Rethinking Life-Sustaining Measures: Questions for Queensland

An Issues Paper reviewing the legislation governing withholding and withdrawing life-sustaining measures

Dr Ben White

Associate Professor Lindy Willmott

QUT

February 2005

Rethinking Life-Sustaining Measures: Questions for Queensland

An Issues Paper reviewing the legislation governing withholding and withdrawing life-sustaining measures

Dr Ben White

Associate Professor Lindy Willmott

February 2005

Published by QUT Printing Services

February 2005

ISBN 1 74107 090 2

How to make a comment or submission

The authors welcome comments and submissions on the questions raised in this Issues Paper. You are invited to contribute your views in any of the following ways:

- **Written comments and submissions can be sent to:**

  Dr Ben White and Associate Professor Lindy Willmott
  Faculty of Law
  Queensland University of Technology
  GPO Box 2434
  Brisbane QLD 4001

- **Email comments and submissions can be sent to:**

  Ben White at **bp.white@qut.edu.au** or
  Lindy Willmott at **l.willmott@qut.edu.au**

- **Comments and submissions can also be made via the project's website:**

  http://www.law.qut.edu.au/research/lifesustain/

The closing date for submissions is 30 May 2005

Further information about the project, including materials that may be useful in making a comment or submission, is also available at the project's website:

http://www.law.qut.edu.au/research/lifesustain/

If you would like your comment or submission to be treated as confidential, please indicate this clearly. However, submissions may be subject to release under the *Freedom of Information Act 1992* (Qld).

Preface

A decision to withhold or withdraw medical treatment that will inevitably result in an adult's death can be extremely difficult. In addition to making the appropriate medical and ethical judgments, there are also legal considerations to take into account, the most important of which is ensuring that the death is lawful. In Queensland, this area of law is governed by the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld).

At the time of their enactment, these pieces of legislation were regarded as very progressive. Preliminary research undertaken by the authors, however, revealed that those aspects of the legislation that govern decisions to withhold or withdraw life-sustaining medical treatment were in need of review. Accordingly, the authors, together with Jennifer Abbey, a Professor in Nursing (Aged Care) in QUT's School of Nursing, applied for and received a Special Projects Grant of $9,842.57 from the Faculty of Law at QUT to research this legislation. Our collaborators in this special project are the Adult Guardian and Palliative Care Queensland.

This project, entitled *Rethinking Life-Sustaining Measures*, is funded by that Special Projects Grant. The goal of the project is to review the Queensland legislation that governs decisions to withhold and withdraw life-sustaining medical treatment and suggest improvements. The project focuses on this kind of decision specifically (rather than decisions about health matters more generally) because preliminary research indicated that the law that governs these decisions is, in some respects, problematic and in need of reform. Some of the difficulties with the legislation that have been identified were apparent from examining the legislation itself. Other issues were raised by those who participated at a public lecture entitled *Lawful Withdrawal: Withholding and Withdrawing Life-Sustaining Care,* which was hosted by the Law Faculty in association with QUT's Faculty of Health, the Centre for Palliative Care Research and Education and Palliative Care Queensland on 7 July 2004.

The *Rethinking Life-Sustaining Measures* project has four stages.

The first stage was the establishment of an Advisory Group. This group is a panel of multi-disciplinary experts with a wide range of relevant experience and its function is to assist in the project. Members of that group (in alphabetical order) are as follows:

- Professor Jenny Abbey – Professor of Nursing (Aged Care), School of Nursing, QUT

- Dr Colleen Cartwright – Foundation Professor of Aged Services, and Director of the Aged Services Learning and Research Collaboration, Southern Cross University, Coffs Harbour Education Campus

- Dr Mark Deuble – Medical Director, Wesley Palliative Care Service and Canossa Palliative Care Unit

- Ms Sue Field – Senior Research Assistant, Centre for Elder Law, University of Western Sydney
- Ms Bronwyn Jerrard – Principal Legal Consultant, Strategic Policy, Department of Justice and Attorney General
- Ms Ann Lyons – President, Guardianship and Administration Tribunal
- Associate Professor Mal Parker – Associate Professor of Medical Ethics, School of Medicine, University of Queensland
- Dr Arnel Polong – Medical Registrar, Gold Coast Hospital (nominated by Queensland Health)
- Ms Paula Scully – Adult Guardian
- Dr Cameron Stewart – Senior Lecturer in Law, Division of Law, Macquarie University

The second stage of this project was the production of this document: an Issues Paper entitled *Rethinking Life-Sustaining Measures: Questions for Queensland*. The goal of this paper is to identify difficulties with the law that governs withholding or withdrawing this sort of medical treatment and seek views as to how it could be improved.

The third stage of this project is a period of consultation. We hope that the Issues Paper will generate debate and prompt those with an interest to make a comment or a submission. We are specifically seeking a wide range of views with copies of the paper being circulated to a broad group of stakeholders including doctors, nurses, lawyers, interest groups, government bodies and members of the general public.

The fourth and final stage involves considering the comments and submissions received and then writing a research report. That report will make recommendations as to how the law should be improved and will be submitted to the Government, and in particular to the Department of Justice and Attorney-General and Queensland Health. It is anticipated that this report will be completed towards the end of 2005.

We have had assistance in writing this Issues Paper for which we are very grateful. The Advisory Group provided valuable practical insight into the matters raised in this document and gave detailed input into previous drafts.

We are also grateful to Mr Jim Cockerill, the former Adult Guardian, for his contribution to the project. We also appreciate the contribution of our research assistant, Mr Simon Quinn and the assistance of Ms Chris Fyfe in preparing this document for publication.

The views expressed in this Issues Paper are those of the authors and are not necessarily shared by those with whom we consulted in preparing this document. In addition, we note that any errors are solely our responsibility.

Finally, we thank the Faculty of Law at QUT for making a grant available to fund this project.

If you would like more information about the *Rethinking Life-Sustaining Measures* project, please visit its website at:

http://www.law.qut.edu.au/research/lifesustain/

Ben White **February 2005**
Lindy Willmott

Faculty of Law, QUT

Contents

Glossary

This Glossary contains a number of terms referred to in the Issues Paper that might not be commonly used, or might have a particular legal meaning in this area of law. In the case of those terms drawn specifically from the legislation, the relevant sections that apply are footnoted in case further detail is required. We thank the non legal members of our Advisory Group for their contributions to the medical and nursing terms included in this list.

Adult Guardian

A statutory officer whose position is established by the *GAA*.[1] The Adult Guardian's role is to protect the rights and interests of adults who have impaired capacity including:

- investigating allegations of neglect, exploitation and abuse of such adults;
- acting as a guardian or personal attorney of last resort;
- acting as a statutory health attorney of last resort; and
- conducting research and providing education in relation to the operation of the *PAA* and *GAA*.

Advance health directive ("AHD")

A formal document through which an adult may give directions about their future health care (both health matters and special health matters) and may appoint one or more people (an attorney or attorneys) to make decisions on their behalf if the directions prove inadequate. An AHD may include directions requiring that life-sustaining measures be withheld or withdrawn.[2]

Artificial nutrition and hydration

The provision of nutrients and hydrating fluid, such as water or normal saline, through a tube if a person is incapable of eating food and drinking water normally. This is regarded as a form of medical treatment and it is usually a life-sustaining measure.

Assisted ventilation

The process of supporting breathing by manual or mechanical means when normal breathing has stopped or is inefficient. It involves the forcing of air or other gases in or about the airway to assist with the movement of that air or other gases in the lungs.

---

1 The position was originally established by the *PAA*, ch 7 in 1998. However, this chapter was later repealed and the provisions relevant to the Adult Guardian now appear in the *GAA*, ch 8.

2 The operation of advance health directives is explained in the *PAA,* ch 3 pt 3.

Capacity The ability to make your own decisions, including decisions about your own health care. Under the *PAA* and *GAA*, "capacity" requires that an adult must be capable of:

- understanding the nature and effect of decisions about a matter;
- freely and voluntarily making decisions about that matter; and
- communicating those decisions in some way.[3]

Cardiopulmonary resuscitation ("CPR") A procedure designed to restore normal breathing and cardiac function after a cardiac arrest. It includes clearing the air passages to the lungs, mouth-to-mouth artificial respiration, and heart massage by external pressure on the chest.

Common law The set of rules made by judges – as opposed to Parliament – to decide cases. Australia's common law derives historically from the common law of England, which is one reason why English decisions have particular relevance in Queensland. Parliament may override the common law on a particular topic by legislation, if it chooses to do so. Unlike legislation, there is no single or simple source for accessing or determining the common law.

Consent Consent has its ordinary meaning. To have legal effect, a person's consent must be given freely and voluntarily so, for example, it must not be given because of another person's pressure or coercion. Consent may be implied by a person's conduct. In some circumstances, consent requires particular legal formalities (for example, the completion of a valid advance health directive).

Criminal law Broadly, the body of law prohibiting those activities that are considered so serious that the State itself has an interest in their prohibition. Importantly, the criminal law includes actions (and sometimes a failure to act when you should) even if the person is not motivated by ill will. For example, continuing to provide medical treatment without consent (even if a person needs it) can amount to the criminal offence of assault under the *Criminal Code 1899* (Qld).

Fraud Intentional deception.

Futile treatment This term can be used by different people to mean different things. As noted in Issue 11, the precise determination of the meaning of "futile treatment" is beyond the scope of this Issues Paper. However, a common formulation sometimes adopted in this area of law is that treatment is futile when it is

---

[3] *PAA*, sch 3; *GAA*, sch 4.

no longer providing a benefit to a patient, or the burdens of providing the treatment outweigh the benefits.

GAA — The *Guardianship and Administration Act 2000* (Qld). It, along with the *PAA*, is the legislation that governs this area of law. A copy of this Act is available at: http://www.law.qut.edu.au/research/lifesustain/others.jsp

General principles ("GP") — A series of principles underpinning the operation of the *PAA* and the *GAA*, set out in virtually identical terms in both Acts.[4] The principles emphasise, among other points, that adults are presumed to have capacity, that all adults have equal human rights and that all adults should be encouraged to be self-reliant and to participate in the life of the community. The legislation requires people making decisions for adults with impaired capacity to use these principles.

Good faith — Though often used in law, "good faith" has no special meaning distinct from its general social use.

Good medical practice — Good medical practice for the medical profession in Australia, having regard to the recognised medical standards, practices and procedures and recognised ethical standards of the medical profession in Australia.[5] The meaning of "good medical practice" is considered in Issue 8 of this paper.

Guardianship and Administration Tribunal ("GAAT" or "the Tribunal") — A Tribunal established by the *GAA* to deal with a range of issues arising under the *PAA* and *GAA*.[6] The Tribunal's functions include:

- making declarations as to capacity;
- appointing guardians and administrators; and
- consenting to the withholding or withdrawal of life-sustaining measures for adults with impaired capacity.

Health care — Care, treatment or a service or procedure to diagnose, maintain, or treat an adult's physical or mental condition, which is carried out by a health provider, or carried out under their direction or supervision.[7] It includes withholding or withdrawal of a life-sustaining measure if the commencement or continuation of the treatment would be inconsistent with good medical practice. The definition excludes some very minor treatment such as administering first aid. Problems with the definition of "health care" are discussed in Issue 12.

---

4 *PAA*, sch 1 pt 1; *GAA*, sch 1 pt 1.
5 *PAA*, sch 2 s 5B; *GAA*, sch 2 s 5B.
6 *GAA*, ch 6.
7 *PAA*, sch 2 s 5; *GAA*, sch 2 s 5.

Health care principle ("HCP") The principle that decisions about a health matter (or special health matter) should be made in a way that is least restrictive of an adult's rights and only exercised if it is necessary and appropriate for the adult's health and wellbeing, or is, in all the circumstances, in the adult's best interests. This is an important principle underpinning the operation of the *PAA* and *GAA* and must be used by people making decisions about the health care of adults with impaired capacity. It is set out in virtually identical terms in both Acts.[8]

Health matter Any matter relating to health care, *except* matters relating to special health care.[9]

Health provider Any person who provides health care (or special health care) in the practice of a profession or in the ordinary course of business.[10] For example, doctors, nurses and dentists are all "health providers".

