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70 Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-Making By and For People With a Decision-Making Disability,* Report No 49 (1996) vol 1, 321.

71 Ibid.

72 For the brief discussion of this amendment, see Queensland, *Parliamentary Debates,* Legislative Assembly, 12 May 1997, 1019–020 (Denver Beanland).

73 There was one explanation provided, but this related to only one aspect of the limitations inserted by the amendments. The Attorney-General noted that the amendments would 'guard against the possibility, remote though it may be, of a person attempting to give a direction for the refusal of life-sustaining measures in a situation in which the person's health can be restored by simple medical procedures': Queensland, *Parliamentary Debates,* Legislative Assembly, 12 May 1997, 1020 (Denver Beanland).

A *Comparison with Common Law Regime*

Both the common law and the Queensland statute attempt to balance the principles of self-determination and sanctity of life by limiting the circumstances in which an adult's advance directive to withhold or refuse a life-sustaining measure can be followed. As evidenced earlier in the article, they do this in very different ways.

At common law, an advance directive can operate only if it is valid. The courts scrutinise the circumstances of each case very carefully to ensure that the adult possessed the requisite competence and that undue influence had not been exercised. Further, the courts go to great lengths to satisfy themselves that a previously given directive is valid, still represents the views of the adult and that the directive was intended by the adult to govern the medical situation that ultimately arose. Once satisfied of these matters, there is no further limitation on when a directive to refuse a life-sustaining measure will operate. It is irrelevant that the adult would have lived for an extended time or even made a full recovery if the life-sustaining measure were given, or that the adult was not suffering from any illness or disease at the time a decision had to be made about treatment. The directive binds a health professional to the extent that it would be unlawful for that professional to provide the treatment that has been refused.

As described previously, the *Powers of Attorney Act 1998* (Qld) imposes certain validity and formality requirements for a direction to be recognised as an AHD under the legislation. In addition, as listed above, the Act imposes significant restrictions about when an AHD about withholding and withdrawing a life-sustaining measure can operate that do not exist at common law. The practical implications of these limitations are considerable as they severely restrict the ability of many adults to plan for their future health treatment. For example, an adult who has been diagnosed with dementia may wish to complete an AHD in which he or she directs that all life-sustaining measures be withheld or withdrawn once the disease has progressed to the stage where the adult is no longer able to make health decisions. If that adult lost his or her decision-making capacity and then suffered a heart attack, it is unlikely that the AHD would operate. Given the nature of the disease, the adult would probably not be sufficiently ill for the purpose of the legislation.[74] The decision about treatment would have to be made by someone else on the adult's behalf. In such a case, the adult's directive becomes one of only a number of factors that is considered in deciding on treatment.

The Queensland legislation weighs principles of self-determination and the sanctity of life differently from the common law. While the common law recognises the tension between the principles, in the context of making an advance direction about treatment, the principle of self-determination prevails. In Queensland, this principle only prevails if the adult is sufficiently ill and, in some

74 A person with such a condition may not be expected to die within a year, is not in a persistent vegetative state or permanently unconscious, and may not be so ill that the person could not live without the continued provision of the life-sustaining measures: *Powers of Attorney Act 1998* (Qld) s 36(2)(a).

cases, where the directive is consistent with notions of good medical practice. Queensland's restrictions on when an AHD in the end-of-life context can operate significantly undermine self-determination. It is submitted that the common law approach is more consistent with accepted principles of autonomy and self-determination regarding a competent adult's right to choose the medical treatment he or she wishes to receive or not to receive. The rationale underpinning the common law recognition of advance directives is that the right to self-determination should not be lost simply because the adult loses his or her decision-making ability. If the adult has made a decision about treatment prior to losing capacity, that decision will be binding on health professionals. The common law recognises the seriousness of such a position and there are a number of safeguards that apply. As observed earlier, the court needs to be convinced that the adult intended the directive to apply in the situation that arose, and the views expressed were held by the adult at the time capacity was lost. Thus, the way that the common law balances the principles of self-determination and autonomy with that of sanctity of life is arguably more appropriate in that the refusal of treatment is still subject to certain safeguards. This approach does not disadvantage a competent person who later loses capacity, yet it protects an adult who lacks competence from the unintended operation of an advance directive to withhold or withdraw treatment.