Legislation Formal enactments of Parliament, setting out the law on a particular matter. Legislation will override the common law on a particular issue, if Parliament intends it to do so. The legislation being considered in this project (the *PAA* and *GAA*) can be accessed at: http://www.law.qut.edu.au/research/lifesustain/others.jsp

Life-sustaining measure Health care that is 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.[11] It includes cardiopulmonary resuscitation, assisted ventilation and artificial nutrition and hydration.

Mediation Any means of bringing parties together to seek a mutually agreed settlement to a dispute.

Necessity (doctrine of) A legal principle, which in the medical context, allows a medical practitioner to provide treatment without consent because it is necessary to do so. The doctrine of necessity does not permit a medical practitioner to treat a patient contrary to that patient's expressed wishes, nor to provide treatment that is not reasonable in the circumstances. Similarly, the doctrine (which is part of the common law) does not override any legislative requirements.

---

8 *PAA*, sch 1 pt 2; *GAA*, sch 1 pt 2.
9 *PAA*, sch 2 s 4; *GAA*, sch 2 s 4.
10 *PAA*, sch 3; *GAA*, sch 4.
11 *PAA*, sch 2 s 5A; *GAA*, sch 2 s 5A.

PAA — The *Powers of Attorney Act 1998* (Qld). It, along with the *GAA*, is the legislation that governs this area of law. A copy of this Act is available at: http://www.law.qut.edu.au/research/lifesustain/others.jsp

Parens patriae jurisdiction — The Supreme Court's power to make a decision on behalf of those people who are incapable of making that decision themselves. This includes the power to consent to the provision or withdrawal of medical treatment on behalf of children, unconscious patients and those whose capacity is sufficiently impaired that they cannot make the relevant decision themselves.

Percutaneous endoscopic gastrostomy ("PEG" or "PEG tube") — A tube placed through the skin into the stomach. This may be inserted to enable the provision of artificial nutrition and hydration when people are unable to eat normally.

Persistent vegetative state — A condition where the upper part of the brain, which controls the more sophisticated functions such as speech, movement and thought, has died. The lower part of the brain (the brain stem) is still functioning and so breathing can continue normally without support. People in a persistent vegetative state do not have any awareness of their surroundings and are unable to make any voluntary movements. The use of the word "persistent" indicates that recovery is extremely unlikely.

Personal matter — A matter relating to an adult's care, *except* for any matter that is a special personal matter or a special health matter. Personal matters include:

- where and with whom an adult lives;
- what education, training or work an adult performs;
- day-to-day issues (including diet and dress); and
- the health care of the adult.[12]

Reasonable care and skill — The care and skill that would be provided by a reasonable person in the circumstances. Reasonableness essentially cannot be further defined, because it must depend upon all the circumstances of a case.

---

[12] *PAA*, sch 2 s 2; *GAA*, sch 2 s 2.

Special health care

Health care that is particularly serious, and so can only be consented to by the adult themselves through an advance health directive, or by the Tribunal.[13] The *PAA* and *GAA* set out six types of "special health care":

- removal of tissue for donation while the adult is alive;
- sterilisation of the adult;
- termination of a pregnancy;
- participation by the adult in special medical research or experimental health care;
- electroconvulsive therapy or psychosurgery; and
- any other prescribed special health care.[14]

Special health matter

A matter relating to special health care.[15]

Special personal matter

Personal matters that are particularly serious, and so require the consent of the particular adult in question. The *PAA* and *GAA* set out five "special personal matters":

- making or revoking a will;
- making or revoking a power of attorney, enduring power of attorney or an advance health directive;
- voting in a government election or referendum;
- consenting to adopt a child; and
- consenting to marriage.[16]

Statutory

The term "statutory" means relating to legislation. Hence, statutory rights are rights created under legislation and statutory duties are duties imposed by legislation.

Statutory health attorney

A person who is empowered by the *PAA* and *GAA* in certain circumstances to make decisions about an adult's health care that the adult could lawfully make if that adult had capacity. A "statutory health attorney" is the first of the following who is readily available and culturally appropriate:

- the patient's spouse, if the relationship is close and continuing;
- an unpaid adult carer of the patient;
- a close adult friend or relation of the patient who is not a paid carer; and
- the Adult Guardian as a last resort.[17]

---

13 Although note that the Tribunal may not consent to electroconvulsive therapy or psychosurgery: *GAA*, s 68.
14 *PAA*, sch 2 s 7; *GAA*, sch 2 s 7.
15 *PAA*, sch 2 s 6; *GAA*, sch 2 s 6.
16 *PAA*, sch 2 s 3; *GAA*, sch 2 s 3.
17 *PAA*, ch 4 and particularly s 63.

Part 1 – Overview

Many members of our community are unable to make some, or even any, decisions about their lives because they lack the capacity to do so. A statutory framework has been established in Queensland to facilitate decision making for adults with impaired capacity to ensure that decisions that need to be made, can be made. That framework is comprised of two statutes –

- the *Powers of Attorney Act 1998* (Qld) (the "*PAA*"); and
- the *Guardianship and Administration Act 2000* (Qld) (the "*GAA*").

These statutes were enacted after the Queensland Law Reform Commission carried out a detailed investigation during the 1990s. The Commission reviewed the existing laws and carried out an exhaustive consultation process with a wide range of individuals and groups. Those consulted included people who need assistance with decision making, individuals caring for those people, peak interest groups, health professionals, relevant government bodies and those holding statutory positions. The legislation that was ultimately enacted is based largely on the Commission's recommendations. The publications that the Commission produced in the course of its review are therefore instructive as to the reasons for enacting various provisions and how the regime operates as an integrated whole. The relevant Commission publications are –

- *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability,* Report No 49 (1996);
- *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability,* Draft Report No WP43 (1995);
- *Assisted and Substituted Decisions: Decision-making for People who Need Assistance Because of Mental or Intellectual Disability,* Discussion Paper No WP38 (1992);
- *Steering Your Own Ship?,* Issues Paper No MP1 (1991).

The *PAA* and *GAA* set out a decision making regime that divides decisions into two types of matters: "financial matters" and "personal matters". The provisions relating to financial matters facilitate someone being able to take care of the financial affairs of an adult or those aspects of an adult's financial affairs that he or she no longer has capacity to carry out for him or herself. A decision about "personal matters" can also be made on an adult's behalf, and this sort of decision includes where and with whom the adult lives, the nature of work that the adult undertakes, the adult's diet and dress and the health care of the adult.

This project focuses on one aspect of an adult's health care (which is a personal matter), namely decisions about withholding or withdrawing life-sustaining measures. The meaning of the term "life-sustaining measure" is considered in more detail in the

next part of this Issues Paper but, as the term suggests, it refers to treatment without which an adult may die. Because of the seriousness of such a decision, the legislation imposes additional safeguards that must be met before that treatment can be withheld or withdrawn. These provisions will be considered in some detail throughout this Issues Paper.

Part 2 of the Issues Paper provides a broad overview of the law that governs these kinds of decisions in Queensland. There are two sources of law that are relevant here and the first is the common law and, in particular, the power of the Supreme Court to make decisions to protect individuals who do not have capacity to make decisions on their own behalf. The second source of law is the statutory regime that consists of the *PAA* and *GAA*.

Part 3 then focuses on 14 issues arising out of the statutory regime that warrant further consideration. An issue might raise an ambiguity in the legislation, a lack of clarity or inconsistency in the law, or some matter of policy that may be worth considering.

Part 3 is divided into four sections. The first deals with issues arising in relation to advance health directives, which are directions about health care that are made by an adult before he or she loses capacity to make a particular decision. The second section deals with a variety of issues that are relevant when someone else is making the decision on behalf of an adult. The third section contains only one issue and this is how the *PAA* and *GAA* interact with particular provisions in the *Criminal Code 1899* (Qld). The final section summarises the reform questions posed throughout the document into a comprehensive list.

In examining each of these 14 issues, a similar approach is employed. First, the problem is outlined, and a hypothetical case study is given to illustrate the particular difficulty. Next, how that issue is resolved under the legislation is examined (often with a comparison of the common law), and generally some reform options that might be available are canvassed. Each issue concludes with one or more questions for consideration by the reader.

Before turning to the substantive part of the Issues Paper, the issue of terminology should be mentioned. The terms used in this paper will generally mirror those used in the legislation. At times this can be cumbersome because the legislation sometimes employs terms that are not ordinarily used. One example is that the *PAA* and *GAA* refer to "health providers" rather than health professionals or some other less formal term. Another example is "life-sustaining measures" rather than life support or life saving medical treatment. Although the definitions in the legislation may be a little cumbersome at times, for reasons of consistency, this Issues Paper will mirror the terminology of the *PAA* and *GAA*.

A second point is to note the inclusion of a Glossary at the beginning of this document. We are hopeful that the Issues Paper will be read by a broad group of stakeholders including doctors, nurses, lawyers, interest groups, government bodies and members of the general public. Because people have varying levels of understanding of the legal, medical and nursing terminology that is used in this area, we have included a Glossary to try and explain what some of these commonly used

terms mean. We are particularly grateful to the non legal members of our Advisory Group for their contributions to the medical and nursing terms in the Glossary.

A third point is to draw attention to the fact that the discussion to date has only been in relation to adults with impaired capacity, and not children. This is because decisions under the *PAA* and *GAA* to withhold or withdraw life-sustaining measures apply only to adults.[18] The scope of this project is similarly focused and will not consider how these decisions are made in relation to children.

We welcome any comments or submissions you may have on this Issues Paper. The details as to how to make your views known are located at the front of this document. If you are interested, some resources are available at the *Rethinking Life-Sustaining Measures* website that may assist in making a comment or submission on this Issues Paper. There are links to the legislation being considered and some of the key cases in the area as well as a range of other information about the project. The address of the website is:

http://www.law.qut.edu.au/research/lifesustain/

---

[18] Note, however, recent amendments to the *GAA* which also grant the Guardianship and Administration Tribunal jurisdiction in relation to the sterilisation of children with impaired capacity: *GAA*, ch 5A.

Part 2 – Law in Queensland

Introduction

A decision to withhold or withdraw medical treatment that will inevitably lead to an adult's death can raise complex legal considerations. If an adult has the capacity to make the decision him or herself, the law is clear. A competent adult may refuse treatment even if that results in his or her death.[19] Indeed, if that adult continues to be treated against clearly stated wishes, medical staff will be committing an assault and can be liable to civil or criminal prosecution.[20]

However, if an adult lacks the capacity to make such a decision, the law becomes more complex. In Queensland, both the common law and legislation may be relevant. The two pieces of legislation that apply in this area, the *PAA* and *GAA*, create a legal framework for how such decisions are made. However, these statutes expressly state that the inherent jurisdiction of the Queensland Supreme Court is not affected by their enactment.[21] This means that if guidance or a determination is needed regarding a decision to withhold or withdraw life-sustaining measures, a person may pursue this either through the legislation (and possibly the Guardianship and Administration Tribunal) or by relying on the inherent jurisdiction of the Supreme Court (and, in particular, its *parens patriae* jurisdiction).

The statutory regime in Queensland

Decisions to withhold or withdraw life-sustaining measures can be made under the *PAA* and *GAA*. The commentary that follows examines three matters that must be considered before such a decision can be made:

- whether the relevant medical treatment is a "life-sustaining measure";
- who can make a decision to withhold or withdraw this treatment; and
- whether such a decision should be made.[22]

---

19 *Re B (Adult: Refusal of Treatment)* [2002] 2 All ER 449.

20 *Criminal Code 1899* (Qld), s 246.

21 *PAA*, s 109; *GAA*, s 240.

22 Part 3 of the Issues Paper identifies some potential difficulties with the legislation that may mean that the relevant law is unclear or unnecessarily complicated, or even that the legislation directs particular results that could not have been intended by Parliament. The discussion of the law in this part, however, will not consider these difficulties, but will address what is probably intended to be the law.