B *Comparison with other Australian Statutory Regimes*

The legislation that regulates directives about future health care in Victoria, South Australia, Australian Capital Territory and the Northern Territory (and that proposed in Western Australia) was considered earlier in the article. In all of these jurisdictions except the Australian Capital Territory (and Western Australia), the advance directive about a life-sustaining measure will only operate if the adult suffers from a particular condition at the time the directive is completed (Victoria), or the adult is sufficiently ill (South Australia and the Northern Territory). To this extent, there are similarities with the equivalent requirement in the Queensland legislation.

Nevertheless, the statutes elsewhere in Australia differ from the Queensland regime in some significant ways. First, only in Queensland is the notion of 'good medical practice' 'relevant' to the operation of an advance directive. An AHD relating to withholding or withdrawing artificial nutrition or hydration will only operate in Queensland if continuing or commencing such treatment is inconsistent with 'good medical practice'.[75] An advance refusal of treatment in other jurisdictions does not have to comply with objective assessments of 'good medical practice' before it can operate.

75 This term is defined in the legislation in the following way: good medical practice is good medical practice for the medical profession having regard to (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and (b) the recognised ethical standards of the medical profession in Australia: *Powers of Attorney Act 1998* (Qld) sch 2 s 5B. See also *GAA* sch 2 s 5B.

Secondly, other Australian statutes do not have the requirement that the adult must have no reasonable prospect of regaining capacity to make a decision before the directive can operate. In other jurisdictions, a directive will operate even if, for example, the incapacity of the adult is temporary, such as where an otherwise healthy adult has suffered a heart attack and, at the time a decision about treatment needs to be made, the adult is unable to do so. In contrast, an AHD about a life-sustaining measure will not operate in Queensland unless the adult has no reasonable prospect of regaining capacity for that decision. This condition will not be satisfied in the above example, where, the adult suffering a heart attack is likely to regain capacity once resuscitation has been provided.

Thirdly, and most significantly, the other statutory regimes have a two-tier system of operation. An adult is able to make an advance directive at common law or, alternatively, rely on the statutory regime.[76] The implications of this are significant. An advance directive about a life-sustaining measure that is not operative under the legislative regime, for example, because the adult is not sufficiently ill, should take effect as an advance directive at common law. The directive, therefore, will bind the health professionals. The Queensland legislation, however, removes the right that is available to an adult at common law to refuse a life-sustaining measure in advance. This right is replaced with a far more limited right to dictate when a life-sustaining measure can be withheld or withdrawn. The decision as to treatment will instead be made by a substitute decision-maker as set out in the legislation. To the extent that the common law is excluded by the statutory regime, an adult is at a disadvantage to his or her counterparts in all other Australian jurisdictions in terms of self-determination of future medical treatment.

C *Comparison with Queensland Substitute Decision-Making Regime*

If the adult has not completed an AHD (or has completed one that is not operative on the facts of a particular case), the decision about withholding or withdrawing treatment is made by someone on behalf of the adult. This person is commonly referred to as a substitute decision-maker. The substitute decision-maker will be the guardian for personal matters[77] if one has been appointed by the Guardianship and Administration Tribunal,[78] or an attorney who has been appointed by the adult under an enduring power of attorney for personal matters.[79] In the absence of either of these appointments, the decision will be made by the person deemed by the *Powers of Attorney Act 1988* (Qld) to be the adult's statutory health attorney.[80]

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76 See s IVC above.

77 A 'personal matter' is defined to include 'health care of the adult': *GAA* sch 2 s 2.

78 *GAA* s 66(3).

79 *GAA* s 66(4).