Life-sustaining measures

The legislation deals with life-sustaining measures differently from other medical treatment, usually imposing additional safeguards before this sort of treatment can be withheld or withdrawn. No doubt this is for policy reasons given the serious implications of such a decision.

A "life-sustaining measure" is defined in the *PAA* and *GAA* as follows:[23]

> **5A Life-sustaining measure**
>
> *(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;*
>
> *(b) assisted ventilation;*
>
> *(c) artificial nutrition and hydration.*
>
> *(3) A blood transfusion is not a "life-sustaining measure".*

It may be argued that some other treatment or care that could be needed to keep an adult alive may not fall within the above definition. One such example *may* be the hand feeding of patients who are capable of swallowing but not feeding themselves. There are some legal arguments that would see it included as a life-sustaining measure, and there are others that suggest it falls outside the definition. If the latter is correct, the law treats that sort of treatment or care differently and different legislative provisions would apply. This is discussed further in Part 3, Issue 13.

Who decides?

If an adult lacks the capacity needed to make a decision to withhold or withdraw life-sustaining measures, then some other decision making mechanism is required. The legislation regards this kind of decision as being one about "health care",[24] and sets out a list of potential decision making mechanisms with the first to apply taking priority:[25]

1. The first is an advance health directive completed by the adult. This is the adult making his or her own decision prior to losing capacity, and that decision then being enforced at a later date when the adult is no longer able to decide for him or herself.

2. The second potential decision making mechanism is a guardian appointed by the Tribunal to make a decision, or an order that the Tribunal makes on the subject.

---

23 *PAA* and *GAA*, sch 2 s 5A.

24 *PAA* and *GAA*, sch 2 s 5(2). Note, however, that to constitute health care within the definition, the commencement or continuation of the treatment must be inconsistent with good medical practice. Some difficulties that arise from this definition are discussed in Part 3, Issue 12.

25 *GAA*, s 66.

3. The third potential decision making mechanism is an attorney appointed under an enduring power of attorney or under an advance health directive.

4. The fourth and final mechanism, if none of the previous ones apply, is that the decision is made by a "statutory health attorney". This is another term that is defined in the *PAA*[26] and again a priority list is used with the statutory health attorney being the first person in the list who is "readily available and culturally appropriate" to make the decision:

    - The first possible statutory health attorney is the spouse of the adult, provided that the relationship is close and continuing. It is important to note that "spouse" will include de facto partners (both heterosexual and same sex partnerships).[27]
    - If such a spouse is not available, the next potential statutory health attorney is the adult's carer, provided the person is eighteen years or over and is not a paid carer of the adult. The definition of a "paid carer" is important because it specifically excludes those who receive a State or Commonwealth carer payment or other similar benefit, or who are funded from compensation awarded due to the adult with impaired capacity being injured through negligence.[28] Accordingly, a person providing care in those circumstances is not regarded as a paid carer and so is still eligible to be the adult's statutory health attorney.
    - If the adult does not have a carer, the third option is a close friend or relation of the adult who, again, must be eighteen or over and must also not be a paid carer.
    - A final option, if an adult has none of these people available to him or her, is that the Adult Guardian will act as the statutory health attorney. The Adult Guardian is a position established by the statutory regime[29] and that person is charged with the responsibility of protecting the rights and interests of adults with impaired capacity.[30] The rationale in making the Adult Guardian a decision maker of last resort is that there will always be someone who can make this decision.

The legislation is clear in setting out how or from whom consent is to be obtained. As we have discussed, it sets out a hierarchy of decision making mechanisms and, for the last of these mechanisms, the statutory health attorney, it sets out a further prioritised list of people who are empowered to act in this role. However, despite this comprehensive approach, problems can arise.

A classic situation is where there are two or more eligible statutory health attorneys who disagree about how an adult should be treated. This might occur, for example, if there is more than one "relation" who would qualify as a statutory health attorney for

---

26 *PAA*, s 63.
27 *Acts Interpretation Act 1954* (Qld), s 32DA.
28 *PAA*, sch 3; *GAA*, sch 4.
29 The position was originally established by the *PAA*, ch 7 in 1998. However, this chapter was later repealed and the provisions relevant to the Adult Guardian now appear in the *GAA*, ch 8.
30 *GAA*, s 174.

the adult. In a situation such as this, the Adult Guardian may become involved, first through mediation.[31] There will be attempts made to resolve the dispute in this way, although if this is unsuccessful, the Adult Guardian is also empowered to make the decision on behalf of the adult him or herself.[32] Less common is when people are behaving in a way inconsistent with the principles set out in the legislation (see later in this Part). If a decision is being made (or not made) for another that is contrary to the health care principle, the Adult Guardian is also entitled to intervene and make (or not make) the decision.[33] These problems may also be resolved before the Tribunal, which is empowered to hear applications seeking a declaration, order, direction, recommendation or advice in relation to a matter involving an adult under the *PAA* and the *GAA*.[34]

Whether to withhold or withdraw

The legislation guides decision making for all kinds of medical treatment including decisions to withhold or withdraw life-sustaining measures. The law treats decisions made in advance health directives (where the decision is made by the adult through this document) differently from decisions made by substituted decision makers (whether they are individuals close to the adult, the Adult Guardian or the Tribunal). These different decision making paths will be considered separately.

Advance health directives

Advance health directives are legally binding documents and **must** be followed.[35] A failure to comply with a lawful request in a directive can result in both criminal and civil actions being brought against the relevant health provider for assault. There are, however, particular conditions that must be met if the direction is one to withhold or withdraw a life-sustaining measure.

The *PAA* provides that such a direction cannot operate unless two or three conditions are met, depending on the circumstances.[36] 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;
- 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.

---

31 *GAA*, s 42.
32 *GAA*, s 42.
33 *GAA*, s 43.
34 *GAA*, s 115. The Tribunal also has the specific power to consent to the withholding or withdrawal of a life-sustaining measure: *GAA*, s 82(1)(f).
35 An advance health directive must, however, satisfy the formal requirements for completion as set out in the *PAA*: ch 3 pt 4.
36 *PAA*, s 36(2).

The second condition is that the advance health directive 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 advance health directive is being relied upon to not provide 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.

If these two conditions (or three if it relates to artificial nutrition and hydration) are satisfied, the advance health directive is legally binding and must be followed. By contrast to when consent is given by another, there is no requirement to consider tests such as the best interests of the adult or whether the treatment is the option that is the least restrictive of his or her rights (see below). The adult is making the decision for him or herself (through an advance health directive) and so is entitled to refuse life-sustaining measures.

Consent from another

The law is more complex if an advance health directive is not being relied upon, and instead consent is being given by another person, such as a statutory health attorney. The *PAA* and the *GAA* do provide guidance, however, for the people who are making these decisions on behalf of another. Schedule 1 in both Acts sets out a number of principles that must inform these sorts of decisions. They are separated into the "general principles" and the "health care principle". The 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 obviously includes the sorts of decisions being discussed.

The principles that are likely to be particularly relevant to a decision to withhold or withdraw life-sustaining measures will require consideration of:[37]

- the adult's views and wishes, if they are known;[38]
- whether the decision is "least restrictive of the adult's rights";[39]
- what is in the adult's best interests;[40] and
- the adult's dignity.[41]

The decisions made, guided by these principles, will depend heavily on the circumstances of each case, and particularly the condition of the patient. In a recent decision of the Guardianship and Administration Tribunal, *Re MC*,[42] the Tribunal

---

37 The principles that may be relevant to this kind of decision are considered in more detail in Part 3, Issue 10.
38 *PAA* and *GAA*, sch 1 GP 7.
39 *PAA* and *GAA*, sch 1 HCP 12(1)(a).
40 *PAA* and *GAA*, sch 1 HCP 12(1)(b)(ii).
41 *PAA* and *GAA*, sch 1 GP 3.
42 [2003] QGAAT 13.

referred to all of these principles but seemed to place considerable emphasis on the invasive nature of the treatment (or whether the treatment would be least restrictive of Mrs C's rights), a consideration of what Mrs C would have wanted and what would be in Mrs C's best interests.

Having weighed the principles and considered the situation of the adult, the legislation contains one further safeguard before life-sustaining measures can be withheld or withdrawn. That safeguard is that the consent to withhold or withdraw the life-sustaining measure given on behalf of the adult cannot operate unless the adult's health provider reasonably considers that the commencement or continuation of the measure is inconsistent with "good medical practice".[43] "Good medical practice" is defined in the legislation by reference to recognised medical standards, practices and procedures of the medical profession in Australia, as well as recognised ethical standards.[44]

Conclusion

Medical treatment needed to keep a patient alive is different from other care, and so the *PAA* and the *GAA* treat it differently. First, the treatment must fall within the definition of a "life-sustaining measure". The legislation then sets out a framework to identify the appropriate decision making mechanism. The list begins with the adult making these decisions him or herself in an advance health directive. The final mechanism is a statutory health attorney, usually a family member or friend, who is not specifically appointed by the adult but empowered to act by law. In any given case, the first in this list of mechanisms that is available will apply.

Then the legislation sets out how these decisions are to be made. In the case of an advance health directive, certain conditions must be met, most notably that the adult must have a sufficiently serious medical condition and there must be no reasonable prospect that he or she will regain capacity to make these decisions. If those conditions are met, that advance health directive is binding and health providers must follow all lawful directions.

Where another is making a decision for the adult, the legislation prescribes two steps. The first is that the person empowered to decide consents to the withholding or withdrawal of life-sustaining measures based on criteria set out in the legislation. But that consent alone cannot operate because of an additional safeguard: the continuation or commencement of the medical treatment must be inconsistent with good medical practice.

The common law

The common law also permits the withholding or withdrawal of life-sustaining measures in appropriate circumstances and, from a Queensland perspective, is worth discussing for a number of reasons. The first reason is that some of the common law

---

43 *GAA*, s 66A.

44 *PAA* and *GAA*, sch 2 s 5B. The meaning of good medical practice is considered in more detail in Part 3, Issue 8.

has specifically been left intact in Queensland by the *PAA* and *GAA*. The Supreme Court retains its power to make decisions for those with impaired decision making capacity under its *parens patriae* jurisdiction.[45] Secondly, the common law has been relied upon when making decisions under Queensland's legislative regime. For example, the Guardianship and Administration Tribunal has referred extensively to the common law cases when considering whether to withhold or withdraw life-sustaining measures under the Acts.[46] A final reason to consider the common law is that it provides a useful starting point from which to assess the reforms enacted by the *PAA* and *GAA*. In Part 3, the issues identified as potentially in need of reform are often compared with the previous common law position.

At common law, there are two considerations that are relevant to decisions to withhold or withdraw life-sustaining measures: who makes the decision and upon what criteria.[47] These two issues are dealt with in turn.

Decision maker

At common law, there are two potential decision makers: the doctor who is treating the adult, and the courts.

Generally at common law, a health provider cannot administer health care without the patient's consent. However, a complication arises in relation to adults with impaired capacity, as they are unable to make such a decision. To ensure that these adults receive necessary treatment, the courts have said that medical treatment that an adult *needs* can be given without consent, based on the doctrine of necessity.[48] This doctrine does not justify the administration of all treatment; only that which is in the adult's best interests.[49] This will include treatment that is administered in an emergency context, but also non urgent treatment provided that treatment is in the adult's best interests. The courts have said that this doctrine specifically applies to decisions to refuse life-sustaining measures.[50] Accordingly, if a patient's best interests require that treatment not be provided, then consent is not needed for a patient's treating doctor to make a decision to withhold or withdraw life-sustaining measures.

The second decision maker, the courts, is empowered to withhold or withdraw life-sustaining measures under its *parens patriae* jurisdiction. This jurisdiction entitles the

---

45 *PAA*, s 109; *GAA*, s 240.

46 *Re MC* [2003] QGAAT 13, [57]-[63]; *Re TM* [2002] QGAAT 1, [154]-[156], [158]; *Re RWG* [2000] QGAAT 2 [51]-[55], [60]-[75], [87].

47 The common law also encompasses declaratory relief that may be granted by the Supreme Court. In the current context, for example, the Court may be asked by a health provider to declare that the proposed withholding or withdrawal of life-sustaining measures is lawful. See, for example, *Airedale NHS Trust v Bland* [1993] AC 789 and *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235. This approach may be appropriate where the reason for the Court being involved is that a health provider is worried about their potential legal liability in stopping or not providing medical treatment. In this situation, the Court is not making the decision to withhold or withdraw life-sustaining measures, instead it is ruling on its lawfulness.

48 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

49 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. See below for a discussion of the best interests test.

50 *Airedale NHS Trust v Bland* [1993] AC 789, 866 (Lord Goff), 883 (Lord Browne-Wilkinson), 892 (Lord Mustill) all citing *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

courts to give consent to medical treatment (among other things) on behalf of people who are incapable of doing so for themselves.[51] Because the Court's order is to give consent, the effect of such a decision is that the withholding or withdrawal of the treatment takes place with the consent of the adult.[52]

Although it is clear that a court ruling will prevail over a decision made by an adult's treating doctor, the courts have said that a decision to withhold or withdraw life-sustaining measures is primarily a medical decision at first instance.[53] In most common law jurisdictions, the courts need only be involved if there is a dispute as to the treating doctor's assessment of a patient's condition, or if the doctor wishes to seek direction from the courts.[54]

It was noted above that in Queensland, some aspects of the common law have been preserved by the *PAA* and *GAA*. In particular, the Supreme Court's inherent jurisdiction, and specifically its *parens patriae* jurisdiction, was expressly protected.[55] However, although Queensland's Supreme Court has retained its jurisdiction, the power that doctors had at common law to withhold or withdraw life-sustaining measures has not survived the *PAA* and *GAA*. As was discussed above, the legal ground for this power was the doctrine of necessity, which was based on the inability of an adult with impaired capacity to give consent. The reason why a doctor is not permitted to rely on this reasoning in Queensland (and hence make a decision without consent) is that the *PAA* and *GAA* create a mechanism through which it is nearly always possible to obtain consent (albeit through other people).[56] Accordingly, the issue of necessity does not arise.

Criterion of best interests

The relevant criterion in deciding the appropriate medical treatment for an adult who lacks capacity is whether such treatment is in the patient's *best interests*.[57] The best

---

51 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1; *Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218; *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 552-554.

52 *Re G* [1997] 2 NZLR 201, 212.

53 *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549,554; *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061, [25].

54 Compare the common law of England where decisions to withhold or withdraw life-sustaining measures from some patients who lack capacity must be approved by the English High Court: *Practice Note: Declaratory Proceedings: Medical and Welfare Decisions for Adults who lack Capacity* [2001] 2 FLR 158.

55 *PAA*, s 109; *GAA*, s 240.

56 However, the legislation recognises that life-sustaining measures may be withheld or withdrawn without consent in an acute emergency in certain circumstances: *GAA*, s 63A. See also other provisions in the *GAA* that deal with health care without consent: s 63 (urgent health care) and s 64 (uncontroversial health care).

57 Note that the appropriateness of the best interests test to this area of law has been questioned. For example, the test has been criticised by those who consider that the *Bland* decision (see below) represents the first dangerous step on the slippery slope of making quality of life assessments without any principled means of making such decisions: see, for example, J Keown, "Beyond *Bland*: a critique of the BMA guidance on withholding and withdrawing medical treatment" (2000) 20 *Legal Studies* 66. Some suggest that the test is flawed for other reasons, for example, that the test "lends itself to interpretation" depending on the "correct framing of the question": JK Mason, RA McCall Smith and GT Laurie, *Law and Medical Ethics* (6th ed, 2002) 518. Others suggest that the notion of an adult having "best interests" in this kind of case is a fiction: *Airedale NHS Trust v*

interests test was considered in detail in the landmark English case of *Airedale NHS Trust v Bland*.[58] Anthony Bland was 17 years old when he was seriously injured in the Hillsborough football ground disaster in 1989. His lungs were crushed and punctured, and the supply of oxygen to his brain was interrupted causing him to sustain irreversible brain damage. He was left in a persistent vegetative state and there was no hope of recovery. The English House of Lords held that it was lawful for the health providers to withdraw artificial nutrition and hydration because the patient's "best interests" no longer required continued treatment. That withdrawing the artificial nutrition and hydration was lawful was also the unanimous view of the judges in the courts below who heard the case before it reached the House of Lords.

The most important consideration in assessing what was in Anthony's best interests in almost all of the judgments was responsible medical opinion, that is, whether from a medical perspective it is appropriate to continue treatment.[59] An assessment of what responsible medical opinion required in this case was based on the seriousness of the patient's condition and the limited likelihood of recovery, together with the lack of therapeutic, medical or other benefit from the treatment that he was being given.

In addition to responsible medical opinion (or even as part of it),[60] a number of other factors were considered to be relevant in assessing what was in Anthony's best interests, namely:

- what he would have wanted;[61]
- the views of his family;[62]
- the lack of dignity for him to continue to be subjected to such invasive measures;[63]
- his desire to be remembered as carefree;[64] and
- the ordeal that the treatment involved for his family.[65]

Bland [1993] AC 789, 897 (Lord Mustill), 858 (Lord Keith). Also of concern is the increased difficulty in applying the test when the adult is not in a persistent vegetative state. Concern has been expressed about the possibility of the test being applied in cases of dementia where an adult has suffered a serious stroke: JK Mason, RA McCall Smith and GT Laurie, *Law and Medical Ethics* (6th ed, 2002) 515.

58 *Airedale NHS Trust v Bland* [1993] AC 789. This "best interests" test has been adopted widely throughout the common law world, including for example, New Zealand (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235; *Re G* [1997] 2 NZLR 201) and Ireland (*In the Matter of a Ward of Court* [1995] 2 ILRM 401).

59 For example, *Airedale NHS Trust v Bland* [1993] AC 789, 883-884 (Lord Browne-Wilkinson), 871 (Lord Goff).

60 *Airedale NHS Trust v Bland* [1993] AC 789, 871 (Lord Goff). See also *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 250-251.

61 For example, *Airedale NHS Trust v Bland* [1993] AC 789, 817 (Butler-Sloss LJ), 833 (Hoffman LJ), 872 (Lord Goff).

62 For example, *Airedale NHS Trust v Bland* [1993] AC 789, 817 (Butler-Sloss LJ), 828 (Hoffman LJ), 871 (Lord Goff).

63 For example, *Airedale NHS Trust v Bland* [1993] AC 789, 813 (Bingham MR), 822 (Butler-Sloss LJ), 869 (Lord Goff), 883-884 (Lord Browne-Wilkinson).

64 For example, *Airedale NHS Trust v Bland* [1993] AC 789, 813 (Bingham MR), 822 (Butler-Sloss LJ).

65 For example, *Airedale NHS Trust v Bland* [1993] AC 789, 813 (Bingham MR), 830 (Hoffman LJ), cf 897 (Lord Mustill).

More recently, there has been a shift since *Bland* for an adult's "best interests" to be informed more by these non medical considerations than had been the case in the past.[66] Criticisms are still made, however, that undue weight is given to the medical aspects of a person's best interests.[67]

---

[66] See, for example, the often quoted statement by Butler-Sloss P in *Re A (Male Sterilisation)* [2000] 1 FLR 549, 555: "best interests encompasses medical, emotional and all other welfare issues."

[67] For example, some commentators have criticised the best interests test as being "medicalised" (JK Mason, RA McCall Smith and GT Laurie, *Law and Medical Ethics* (6th ed, 2002) 513-514) while others are critical of the paternalism (which they describe as "doctor knows best") as being "endemic in English medical law" (I Kennedy and A Grubb, *Medical Law* (3rd ed, 2000) 2105).

Part 3 – Issues for Consideration

This Part identifies 14 issues for consideration in the law that governs withholding or withdrawing life-sustaining measures under the *PAA* and *GAA*. These issues are grouped loosely around three themes that are considered in their own sections: advance health directives, general decision making considerations and issues of criminal law.

Each issue is considered in the same way. First, the potential problem is briefly identified and a case study or case studies are proposed to illustrate why the issue may cause difficulties. Then the law under the *PAA* and *GAA* is outlined, often supplemented by a comparison with the position under the common law. That discussion of the law is applied to the proposed case study to illustrate why the issue is seen as problematic. The consideration of each issue then concludes with a discussion of potential reform options and one or more questions designed to generate and focus comment.

Section 1 – Advance Health Directives

Section 1 brings together a group of issues associated with advance health directives ("AHDs"), and sometimes enduring documents generally. The first issue raises a broad policy consideration relating to whether common law advance directives (which are directives that do not comply with the formality requirements of the Queensland legislation) should be binding on health providers. The second issue also raises an important matter of policy, namely the circumstances in which an AHD that directs the withholding or withdrawal of a life-sustaining measure should operate. At common law, there are not any restrictions, yet a number are imposed by the statutory regime.

The third, fourth and fifth issues consider protection of health providers regarding compliance with AHDs:

- What is the position where they rely on an invalid AHD?
- What if they provide treatment without knowing of the existence of an AHD?
- What if they are aware of an AHD and its contents but consider that, in the circumstances of the case, its directions should not be followed.

The sixth issue deals with a practical concern regarding AHDs, namely the ways in which health providers can be satisfied that the document that they sight is the patient's AHD, or a true and correct copy of it. Finally, a seventh issue examined is the protection that is given to health providers in an emergency context, particularly in terms of their obligations where they have become aware that an AHD might have been completed by the patient.

Issue 1 – Wider recognition of advance directives about health care

1.1 The problem

Under the common law, an individual can give a direction about their future health care and this must be followed by health providers. There are no specific requirements as to the form of such a direction so, for example, a card completed by a Jehovah's Witness about refusing blood products would constitute a common law advance directive. A discussion by an adult with his or her family about future treatment following a diagnosis of a serious illness such as dementia could also be a common law directive.

The Queensland legislation specifically provides for advance health directives ("AHDs") to be given before losing capacity. For them to be valid, the legislation requires that certain formalities be met such as witnessing by particular groups of people. This raises two issues:

- Do common law advance directives continue to have legal force after the enactment of the Queensland legislation?
- If they do not, should the law be changed so that common law advance directives have legal force?

Case studies A and B illustrate the problem.

Case study A

Patricia is a strongly committed Jehovah's Witness and thus holds firmly to the religious belief that she should not receive any blood or blood products, including blood transfusions. So that others are aware of her decision, including health providers who may treat her in the future, she carries a "No Blood" card. Her husband, Michael, shares her religious beliefs and is also opposed to this sort of treatment.

Patricia is involved in a serious car accident and is unconscious when she is found. She is transferred to a local hospital where it becomes clear that she will require a blood transfusion to stay alive. Michael is torn between his religious beliefs and his concern that his wife will die. Faced with the reality of his wife's death, he now argues with hospital staff that the transfusion should be given. The hospital staff are uncertain of their legal position given Patricia's "No Blood" card and Michael's insistence that she receive the transfusion.

Case study B

Diane was 60 years old when she was diagnosed with dementia. She researched the illness and told her family that she did not want to receive any life-sustaining measures once she reached the stage that she lacked capacity to make health decisions for herself. She specifically said that she did not want antibiotics if an infection threatened her life. She only wanted to receive palliative care. Some years later, when Diane lost capacity, she suffered a chest infection and her doctor wanted to commence antibiotics because she regarded this as good medical practice. The antibiotics would cure the chest infection, but without them Diane could die. Diane's children advised the doctor that this was contrary to Diane's express wishes and clear verbal directions to them, but because they felt that Diane still had many years left to live, they consented to the antibiotics. The treating doctor is uncertain of her legal position.