80 *GAA* s 66(5). Note also that consent to withholding or withdrawing of a life-sustaining measure may be given by the Guardianship and Administration Tribunal and that consent will take priority over any other consent: *GAA* s 66(3). The term 'statutory health attorney' is defined in s 63 *Powers of Attorney Act 1998* (Qld) and is the first of the following who is 'readily available and

In reality, in almost all cases, the decision-maker will be a relative or close friend of the adult.[81]

To compare the substitute decision-making regime with that which applies to a direction in an adult's AHD, it is necessary to consider how a substitute decision-maker is required to make a decision about the withholding or withdrawing a life-sustaining measure. The *Powers of Attorney Act 1988* (Qld) and the *GAA* provide guidance for the substitute decision-maker about what to consider in making a decision about treatment. Schedule 1, in both Acts, sets out a number of principles that must inform these sorts of decisions. They are separated into 'general principles' and 'health care principle'. General principles apply to all decisions made under the legislation, of which withholding and withdrawing life-sustaining measures is just one, and so are necessarily broad. The health care principle is to be used for health related decisions only, which include decisions about withholding or withdrawing treatment.

The Guardianship and Administration Tribunal has considered these principles in the context of withholding and withdrawing treatment on a number of occasions.[82] In the most recent decision, *Re HG*,[83] the Tribunal considered that the following principles are likely to be particularly relevant to a decision to withhold or withdraw life-sustaining measures: the right of all adults to the same basic human rights regardless of capacity;[84] an adult's right to respect for his or her human worth and dignity;[85] the adult's views and wishes, if they are known;[86] and the health care principle which requires a consideration of whether the decision is 'least restrictive of the adult's rights'[87] and what is in the adult's best interests.[88]

It is interesting to compare the legislative restrictions governing a substitute decision-maker with those that affect directions in an AHD. The following example may facilitate the comparison.

> An adult has being diagnosed with cancer and is receiving chemotherapy. The adult is not regarded as being in the terminal phase of the disease and is expected to live for a number of years. The adult has made an AHD under which he has directed that he not receive antibiotics (or any other life-sustaining treatment)

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culturally appropriate' to make the decision about health care: spouse of the adult, provided that the relationship is close and continuing; the adult's carer, provided the person is 18 years or over and is not a paid carer of the adult; a close friend or relation of the adult who, again, must be 18 or over and must also not be a paid carer; or the Adult Guardian.

81 It should also be noted that although the decision about withholding or withdrawing a life-sustaining measure can be made by a substitute decision-maker, the legislation effectively gives a right of veto to health professionals. A decision to withhold or withdraw treatment will not operate unless the adult's health provider must reasonably consider that the commencement or continuation of the measure is inconsistent with good medical practice: *GAA* s 66A.

82 *Re HG* [2006] QGAAT 26, *Re MC* [2003] QGAAT 13, *Re TM* [2002] QGAAT 1 and *Re RWG* [2000] QGAAT 2.

83 [2006] QGAAT 26.

84 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 general principle 2(1).

85 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 general principle 3.

86 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 general principle 7.

87 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 health care principle 12(1)(a).

88 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 health care principle 12(1)(b)(ii).

> even if such treatment is needed to save his life. The adult develops a serious infection and is admitted to hospital. He lapses into unconsciousness and a decision must be made about treatment.

It is unlikely that the directive in the AHD would operate because the adult is unlikely to satisfy the condition that he was sufficiently ill.[89] Further, if the adult were given the treatment (antibiotics), he would have a reasonable prospect of regaining capacity for health matters.[90]

The same restrictions do not apply if the decision is made by a substitute decision-maker. A decision not to administer antibiotics can be made even though the adult does not fall within one of the categories relevant to the operation of an AHD and even though he has a reasonable prospect of recovering capacity for health decisions if the treatment was given. Instead, the decision-maker would be required to apply the general principles and health care principle, including a consideration of the adult's views and wishes[91] and the adult's dignity.[92] In addition, health care principle 12(4) specifically states that the principle does not affect any right an adult has to refuse health care. Although this provision has not yet been tested, it appears to reinforce the principle that a person is able to refuse life-sustaining treatment. This would be particularly relevant in a case where the adult has indicated a desire not to be resuscitated.