1.2 Operation of common law directives after the *PAA* and *GAA*

The common law

The common law that existed before the statutory regime came into operation was simple. A "mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death."[68] The right to refuse life-sustaining measures could operate even if the refusal was given in advance of the medical situation arising.[69] In other words, before a patient lost capacity to make a decision about treatment, he or she could give a direction about their future medical treatment which would be binding on health providers. For such a directive to be legally binding, the adult must have had the capacity to make such a decision.[70] In addition, a directive given in advance must also be clearly intended by the patient to cover the situation that subsequently arises.[71]

Although the Australian courts have not yet considered the validity of a common law advance directive, it is likely that the position as outlined would be accepted as part of Australia's common law.[72]

---

68 *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; *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649; *Airedale NHS Trust v Bland* [1993] AC 789; *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385.

69 *Re C (adult: refusal of medial treatment)* [1994] 1 All ER 819; *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff); *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 653, 662-663, 665-666 and 669; *Malette v Shulman* (1990) 67 DLR (4th) 321.

70 Where the decision regarding future treatment is particularly grave as in the case to refuse life-sustaining medical treatment, the patient's competence must be correspondingly high: *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449.

71 Compare *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649.

72 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, 357. Although not expressly addressing the point, the Victorian Court of Appeal in *Qumsieh v Guardianship and*

In case study A, Patricia has refused medical treatment needed to save her life through her "No Blood" card. Provided the card is sufficiently unambiguous in its terms, this refusal of treatment will be effective. At common law, this remains the case even though Patricia has now lost capacity due to the accident. If medical staff were to provide treatment contrary to those wishes, they would be guilty of an assault exposing them to both criminal[73] and civil[74] liability. The same would apply in case study B. If there was clear evidence of Diane's direction not to be given antibiotics, that refusal will be binding on medical staff.

Impact of the PAA and GAA

It seems that the legislature intended that common law advance directives would operate alongside the scheme for AHDs that is set out in the *PAA*. Section 39 of the *PAA* provides as follows:

> ***39 Common law not affected***
>
> *This 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.*

However, despite the clear attempt to retain this aspect of the common law, it is suggested that s 66 of the *GAA* precludes its recognition. Section 66(1) of the *GAA* states: "If 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). The subsections that follow do not include directives that are recognised at common law.[75]

Outcome

It seems therefore that rather than an individual's previously expressed wishes governing the situation, the decision making process established by the statutory scheme would apply. In other words, common law advance directives no longer have legal force under the statutory regime. This means that Patricia's statutory health attorney in case study A and Diane's in case study B would make the decision, rather than the earlier direction given by the adult resolving the matter. While this may lead to the same result in both cases, this would not be certain. Factors besides the views and wishes of the adult must be taken into consideration by the decision maker.

Administration Board & Anor [1998] VSCA 45 and the High Court in refusing special leave to appeal (*Qumsieh v Pilgrim* M98/1998 (29 October 1999, 11 February 2000)) seemed to accept that a common law advance directive would be binding in that jurisdiction.

73 Assault is an offence under the *Criminal Code 1899* (Qld), s 246.

74 Civil liability arises as a result of a trespass to the person and an action in assault or battery may be brought against the health provider: *Department of Health and Community Services (NT) v JWB* (1992) 175 CLR 218, 232. In Queensland, the appropriate tort is assault because, as defined by s 245 of the *Criminal Code 1899* (Qld), it includes the tort of what was battery at common law: *White v Connolly* [1927] St R Qd 75.

75 For a more detailed examination of why common law directives do not operate following the enactment of Queensland's statutory regime, see B White and L Willmott, "Will You Do As I Ask? Recognition of Instructions about Health Care under Queensland's Legislative Regime" (2004) 4 *Queensland University of Technology Law and Justice Journal* 77.

1.3 Should common law directives continue to operate?

Case studies A and B raise squarely the issue of whether common law advance directives should continue to operate notwithstanding the establishment of a regime under the *PAA* for executing a formal AHD. In other words, if an adult has not completed an AHD that complies with the formality requirements of the legislation, but has clearly indicated in some other way his or her desired treatment (as occurred in case studies A and B), should those directions be followed?

Whether a common law directive that does not comply with the formality requirements of the *PAA* (and therefore is not an AHD under the legislation) should continue to be binding was considered by the Queensland Law Reform Commission (the "QLRC").[76] The relevant issue to be resolved was whether common law instructions should be allowed to continue to operate given that the QLRC was proposing to include statutory AHDs as part of the decision making regime. These directives, under the proposed reforms, needed to comply with certain formal requirements that were not necessary for recognition of directives at common law.

The Commission recognised that there are arguments both in support of and against recognising common law directives. The arguments identified by the QLRC and others are considered below.

Arguments in favour of recognising common law advance directives

A compelling reason why common law advance directives should be recognised is that this is consistent with the notions of self-determination and autonomy that were discussed earlier. The right to refuse medical treatment should not be lost simply because legislation exists that formalises the procedure for giving advance directives. The QLRC recommended preserving the common law as it would "maximise the opportunity for people to exercise control over their future medical treatment".[77]

Secondly, it is likely that the community would expect that directives that an adult has made in advance of losing capacity would be binding at a future time. In case studies A and B, for example, Patricia and Diane respectively are likely to think that their wishes would be binding on health providers. Recognising common law advance directives would therefore reflect existing community beliefs and views.

Thirdly, recognition of a less formal kind of advance directive (that is, a common law advance directive) could promote advance care planning within the community to a larger extent. Such planning is likely to result in treatment being more in accordance with patients' wishes, and there is some evidence to support this suggestion. A pilot program was conducted in Melbourne's Austin and Repatriation Medical Centre based on a United States program "Respecting Choices". Part of this program involved discussions with patients and families about end of life health care options.

---

[76] 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. As was discussed in Part 1, the *PAA* and *GAA* are based largely on recommendations made by the QLRC after a comprehensive review of the law in Queensland.

[77] 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, 358.

"Patient advance request" documents were completed on admission and placed at the front of the patient records.[78] A detailed review of the United States program indicated that completion of advance requests and enduring medical powers of attorney increased from 4% to 96% of patients over two years.[79] There was also evidence that in 98% of cases, end of life treatment was in accordance with the patient's wishes.

The extensive nature of the formal requirements for AHDs in Queensland may mean that fewer individuals complete these documents than would otherwise be the case. It is arguable that if there was a more informal way to document patient wishes, more patients may give an advance directive. This could occur, for example, on admission to hospital. However, because these instructions would not comply with the formality required by the *PAA*, they would not constitute AHDs under the legislation. Further, as the law currently stands, these sorts of instructions, although amounting to advance directives at common law, would not be recognised in Queensland.

Arguments against recognising common law advance directives

The first argument against recognising common law advance directives is that it would create a two-tier system under which both statutory AHDs and common law advance directives operated. This prompted the QLRC to comment that this "might lead to unnecessary uncertainty and could undermine any restrictions which the legislation attempted to impose."[80] One worry was that the legislation could be circumvented, for example, if the formality requirements regarding execution of an AHD were not met. In that case, the document could still be enforceable at common law despite not complying with the formality requirements that were imposed for sound policy reasons.

Secondly, and following on from the first argument, recognition of common law advance directives would not only result in a two-tier system, but those tiers would also apply different law without any justification for that difference. As will be discussed in Issue 2, AHDs in relation to withholding or withdrawal of life-sustaining measures will only operate in limited circumstances. For example, the adult must be very sick and fall within one of the conditions set out in s 36(2)(a) of the *PAA*. These limitations were inserted in the legislation for policy reasons. If common law advance directives were recognised, and they are not subject to these same limitations, it would undermine the policy choices made in the legislation.

Thirdly, common law advance directives may lack the specificity needed to be of assistance to health providers. To satisfy the formal requirements of the *PAA*, a doctor must certify as to the capacity of the adult to complete an AHD, the process of which would involve discussing the nature and content of the proposed document. This means that the adult will give careful consideration to the kind of treatment that

---

78 "Respecting Patient Choices – Use of Advance Care Plans" Australian Resource Centre for Healthcare Innovations Net News, 31 October 2002, available at http://www.archi.net.au/content/index.phtml/itemId/118374/fromItemId/117149.

79 BJ Hammes and BL Rooney, "Death and end-of-life planning in one mid-western community" (1998) *Archives of Internal Medicine* 158, 383-390.

80 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, 358.

he or she wishes to receive or refuse. It is likely that the document that is then completed will provide specific guidance to health providers who are later confronted with a decision regarding life-sustaining measures. A common law advance directive that results, for example, from a discussion with family members (as in case study B) is unlikely to provide the same detailed guidance to the health provider.

1.4 Reform issues

On balance, the QLRC recommended that the recognition of common law instructions should be preserved.[81] It was of the view that reform in this area should not detract from the common law rights that a person already had. The effect of the Commission's recommendations was that a person's common law instructions would be enforced without recourse to the statutory decision making regime if there were sufficient evidence that it represented the wishes of the person in the context of the particular health decision. Alternatively, a person had the right to execute an AHD under the proposed legislation. In the case of a conflict between the two, the Commission recommended that an AHD executed under the legislation would take priority.

The current position does not reflect what was intended to be the law by the QLRC. However, it would be possible to alter the *PAA* to give effect to common law advance directives should that be the approach desired. This could be done by amending s 39 of the *PAA*. It currently reads:

> ***39 Common law not affected***
>
> *This 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.*

It is suggested that the words "This Act does not affect" be replaced by "Neither this Act nor the *Guardianship and Administration Act 2000* affects" so that it would read:

> ***39 Common law not affected***
>
> *Neither this Act nor the Guardianship and Administration Act 2000 affects common law recognition of instructions about health care given by an adult that are not given in an advance health directive.*

Such a provision would permit the recognition at common law of instructions given about health care despite those instructions not being in an AHD that complies with the formal requirements of the legislation. This would mean that Patricia's "No Blood" card and Diane's directions to her family in our case studies could be effective to refuse treatment.

---

[81] 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, 357-358.

Q1: Should the *PAA* and *GAA* recognise a valid common law advance directive as being binding on health providers?

Q2: If you answered "yes" to Q1, should there be any limitations (like those discussed in Issue 2) on the extent to which a common law advance directive can operate?

Issue 2 – Limits on the operation of advance health directives

2.1 The problem

The *PAA* imposes some limits on when an AHD that directs the withholding or withdrawal of a life-sustaining measure can operate. For example, one limit is that an adult's health must be sufficiently poor. The effect of these limits is that a person cannot use an AHD executed under the legislation to make all of their health decisions. The question posed here is whether these limitations are appropriate.

Case studies C, D and E illustrate a number of issues that arise out of the limitations set out in the legislation.

Case study C

Jeremy is a 45 year old man who has just had a significant stroke. It has severely damaged his mental capacity and he is now unable to leave his bed. His condition will not improve but he will continue to live for at least another decade. Unfortunately, Jeremy is also unable to swallow and so requires the insertion of a PEG tube to be artificially fed and hydrated. Prior to the stroke, Jeremy executed an AHD which stated that he did not want to receive life-sustaining measures (including artificial nutrition and hydration) if he was not able to live independently.

Case study D

Francesca is a 22 year old woman who has multiple sclerosis. She has become increasingly tired of the extensive health regime needed to manage her illness (which includes 3 hours of physiotherapy a day). Although her doctors have advised that she probably has between three to five years before she dies, she decides to complete an AHD which states that she does not want life-sustaining measures if they become necessary.

Francesca takes a turn for the worse and develops pneumonia which is so severe that she develops a fever, loses capacity to make decisions and requires artificial ventilation. The doctors are confident that she will recover from this bout of pneumonia but, in the meantime, ventilation is maintained. Francesca's mother produces the validly executed AHD to the doctor.

Case study E

Katrina is terminally ill with bone cancer and is expected to die within a year. She develops an infection in her thigh bone but decides that she does not want it to be treated. Accordingly, she executes a valid AHD which states that she does not want life-sustaining measures, including antibiotics. As the infection takes hold, she develops a fever and becomes unable to make decisions about her own health care. The infection can be treated cheaply and easily with antibiotics. Dr Wilson is aware of the AHD but decides that because the infection is relatively easy to cure, the antibiotics should be given.

2.2 The common law

At common law, there are no limits placed on the circumstances when an advance direction about health care can operate. Once it is established that the person had capacity at the time of making the direction and that the direction applies to the decision to be made,[82] it is binding.[83] So there is, for example, no requirement that a patient be suffering from a terminal illness before their advance direction could operate. This is based on the right to self-determination in that an adult can make decisions about their bodily integrity.[84]

Accordingly, in the three case studies list above, the wishes of Jeremy, Francesca and Katrina not to receive life-sustaining measures will be followed.

2.3 The *PAA*

As was discussed in Part 2 of the Issues Paper, the *PAA* provides that a direction to withhold or withdraw life-sustaining measures in an AHD cannot operate unless two or three conditions are met, depending on the circumstances.[85]

The first is that the adult's health must be sufficiently poor and the legislation requires the adult's condition to fall within one of four categories:

- a terminal illness (or a condition that is incurable or irreversible) from which the adult is expected to die within a year;
- a persistent vegetative state;
- permanently unconscious; or

---

82 Compare *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649 where the adult's direction not to receive blood products did not apply to the ultimate clinical decision that had to be made because the adult's direction related to a situation in which alternative products would have been adequate treatment.

83 For a more detailed consideration of when an advance directive will be binding at common law, see B White and L Willmott, "Will You Do As I Ask? Instructions About Health Care in Queensland" (2004) 4 *Queensland University of Technology Law and Justice Journal* 77, 78-80.

84 *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, 661-662.

85 *PAA*, s 36(2).

- 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. This condition is clearly satisfied where, for example, the adult is in a persistent vegetative state or suffering from end stage dementia.

However, the position is not so clear in a situation such as case study E. As Katrina's infection worsens, she loses the capacity to make a decision about a health matter. The problem is that it is unclear whether the requirement of s 36(2)(c) that the adult "has no reasonable prospect of regaining capacity" is satisfied in this kind of case. If her condition is not treated, Katrina certainly does satisfy the requirement as she will not regain capacity. However, if treatment is given, she will regain capacity. Given these two potential interpretations, the meaning of the limitation in s 36(2)(c) should be clarified.

This issue also has significant implications where a person executes an AHD refusing CPR. If CPR provides a reasonable prospect of regaining capacity, then the legislative requirement contained in s 36(2)(c) may prevent the AHD from operating. This may be an issue, for example, if an adult has terminal cancer and executes an AHD directing that he or she does not wish to receive CPR. If his or her condition is such that CPR provides a reasonable prospect of regaining capacity, that requirement in the legislation may not be met and the direction in the AHD will not operate.

The third condition that can limit the operation of an AHD as it relates to life-sustaining measures applies only if the document is being relied upon to not provide 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.

2.4 Reform issues

The limitations in the legislation are obviously a change to the common law and may raise some difficulties.

In case study C, Jeremy's wishes as stated in his AHD cannot operate unless inserting the PEG tube and providing artificial nutrition and hydration is inconsistent with good medical practice. This veto of good medical practice goes beyond what exists at common law.

It is worth noting that this requirement regarding good medical practice applies only in relation to artificial nutrition and hydration. This raises two issues, the first of which is whether it is appropriate for good medical practice to have a veto over such a decision. This issue is addressed generally below in Issue 9. The second issue (and the primary one being considered here) is whether there is any justification for the special treatment given to artificial nutrition and hydration. By contrast, if Jeremy needed to be ventilated or given life saving antibiotics after his stroke, compliance with good medical practice would be irrelevant.

In case study D, Francesca's AHD cannot operate because Francesca's condition does not meet one of the required conditions in the *PAA*. She is not expected to die within one year, she is not permanently unconscious nor in a persistent vegetative state and her illness is also not so serious at this stage that she won't recover from it. Accordingly, her wishes as set out in the AHD need not be followed.

A further difficulty in this area, as illustrated in case study E, is the uncertainty that arises in relation to operation of s 36(2)(c). It is likely that it was the intention of the legislature that AHDs would only be effective in allowing life-sustaining measures to be withheld or withdrawn if the adult had no reasonable prospect of regaining capacity *if given appropriate treatment*. This is consistent with the legislature's attempt in s 36(2) to limit the circumstances in which the AHD would operate in the context of life-sustaining measures. If this is correct, Katrina's AHD would not operate. A similar issue may arise in case study D.

Two matters probably need to be addressed in relation to this condition. The first is whether, as a matter of policy, Katrina's and Francesca's AHDs should operate. The second is that, whichever policy option is chosen, the provision should be redrafted so that its meaning is clear.

A final point is to contrast the common law with the law as stated under the *PAA* and, for the purposes of this exercise, we will assume that the legislative regime recognises the validity of common law directives, as Parliament originally intended.[86] An AHD completed under the *PAA* is more likely to be a reliable and honest reflection of the wishes of a person than a common law directive because of the extensive procedural safeguards, including the requirement to have a doctor discuss the adult's views and then witness the document. The conditions in s 36(2) lead to the absurd situation that the greater the formal safeguards attached to the directive, that is an AHD under the *PAA* rather than at common law, the less scope for operation it has. By contrast, a common law directive, which can simply be a verbal statement prior to losing capacity, can apply in a range of situations where a formal AHD could not.

Q3: Should the *PAA* continue to require that AHDs cannot operate unless the adult's health is sufficiently poor such that it meets one of the conditions described in s 36(2)(a) as set out above?

Q4: Should the *PAA* continue to require that AHDs cannot operate unless the adult does not have a reasonable prospect of regaining the capacity needed to make decisions about his or her health?

---

[86] It was suggested in Issue 1 that common law directives are not able to operate in Queensland after the *GAA* was passed.

Q5: Should the condition discussed in Q4 (that the adult has no reasonable prospect of regaining capacity for health matters) be regarded as being met if the treatment that the AHD purports to refuse could enable the adult to recover that capacity?

Q6: Should the *PAA* continue to draw a distinction in AHDs between artificial nutrition and hydration and other kinds of life-sustaining measures by imposing a requirement of good medical practice on the former but not the latter?

Issue 3 – Protection for health providers relying on invalid advance health directives

3.1 The problem

The *PAA* sets out rigorous formality requirements for executing an AHD. An AHD must be in writing, signed by the adult, and be signed and dated by a witness[87] who must certify that the adult appeared to have capacity to make the document.[88] It must also include a certificate signed and dated by a doctor stating that the adult had the capacity to make the AHD.[89] These complex requirements may inadvertently not be satisfied and this raises the issue of whether there is sufficient protection afforded to a health provider if he or she relies, in good faith, on a document that does not comply with the formalities of the legislation.[90]

Case studies F, G and H illustrate this concern.

Case study F

Rhonda was 65 years old when she was diagnosed with dementia. Soon after her diagnosis, she completed an AHD under which she directed that, should she lose her capacity to make decisions for herself, she did not want to receive any life-sustaining measures that might be needed to keep her alive. The AHD is duly executed in all respects except that the witness did not date the document.

Rhonda's condition deteriorated quickly and she has now lost capacity to make health decisions for herself. She is being cared for by her daughter, Gloria, who is also her statutory health attorney under the legislation.[91] Rhonda is in hospital for a minor procedure and unexpectedly suffers a cardiac arrest. Dr Jones had read Rhonda's AHD and so relies on it to not provide Rhonda with cardiopulmonary resuscitation ("CPR"). He did not notice that the witness did not date the document. Rhonda dies.

If the decision had been left to Gloria as statutory health attorney (which would have been the case in the absence of an AHD), she would have directed that her mother be given CPR. Such a course would also have been consistent with good medical practice.

---

87 *PAA*, s 44(2)-(3). There is also provision for an AHD to be signed on behalf of the adult: *PAA*, s 44(3)(a)(ii).

88 *PAA*, s 44(4).

89 *PAA*, s 44(6).

90 The formality requirements of the legislation also extend to enduring powers of attorney under which an attorney can be appointed to make a decision about a health matter. Some of the concerns about the protection of health providers that are discussed in this issue may also apply where a health provider acts upon the instructions of an attorney appointed under a document that fails to comply with the formal requirements.

91 *PAA*, s 63(1).

Case study G

Assume the same factual situation as in case study F, except that the AHD did not contain a certificate by a doctor testifying to Rhonda's capacity to complete the AHD.

Case study H

Assume the same factual situation as in case study G, except that Dr Jones asked a nurse about directions that were contained in Rhonda's AHD, but did not check the document himself. The nurse did not notice that the AHD was not certified by a doctor. Dr Jones relies on the information from the nurse when Rhonda suffers a cardiac arrest and does not provide Rhonda with CPR.

3.2 Protection for health providers

A health provider who relies on an invalid AHD in many cases will be protected by s 100 of the *PAA*.

> ***100 Additional protection if unaware of invalidity in health context***
>
> *A person, other than an attorney, who, without knowing an advance health directive or a power for a health matter under an enduring document is invalid, acts in reliance on the directive or purported exercise of the power, does not incur any liability, either to the adult or anyone else, because of the invalidity.*

If a health provider does not fall within the protection of s 100, he or she may be at risk of prosecution. For example, in the circumstances of case study F, it may be that good medical practice required CPR to be administered to Rhonda. A failure to provide that treatment, that failure being contrary to good medical practice, may potentially expose Dr Jones to civil and criminal sanctions. He may have breached his duty to provide Rhonda with appropriate medical treatment.[92]

The following two requirements must be satisfied for a health provider to receive protection under s 100 of the *PAA*:

- the AHD was invalid; and
- the health provider did not know that the AHD was invalid.

Meaning of Invalidity

Section 100 contemplates either of the following being invalid:

- an AHD; or

---

[92] Further, if the AHD is invalid, Dr Jones may have committed an offence because he has withheld a life-sustaining measure (which may fall within the definition of "health care") without obtaining the appropriate consent under the legislation: *GAA*, s 79.

- a power for a health matter under an enduring document.

A "power for a health matter under an enduring document" refers to the situation where, for example, an adult confers upon another (through either an enduring power of attorney or an AHD) a power to make decisions regarding health matters.

Section 96 of the *PAA* defines "invalidity", but only as it relates to "a power under a document".

> ***96 Interpretation***
>
> *In this part –*
> *"invalidity", of a power under a document, means invalidity because –*
>
> *(a) the document was made in another State and does not comply with the other State's requirements; or*
>
> *(b) the power is not exercisable at the time it is purportedly exercised; or*
>
> *(c) the document has been revoked.*

The definition seems to be exhaustive in its terminology in that a power will only be invalid if any of paragraphs (a) – (c) apply. Section 96 is silent regarding the situation where the document conferring the power is not properly executed as required by the legislation. Ordinarily a document that does not comply with formal requirements is regarded as "invalid". It is therefore surprising that such a situation is not included within the definition of invalidity in s 96.

The meaning of "invalidity" in the context of AHDs also raises difficulties. The *PAA* does not specify what is meant by "invalid" in the context of an AHD as the s 96 definition only applies to invalidity of "a power under a document".[93] It is likely that the meaning of "invalid" would include an AHD that does not comply with the formal requirements of the *PAA*, but this is not stated in the legislation. If this approach is correct, the AHDs referred to in case studies F, G and H would be invalid within the meaning of s 100 and its protection may apply.

Also unclear is whether the term "invalidity" includes an AHD that has been revoked or indeed never existed. Assume, for example, that the AHD in case study F had been duly executed but subsequently revoked. Dr Jones relied on the AHD and did not provide life-sustaining measures, not knowing that Rhonda's wishes had changed and the document had been revoked. It is probably the intention of the legislature that a doctor would be protected by s 100 in such a case. However, on a strictly legal analysis, the AHD is perhaps more correctly described as "no longer operative" rather than "invalid".

Knowledge of invalidity

A health provider who relies on an invalid AHD is protected under s 100 only if he or she does not "know" that the AHD (or the power for a health matter under an enduring document) is invalid. Again, s 96 of the *PAA* defines "know" but only in the

---

[93] Note, however, that s 96 may apply to an AHD if it grants power to an attorney to make a decision about a health matter. The authors are of the view that s 96 would not otherwise apply to an AHD.

context of knowing of the invalidity of a "power under an enduring document" rather than knowing of the invalidity of an AHD.