This comparison illustrates the fact that fewer restrictions are imposed on a substitute decision-maker who wants to withhold or withdraw a life-sustaining measure for someone else, than on the adult himself or herself who seeks to do so through an AHD.[93] This result is anomalous because the legislation imposes more restrictions on an adult attempting to direct his or own future treatment through an AHD than on a substitute decision-maker who makes the decision on behalf of someone else.

D *Favoured Status of Some Individuals under the Queensland Regime*

The Queensland legislation defines 'life-sustaining measure' as follows:[94]

> (1) A 'life-sustaining measure' is health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation.
>
> (2) Without limiting subsection (1), each of the following is a 'life-sustaining measure' –
>
> (a) cardiopulmonary resuscitation;

89 *Powers of Attorney Act 1998* (Qld) s 36(2)(a).

90 *Powers of Attorney Act 1998* (Qld) s 36(2)(c).

91 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 general principle 7(4).

92 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 1 general principle 3.

93 Note, however, the health professional's right of veto. See above n 81.

94 *Powers of Attorney Act 1998* (Qld) and *GAA* sch 2 s 5A.

(b) assisted ventilation;

(c) artificial nutrition and hydration.

(3) A blood transfusion is not a 'life-sustaining measure'.

With one significant exception, the definition is comparable to that used in other jurisdictions. What is peculiar to Queensland, is the exclusion of 'blood transfusion' from the definition. From a medical perspective, such an exclusion is surprising because a blood transfusion is a medical procedure that could 'sustain or prolong life' and that would 'supplant or maintain the operation of vital bodily functions that are temporarily or permanently incapable of independent operation' to the same extent as cardiopulmonary resuscitation, assisted ventilation or artificial nutrition and hydration.

There are various reasons why an adult may not wish to receive life-sustaining medical treatment and may wish that decision to apply to future events as well. The following are some contexts in which an adult may make such a decision and complete an AHD directing life-sustaining measures to be withheld or withdrawn:

Example 1

Alex wants to have some control over the timing of his death. He is 80 years old and has lived a full and fulfilling life, and is ready to die if an acute event occurs. Despite being in good health, he does not want to be resuscitated in such a situation.

Example 2

Wendy is 45 and has just been diagnosed with early onset dementia. At this stage of her disease, she still has capacity to make health decisions. Wendy has researched the disease, discussed the likely progress of the disease with her doctor and wants to have some control over the manner of her death. She would rather die from an acute event rather than experience a gradual deterioration of her health.

Example 3

Shane is of the Christian Science faith. He believes that prayer will heal any illness that he might suffer and does not want to receive any medical intervention in any circumstances.

Example 4

Danielle is a Jehovah's Witness. Because of her faith, she does not wish to receive blood products in any circumstances.

Assume that in all of these examples, the adult has been involved in a car accident. In the first three cases, the adult has suffered a heart attack and needs cardiopulmonary resuscitation to survive. In the fourth case, the adult has lost a lot of blood and needs a blood transfusion to survive.

In all of these examples, the adult does not satisfy the criteria set out in the Queensland legislation regarding when a direction to refuse life-sustaining treatment can operate. None of them suffers from a terminal illness with the expectation of death within 12 months, 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 the adult will recover to an extent that life-sustaining measures will not be needed. As a result, in examples 1, 2 and 3, the AHD refusing treatment cannot operate and the decision regarding treatment will be made by a substitute decision-maker.[95] However, the AHD in example 4 will operate. Because the definition of 'life-sustaining measure' in the legislation excludes a blood transfusion, the restrictions set out in the legislation about when an AHD about withholding or withdrawing treatment can operate, do not apply. A Jehovah's Witness therefore can give a direction to refuse a blood transfusion in an AHD that will operate in the future, yet other adults are more restricted in terms of when an AHD about a life-sustaining measure must be followed.

It is not clear why blood transfusions are excluded from the definition of 'life-sustaining measure'. They were not excluded when the *Powers of Attorney Act 1998* (Qld) was originally enacted. This exception was inserted by the *GAA*. Unfortunately, the explanatory memorandum to the Bill and the debate in Parliament do not provide an explanation for this decision. Regardless of the motive for the amendment, the exclusion of blood transfusion from the definition accommodates people of the Jehovah's Witness faith. Such individuals have religious objection to receiving blood transfusions and, understandably, may want to complete an AHD directing that such treatment not be administered.

The problem with the current drafting is that those who refuse a blood transfusion that is needed to save their lives can insist on their direction being followed, yet those seeking to refuse other kind of life-sustaining medical treatment (as in examples 1–3 above) cannot. The current drafting can be criticised at two levels. First, providing greater respect to the autonomy of one group of individuals over another cannot be justified. In a secular society, it is not appropriate to respect the decision about medical treatment made by one group in our community because failure to do so offends their religious belief, yet fail to respect the views that others may make about future medical treatment because the decision is based on other grounds. Secondly, it appears that the legislation discriminates between different kinds of religious faith. Those of the 'Christian Science' faith, for example, may not want medical treatment as they believe they will be healed through the power of prayer. Those of the Jehovah's Witness faith regard blood transfusions to be forbidden by biblical passages.[96] There can be no principled reason for accommodating the faith-driven needs and wishes of one group and not another.

E *Comparison with Gillick v West Norfolk and Wisbech Area Health Authority* ('*Gillick*')*: The Competent Child*

A minor should not have greater rights than an adult to refuse future medical treatment. Yet this might represent the legal position in some of the statutory

95 In the case of urgent health care, the treatment decision will be made by the health professional: *GAA* s 63.

96 http://www.watchtower.org/library/hb/article_06.htm [last accessed 7 December 2006].

jurisdictions, including Queensland. The Queensland legislation does not permit minors to complete an AHD; only an adult is able to give directions about future treatment through an AHD.[97] Consent to and refusal of medical treatment for minors in Queensland will, therefore, be governed by common law principles.[98] The Australian common law in this area is not settled, but it is at least arguable that a child with the requisite competence can give an advance directive to withhold or withdraw life-sustaining medical treatment. This argument is based on the principle, accepted by the High Court, that a competent minor can consent to his or her medical treatment.

In *Gillick*[99] the House of Lords held that a minor is capable of giving informed consent if he or she 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.[100] The degree of understanding and intelligence required in a particular case will depend on the seriousness and complexity of the medical treatment being considered. As is the case for an adult, the degree of capacity required for a decision to withhold life-sustaining treatment would be higher than capacity to consent to a medical examination for a trivial injury.[101] If the minor is competent to consent to treatment, then a health professional may lawfully treat the child even if the parents oppose the treatment. These legal propositions now form part of the common law of Australia[102] and, therefore, represent the Queensland law on consent to medical treatment by minors.

Applying the principle set out in *Gillick's* case, it should follow that if a child has sufficient understanding and intelligence, he or she should be able to give a valid *refusal* of treatment, even if that treatment is necessary to save his or her life. However, the English courts that have considered the refusal of life-sustaining medical treatment by a minor have indicated that such refusal could be overridden by either the minor's parents or the court consenting to treatment. The English decisions have been based on one of two grounds. First, that the minor could not be regarded as *Gillick* competent.[103] Most decisions have been decided on this basis and those decisions underscore the high level of capacity that would be required before a minor would be regarded as *Gillick* competent in the context of

97 *Powers of Attorney Act 1998* (Qld) s 35(1).

98 This reflects the case in most Australian jurisdictions. Compare *Minors (Property and Contracts) Act 1970* NSW s 49(2) and *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6 which regulate consent to treatment.

99 *Gillick* [1986] AC 112.