> ***96 Interpretation***
>
> *In this part –*
> *"know", of a power's invalidity, includes –*
>
> *(a) know of the happening of an event that invalidates the power; or*
>
> *(b) have reason to believe the power is invalid.*

The legislation does not clarify when a health provider will be regarded as having "knowledge" of invalidity of an AHD. This can create problems as there are a number of levels on which a person can be regarded as having "knowledge".

- Actual knowledge

The law as to what will be included as knowledge is somewhat unclear.[94] However, in general, a person will be held to know something only if he or she has actual belief in its truth,[95] so that knowledge is never imputed.[96] The term clearly incorporates actual knowledge, so if the health provider has actual knowledge that an AHD is invalid, he or she will not be able to rely on s 100. It would, of course, be unusual for a health provider to base their decision not to treat on an AHD that they know is invalid.

Case study F is likely to represent a more common scenario where an AHD is relied upon in the belief that it is valid, but it is in fact invalid through a failure to comply with the formalities of the legislation. In case study F, the witness did not date the document, and Dr Jones was not aware of this omission. Section 100 is likely to afford protection in this case. The legislation does not impose on a health provider a precondition for protection under s 100 that he or she takes reasonable steps to check the AHD to ensure that it is validly executed.

- "Imputed" knowledge

Although the health providers in case studies G and H do not have actual knowledge of invalidity of the AHD, these examples are more problematic. In case study G, Dr Jones himself read the document but did not realise that a doctor had not certified as to the adult's capacity to complete the AHD. In case study H, Dr Jones relied on the nurse who failed to notice this deficiency. The AHD is clearly invalid because the formality requirements have not been met, but in neither case does Dr Jones have actual knowledge of the invalidity. However, this is knowledge that he would have if he had read the AHD more closely in case study G, or read it at all in case study H. This raises the question of whether Dr Jones should be regarded (or imputed) as having the knowledge that a person would have possessed if he or she had made the inquiries that a reasonable person would have made in the circumstances.

---

94 See generally "Knowledge", Butterworths Online, [6-515], available at http://www.butterworthsonline.com. In particular, the uncertainty arises because cases in this area involve interpretation of other statutes, which have different purposes and often use different language and concepts (for example, the word "knowing", or the concept of intention).

95 *R v Raad* [1983] 3 NSWLR 344, 346.

96 *Giorgianni v R* (1985) 156 CLR 473, 504-507.

As the legislation currently stands, it is not a precondition for protection under s 100 that a health provider takes reasonable steps to check the AHD to ensure that it is validly executed. The health provider therefore would probably not be regarded as having knowledge in case studies G and H.

- "Wilful blindness"

Another possible scenario which is not adequately addressed by the legislation is where a health provider *suspects* an AHD has not been properly completed but *deliberately* refuses to check in case he or she discovers that the document has not been properly executed.[97] In a case such as this, it may be that "knowledge" is interpreted more broadly than just actual knowledge. It has been said that "…if the suspicions of [a person] are aroused, and he [or she] deliberately refrains from making any inquiries for fear that he [or she] may learn the truth, his [or her] 'wilful blindness' may be treated as equivalent to knowledge."[98] Wilful blindness is a refusal to acknowledge the existence of facts that are apparent from the circumstances, such as failing to make inquiries in a situation that makes clear that further investigation is needed.[99] In our situation, if the health provider had information that alerted him or her to the fact that the AHD may be invalid but deliberately avoided checking the document so that he or she would not actually know of the invalidity, then perhaps this may be regarded as "knowledge" of the invalidity.

3.3 Reform issues

The preceding discussion raises two issues that are in need of clarification.

Meaning of invalidity

First, what is the meaning of "invalid" in s 100 in the context of an AHD? It is likely that it refers to a failure to comply with the formality requirements imposed by the *PAA*, but there are some doubts as to whether the term includes situations where an AHD has been revoked, or where the document has never existed. It may be desirable to define the term "invalidity" as it applies in the context of an AHD as well as in the context of a "power … under an enduring document" to clarify this issue. (It may also be helpful if the definition of "invalidity" in the context of a power under a document be expanded to include the situation when the document does not comply with the formality requirements of the legislation.)

Circumstances in which protection should be afforded

Secondly, there are difficulties regarding what is meant by "knowing" within s 100 in the context of an AHD. As the provision is currently drafted, it is unclear whether protection is only lost if the health provider has actual knowledge of the invalidity, or whether something less than that (for example, the potential imputed knowledge in case studies G and H) will mean that the health provider will lose the benefit of this protection.

---

97 Compare para (b) of the definition of "know" in s 96 of the *PAA*.

98 *He Kaw Teh v R* (1985) 157 CLR 523, 536 (Gibbs CJ, with whom Mason J agreed).

99 *He Kaw Teh v R* (1985) 157 CLR 523.

This raises a broader policy consideration. Protection is not, and should not, be afforded to a health provider who has actual knowledge of the invalidity of an AHD yet relies upon it. However, as we have seen, not all cases are so clear cut.

- Requirement to act in good faith?

Should a health provider be protected if he or she suspects that an AHD is not validly executed but deliberately chooses not to investigate its execution so that he or she will not have actual knowledge of its invalidity? In this case, the doctor has not acted in good faith and arguably should not be protected.

- Requirement for reasonable care and skill?

Should a health provider be protected if he or she does not use reasonable care and skill to determine whether the AHD is validly executed? If protection were given only if this could be satisfied, it would mean that the health provider would need to take steps to ensure that the AHD has been validly executed. Whether the steps taken are reasonable or not will depend on the circumstances of the particular case. For example, a less demanding standard would be asked of a health provider if there was some element of urgency, as there may be less time to examine the AHD.

It may be a preferable approach for protection to depend on whether the health provider has acted in good faith and with reasonable care and skill, rather on the notion of "knowledge". This would mean that each case would be judged on its own circumstances. In some cases, for example, where the invalidity is less obvious (such as in case study F) and there was some urgency attached to treatment, it may be appropriate that the doctor is excused for not discovering the invalidity. On the other hand, if the AHD is clearly invalid (as in case study G and H) and there was no urgency associated with treatment, then it may not be appropriate for the health provider to receive protection under s 100. The invalidity of the AHD would have been apparent had the health provider acted with reasonable care and skill.

Under this alternative approach, the determining factors would be good faith and reasonable care and skill, rather than "knowledge" with the associated difficulties regarding the meaning of this term.

Q7: Should the word "invalidity" as used in the context of an AHD in s 100 of the *PAA* be defined to clarify the circumstances in which the protection will apply?

Q8: Should protection in s 100 of the *PAA* depend on whether the health provider has "knowledge" of the invalidity (as is currently the case), or on whether the health provider was acting in "good faith with reasonable care and skill" in ascertaining the validity of the AHD?

Q9: If you think that protection should depend on the health provider's "knowledge" (as is currently the case), should the meaning of the term be clarified in the legislation?

Q10: If you answered "yes" to Q9, which of the following should "knowledge" include:

(a) actual knowledge?
(b) imputed knowledge?
(c) wilful blindness?
(d) other (if so, please elaborate)?

Issue 4 – Protection for health providers where no knowledge of advance health directives

4.1 The problem

The previous issue considered the protection that is given to a health provider who acts upon a direction in an invalid AHD. This issue also deals with protection that is given to a health provider, but in circumstances where directions in an AHD are not followed because the health provider did not know that the document existed.

Case studies I and J illustrate the issue.

Case study I

Scott is a 60 year old University academic who lives on his own. He executed a valid AHD after he was diagnosed with terminal cancer. He is expected to die within one year. His AHD indicates that he did not want to receive life-sustaining treatment under any circumstances. Scott suffered a heart attack and was taken to hospital. His condition stabilised but he was still very ill and it looked unlikely that he would recover to the extent that he would have much decision making ability left intact. Scott's sister was his statutory health attorney and was contacted on his admission. Scott's condition deteriorated further and it looked as if life-sustaining measures would be required to keep him alive so his sister consented to the giving of this treatment. Neither the treating doctor, Dr Walsh, nor Scott's sister were aware of the existence of the AHD.

Case study J

Assume the same facts as in case study I, except that Scott's sister told Dr Walsh that she knew Scott had executed a document regarding future treatment. Dr Walsh did not believe in AHDs so had not taken any notice of the statement, nor asked Scott's regular doctor for details about the document.

4.2 Protection for health providers

Section 102 is the relevant provision of the PAA that may provide protection to a health provider who acts contrary to a direction in an AHD of which he or she is unaware.

102 Protection of health provider unaware of advance health directive

A health provider is not affected by an adult's advance health directive to the extent the health provider does not know the adult has an advance directive.

Knowledge of AHD

As in the previous issue, the protection of a health provider turns on his or her "knowledge" of the AHD. The meaning of this term for the purpose of s 102 is not clear because it is not defined and the same problems arise as outlined in Issue 3.

- Actual knowledge

The protection clearly extends to the situation, as in case study I, where the health provider does not follow the direction in an AHD because he or she did not have knowledge that one existed. The treating doctor, Dr Walsh, would therefore be protected.

- "Imputed" knowledge

Case study J is more difficult. Although Dr Walsh does not have actual knowledge that a valid AHD exists, if he had made the inquiries that a reasonable person would have made in the circumstances, he may have discovered its existence and whereabouts. As in Issue 3, however, it is currently not a precondition for protection under s 102 that a health provider take reasonable steps to establish whether or not an AHD exists.

- "Wilful blindness"

Case study J may alternatively raise the issue of wilful blindness. This concept was explained in Issue 3. Dr Walsh did not have actual knowledge of the AHD; he was, however, put on notice that a document regarding future treatment existed. It is likely that he surmised that this was an AHD and, for his own reasons, he did not take any action to establish its existence or contents. If the term "knowledge" refers to actual knowledge of its existence, then Dr Walsh would be protected because he does not know it is an AHD. On the other hand, if "wilful blindness" can be regarded as the equivalent of "knowledge" (and, if the evidence suggests that Dr Walsh has been "wilfully blind" in this case), then he will not be protected by s 102. The uncertainty in the provision is unsatisfactory and should be clarified.

4.3 Reform issues

In addition to the lack of clarity regarding the meaning of the word "know", a broader policy consideration arises from s 102 and that is whether protection should only be given if health providers act in good faith and with reasonable care and skill in establishing whether an AHD exists. This was considered under Issue 3 and that discussion is also relevant here. If Dr Walsh had acted in good faith and with reasonable care and skill in case study J, he would have made inquiries of Scott's treating doctor about the existence of an AHD and ascertained its contents. If this occurred, the AHD is likely to have governed his treatment rather than a decision being made by Scott's sister as statutory health attorney.

A possible reform option would be to make the protection conferred by s 102 conditional upon a health provider acting in good faith and with reasonable care and skill to establish whether an AHD existed. A requirement to act in good faith would

mean that a health provider could not turn a blind eye when put on notice as to the possibility that an AHD has been executed. Secondly, a requirement to act with reasonable care and skill means that different steps would be required to satisfy this requirement depending on the circumstances of the case. It may be that in the ordinary course of treatment, reasonable care and skill would require a health provider to enquire of a patient (or his or her family) as to whether an AHD had been executed. However, if there is a degree of urgency with the treatment, it may be reasonable for the health provider to take fewer steps to ascertain the existence of such a document due to the need to treat quickly.

Q11: Should protection in s 102 of the *PAA* depend on whether the health provider has "knowledge" that the adult has an AHD (as is currently the case), or on whether the health provider was acting in "good faith with reasonable care and skill" in ascertaining whether an AHD exists?

Q12: If you think that protection should depend on the health provider's "knowledge" (as is currently the case), should the meaning of the term be clarified in the legislation?

Q13: If you answered "yes" to Q12, which of the following should "knowledge" include:

- **(a) actual knowledge?**
- **(b) imputed knowledge?**
- **(c) wilful blindness?**
- **(d) other (if so, please elaborate)?**

Issue 5 – Deliberate non-compliance with advance health directives: a statutory excuse?