100 Ibid 189.

101 In *Gillick,* for example, Lord Fraser commented that it would be 'verging on the absurd to suggest that a girl or a boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to [her or] his body or even to have a broken arm set': [1986] AC 112, 169.

102 *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1991) 175 CLR 218, 239.

103 *Re R (a minor) (wardship: consent to treatment)* [1992] Fam 11; *Re E (a minor)* [1993] 1 FLR 386; *Re S (a minor) (consent to medical treatment)* [1994] 2 FLR 1065; *Re L (medical treatment: Gillick competency)* [1998] 2 FLR 810; *Re M (medical treatment: consent)* [1999] 2 FLR 1097; *Re K, W and H (minors) (consent to treatment)* [1993] 1 FCR 240.

refusing life-sustaining medical treatment. Secondly, even if the minor is regarded as being *Gillick* competent, the courts have allowed parental or court consent to override the minor's refusal on the basis of the treatment being in the minor's 'best interests'.[104]

The approach taken by the English courts in allowing a competent minor's refusal to be overridden by parents or by court order has been resoundingly criticised as being contrary to the principles set out in *Gillick's* case. Some commentators suggest that if a minor has the understanding and intelligence to refuse life-sustaining treatment, he or she should be in the same legal position as an adult.[105] It should not be possible for that refusal to be overridden by a parent or court.

There is very little primary authority on this point in Australia. In *Secretary, Department of Health and Community Services v JWB and SMB* ('*Marion's* case'*)*, McHugh J expressed the view that 'the parent's authority is at an end when the child gains sufficient intellectual and emotional maturity to make an informed decision on the matter in question'.[106] He then cited an English case which involved a minor's refusal of treatment being overridden by a court,[107] and commented that, to the extent that this case 'suggests the contrary, it is inconsistent with *Gillick*'.[108]

In *Director General, New South Wales Department of Community Services v Y,*[109] the issue of refusal of treatment by a minor was considered by the New South Wales Supreme Court. Austin J cited, with approval, a number of English decisions which permitted treatment contrary to the expressed wishes of the child, although on the facts of the case, the minor was held not to be competent to decide her own medical treatment.

Finally, the issue of refusal of treatment by a competent minor was mentioned, but not decided, by the Family Court in *Re Alex: Hormonal Treatment for Gender Identity Dysphoria*,[110] a case involving a 13 year old child who wished to undergo sex change treatment. The Human Rights and Equal Opportunity Commission contended that:

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104 *Re W (a minor) (medical treatment)* [1992] 4 All ER 627. Further support for the right of the court or parent to override a *Gillick* competent minor's refusal of treatment can be found in the following cases: *Re R (a minor) (wardship: consent to treatment)* [1992] Fam 11; *Re S (a minor) (consent to medical treatment)* [1994] 2 FLR 1065; *Re L (medical treatment: Gillick competency)* [1998] 2 FLR 810; *Re K, W and H (minors) (consent to treatment)* [1993] 1 FCR 240**.**

105 See, for example, Andrew Hockton, *The Law of Consent to Medical Treatment* (2002) 78-84 and Leanne Bunney, 'The Capacity of competent Minors to consent to and Refuse Medical Treatment' (1995) 5 *Journal of Law and Medicine* 53. See also concerns expressed by John Eekelaar in 'The Eclipse of Parental Rights' (1986) 102 *Law Quarterly Review* 4 and Andrew Bainham in 'The Judge and the Competent Minor' (1992) 108 *Law Quarterly Review* 194.

106 *Marion's* case (1991) 175 CLR 218, 316.

107 *Re R (a minor) (wardship: consent to treatment)* [1992] Fam 11.

108 Ibid 317. Although McHugh J dissented in this case, his comments about the application of *Gillick's* case to refusal of treatment by a competent minor was not the basis of his dissent.

109 [1999] NSWSC 644.

110 [2004] FamCA 297.

> [A] court has no power to override either the informed consent or informed *refusal* of a competent minor to medical treatment, or, if it does have such a power, it should not as a matter of discretion exercise that power except, perhaps, in extreme circumstances (emphasis added).

Nicholson CJ expressed doubt about the correctness of that proposition but found it unnecessary to decide the matter on the facts of the case because the child was held not to be *Gillick* competent.[111]

The common law position in Australia, therefore, must still be regarded as inconclusive. However, *if* Australian courts adopt the *Gillick* principle in the context of a minor refusing life-sustaining medical treatment, then it should also follow that a minor could refuse treatment in *advance* of the medical situation arising. Although it is unlikely to be a frequent occurrence, there may be occasions when a minor wishes to make an advance directive to refuse life-sustaining medical treatment. One such case may be where a child has suffered from leukemia since early childhood and has undergone invasive treatment for most of his or her life. At 16, the child may decide that he or she does not wish to be resuscitated should an acute event occur at some time in the future and a life-sustaining measure is needed to keep him or her alive. If the child subsequently lapses into unconsciousness, a decision about the validity of his or her advance directive would need to be made. If *Gillick* is followed in Australia in the context of refusing treatment, then a *Gillick* competent child's advance directive should be binding on health professionals and treatment could not be given contrary to that directive.

If the legal position, just described, represents the common law in relation to competent minors, it sits uncomfortably with the legal regime that applies to competent adults in Queensland who complete an AHD about refusing life-sustaining medical treatment. While an adult's AHD can only operate in limited circumstances, no such restrictions would apply to the advance directive of a competent minor.

VI CONCLUSION

A competent adult's right to make his or her own decision about medical treatment is well entrenched in our legal system. Provided the adult is competent to make the decision, it is irrelevant that the decision may be contrary to notions of good medical practice. At common law, this right extends to making decisions about treatment in advance of the medical situation arising. Again, the right is an integral

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111 In *Royal Alexandra Hospital v Joseph* [2005] NSWSC 422 per Gzell J and [2005] NSWSC 465 per Einstein J, it was held that it was within the inherent jurisdiction of the Supreme Court to order that a 16 year old child be given a blood transfusion notwithstanding the child's objection. However, there was no discussion in the judgment about whether the child was competent to make the refusal.

part of an adult's right to self-determination and is consistent with principles of personal autonomy. Review of existing laws is currently, or has recently been, on the agenda of governments in many Australian jurisdictions. As part of that review, governments must consider whether legislation should be enacted, or whether the common law should continue to regulate individual rights in this area. There are some important advantages to having a legislative regime which have been rehearsed in this article. The enactment of legislation, however, will, of necessity, impose restrictions on an individual's right to refuse future treatment.

When considering the appropriate legal regime to govern advance directives, governments would do well to learn from the Queensland experience. The motive for Queensland's legislative restrictions may have been a political response to pressures exerted by influential lobby groups. There needs to be a more principled basis than this for restricting an individual's right to refuse their future treatment. What can be the justification for restricting the operation of advance directives about life-sustaining measures? Is it because, as a society, we feel comfortable about withholding or withdrawing treatment in some circumstances, but not in others? Should an adult in the terminal phase of a terminal illness be permitted to refuse life-sustaining treatment, but not someone who has a severe and debilitating illness which is not terminal? Is it the case that personal autonomy is acceptable, but only if it is exercised to the extent that we, as a society, feel comfortable? If this is the reason that restrictions are being imposed, governments are taking an unprincipled and dangerous step in restricting individual rights.

Establishing a legal regime about advance directives is a process fraught with difficulty. It requires governments to balance competing principles of personal autonomy with societal and state interests in preserving life and, in the legal context, will have significant political implications. As the Queensland experience illustrates, lobby groups can influence outcomes. However, the views expressed by such influential groups may not necessarily, and indeed are unlikely to be, representative of the majority of the public. Governments must undertake any review in a principled way. Without legislative intervention, individuals enjoy an almost unfettered common law right to decide not to receive treatment at a future time. Governments must think very carefully before eroding those rights.