5.1 The problem

The previous issues considered the protection that is given to a health provider in two cases. The first case was where a health provider acts upon a direction in an invalid AHD, and the second was where he or she does not act upon a direction because he or she did not know about the AHD. This issue deals with a different but associated issue: the protection that is given to a health provider who does not rely on a valid AHD even though he or she knows of its existence.

A person who executes an AHD directing that he or she not be given life-sustaining measures in specified circumstances does so in the expectation that those directions will be respected. Yet, the *PAA* provides very broad protection for a health provider who chooses not to comply with a direction in an AHD that is otherwise legally binding. The health provider may prefer to treat the adult on the basis of what he or she regards to be principles of good medical practice, despite the adult's wishes.

Case studies K and L raise two different examples of this issue.

Case study K

Tran is a 30 year old woman with terminal cancer who is expected to die within a year. She has completed an AHD directing that she not receive life-sustaining measures even if they are needed to keep her alive. She has advised her treating doctor, Dr Jones, of the directions in her AHD. Dr Jones does not approve of AHDs, particularly in the circumstances of a patient like Tran who is still young and should be able to derive some enjoyment from her last year of life.

Tran collapses and is rushed to hospital. Dr Jones is contacted and directs the staff to commence artificial respiration despite Tran's directions not to do so in her AHD. Although Dr Jones has serious doubts about whether Tran will recover from this unexpected set back, he thinks it inappropriate, as a matter of good medical practice, to follow the directions in the AHD at this stage. He prefers instead to provide artificial respiration and assess her condition once she stabilises.

Case study L

Assume the same facts as in case study K, except that after completing the AHD, Tran's personal circumstances have altered and she has indicated to Dr Jones that she is pleased that she still has a year left to live so that she can put her affairs in order and make peace with members of her family.

5.2 Protection for health providers

Section 103 is the provision of the *PAA* that may provide protection to a health provider who has not followed directions in an AHD.

> ***103 Protection of health provider for non-compliance with advance health directive***
>
> *(1) This section applies if a health provider has reasonable grounds to believe that a direction in an advance health directive is uncertain or inconsistent with good medical practice or that circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.*
>
> *(2) The health provider does not incur any liability, either to the adult or anyone else, if the health provider does not act in accordance with the direction.*
>
> *(3) However, if an attorney is appointed under the advance health directive, the health provider has reasonable grounds to believe that a direction in the advance health directive is uncertain only if, among other things, the health provider has consulted the attorney about the direction.*

Section 103 of the *PAA* permits a health provider to avoid liability for not following an AHD in three circumstances. The first is if the health provider has reasonable grounds to believe that the direction is uncertain. This mirrors the common law as it requires a person to state their wishes clearly if they are refusing life-sustaining measures.[100]

The second circumstance is where the health provider has reasonable grounds to believe that a direction is inconsistent with good medical practice. This is the most controversial of the three circumstances in s 103 and such a defence has not been recognised at common law. Case study K provides an example of this situation. Dr Jones has decided not to follow Tran's AHD because he regards her decision as being inconsistent with good medical practice.

One of the difficulties that this part of the defence raises is that an AHD may only be effective to the extent that it is not inconsistent with a health provider's view (based on reasonable grounds) of what is good medical practice. This may erode one of the important functions of these documents: to make choices that others (including an adult's health provider) may not agree with.

Such a defence is also inconsistent with the philosophy behind s 36 which purports to allow AHDs to operate in situations where the direction is not consistent with good medical practice. Stating that artificial nutrition and hydration cannot be withheld or withdrawn unless its commencement or continuation is inconsistent with good medical practice implies that good medical practice will not limit the operation of an AHD directed to other life-sustaining measures.

The third circumstance where a health provider need not follow an AHD is if the health provider has reasonable grounds to believe that "circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate." This aspect of the section may also have a common law equivalent

---

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

in that there is case law which suggests that wishes in an advance directive "will not survive a material change in circumstances".[101] Case study L may be an example of where it is reasonable to disregard an AHD. Tran's wishes are no longer adequately reflected by her AHD and health providers should be able to treat her accordingly without fear of committing an offence.

5.3 Reform issues

The two different case studies above illustrate the difficulties in this area. Although AHDs are important documents and should not be capable of being disregarded, there may be circumstances where it is appropriate not to follow their directions. However, if it is accepted that people should have the right to disagree with what might be medically indicated, it is important to limit those situations where AHDs are not followed to appropriate cases.

Q14: Should health providers be able to not follow AHDs if they believe that the directions in these documents are:
(a) uncertain?
(b) inconsistent with good medical practice?
(c) inappropriate because circumstances have changed since the document was executed?

[101] *Re HE* [2003] 2 FLR 408, [29].

Issue 6 – Proving copies of advance health directives

6.1 The problem

The *PAA* sets out rigorous requirements for the execution and witnessing of an AHD before it will be valid. The legislation also sets out a rigorous set of requirements for proving that a copy of an AHD (and enduring documents in general) is a true and complete copy of the original document. This raises the question of when and whether a health provider can rely on a copy of an AHD.

Case studies M and N illustrate the issue.

Case study M

Greg is suffering from terminal cancer and his prognosis is that he has only months left to live. He has executed an AHD directing that he not receive life-sustaining measures if this sort of medical treatment is needed to keep him alive. The AHD is duly executed and is kept at home with his personal documents. He has photocopied the document and given the photocopy to his wife, Amanda, so that she will know what medical treatment he wants (or does not want) should he lose capacity to make his own decisions.

Greg is having trouble breathing and Amanda takes him to hospital. By the time they arrive, Greg has collapsed and the medical staff want to commence artificial respiration. Amanda shows the treating doctor her copy of the AHD but the treating doctor, Dr Wilson, responds that he is unable to act on that copy as it is not duly certified as a true copy.

Case study N

Glenda is a 58 year old woman who lives in Brisbane. She is suffering from a terminal illness and has only a few months to live. Recently, Glenda had a heart attack and the ambulance was called by her neighbour. Glenda was revived and taken to hospital where her condition remained unstable. Mary is Glenda's daughter and the only one of Glenda's relatives living in Brisbane. The treating doctor, Dr Gordon, discussed Glenda's condition with Mary and said that he thought it likely that she will have another heart attack. Glenda has also suffered significant brain injury and it is unlikely that she will recover her mental capacity.

The next day, Mary returns with some papers she found amongst her mother's belongings. One of these documents is a photocopy of an AHD which states that Glenda does not want CPR if it is needed. When Glenda suffers a second heart attack, Dr Gordon does not commence CPR in accordance with the AHD that Mary produced, and Glenda dies.

Three days later, Arnold, Glenda's son, flies to Brisbane for her funeral and in the course of being executor of her will discovers evidence that Mary has faked the AHD by photocopying Glenda's signatures in the relevant places.

6.2 Authenticity of AHD

The issue here is how a copy of an enduring document, in our cases, an AHD[102] may be proved so that a health provider can rely on it as a true and complete copy. The relevant provision is s 45 of the *PAA* which provides for a procedure that involves certifying that each page of the copy, other than the last page, is a true and complete copy of the original.[103] The last page of the copy must also then be certified to the effect that the copy is a true and complete copy of the original.[104] Having outlined this process for proving a copy of an enduring document, s 45(6) then states: "This section does not prevent an enduring document being proved in another way."

One problem with s 45 is that, although the section sets out clearly one way in which a copy can be proved, there is no guidance as to how it may be "proved in another way". Accordingly, a health provider confronted with a copy that is not proved by the certification method discussed above may *potentially* be able to rely on that copy (because an uncertified copy could be "another way" to prove the document), but this is uncertain because the legislation is so general.[105]

6.3 Outcomes

There are situations where this uncertainty won't matter. One example, using case study M, is if Dr Wilson relied on the uncertified copy of Greg's AHD and the original document is later produced. The *GAA* provides that if there is a valid and applicable AHD, then the matter must be dealt with according to that document,[106] which is what has occurred here.

But there are situations where this uncertainty can cause problems. One is illustrated by case study M where Dr Wilson refuses to act on an uncertified copy of an AHD because he is unsure whether it is a true and complete copy. Although a photocopy *may* be considered sufficient proof of the original as discussed above, this is not certain and Dr Wilson would be entitled to refuse to follow the AHD. Section 102 excuses not following an AHD if the health provider does not know of it[107] and

---

102 *PAA*, s 28.
103 *PAA*, s 45(2).
104 *PAA*, s 45(3).
105 Indeed, an argument has been put forward that the effect of s 45(1) and (6) is that "another way" of proving the document cannot be by using such a copy because the section prescribes the only way that a *copy* can be proved and that is as certified as required by the section. This interpretation contemplates that the document may be proved in another way, for example, verbal authentication by a third party.
106 *GAA*, s 66(2).
107 See further Issue 4 regarding the meaning of "know" in the context of s 102.

presumably if the document is not *proven* a health provider could reasonably say that he or she did not have the required knowledge.

Another set of problems can arise where a doctor does act on an uncertified copy of an AHD. One example, illustrated by case study N is where fraud has been committed and the copy produced is not one of a document completed by the adult. The copy purporting to be Glenda's AHD has not been certified under s 45 so unless it is proved in "another way" (which seems very unlikely given that fraud has been involved), Dr Gordon could be liable for withholding CPR if this is not the appropriate treatment in the circumstances. He could perhaps try to seek the protection of Chapter 5 Part 5 of the *PAA* but for reasons discussed above, there is some doubt as to whether this Part would apply.[108] It may be, however, that there are other defences that could apply such as the defence of an "honest and reasonable" mistake of fact[109] in that Dr Gordon honestly and reasonably believed the copy to be genuine.

6.4 Reform issues

The foregoing discussion raises an important issue, namely whether there is a more effective and convenient way to ensure the authenticity of an enduring document. One possibility that may be worth investigating is establishing a central registry in which AHDs can be registered. Registration of an AHD would constitute evidence of validity and authenticity upon which a health provider could rely. If health providers are able to search such a register, the problems illustrated in case studies M and N would be avoided.

Registries of various kinds of enduring documents have been established in other jurisdictions. In Singapore, for example, a register of "advance medical directives" has been established by statute,[110] and a person who makes an advance medical directive must register it with the Registrar.[111] A health provider is prohibited from acting on an unregistered directive.[112] In the United States, private registries have been established for the electronic storage of advance directives. Such registries are funded through registration fees paid by health providers for the right to access and search the register and, in some cases, by those seeking to register their directives. For examples of private registries that have been established in the United States, see www.webdirectives.com or www.uslivingwillregistry.com.

In the absence of a strategy to deal with problems of authenticity, such as a registry, there are two aspects of s 45 of the *PAA* that may need to be addressed. The first issue is whether the provision should be amended so as to clarify its operation. In particular, how an enduring document can be proved in "another way" should be

---

[108] See Issue 3 for a discussion of circumstances where those relying on an invalid enduring document will be protected under s 100 *PAA*. This protection may not cover case study N because arguably there is no AHD at all, only a fraudulently produced document purporting to be an AHD. See Issue 5 for a discussion of protection given by s 103 *PAA*. This too is not likely to apply because it excuses circumstances where AHDs are not followed, which is not the situation here.

[109] *Criminal Code 1899* (Qld), s 24.

[110] *Advance Medical Directive Act 1996* (Singapore).

[111] *Advance Medical Directive Act 1996* (Singapore), s 5(1).

[112] *Advance Medical Directive Act 1996* (Singapore), s 5(3).

explained and it would perhaps be useful to include examples of how this might be done in the legislation.

The second issue is whether it is appropriate to require copies of enduring documents to be certified in such a formal way. It is very unlikely that those who complete such a document are aware of these formality requirements. Rather, it is suggested that most people would simply photocopy their AHD and give those uncertified copies to the relevant people. Although there may be some concerns about protecting against fraud, there may also be compelling arguments to try and give effect to an adult's wishes as simply and effectively as possible.

Q15: Would establishing a central register of AHDs be an appropriate way to resolve concerns about the authenticity of these documents? Please provide reasons for your view.

Q16: In the absence of a central register, should s 45 of the *PAA* be clarified to explain how an enduring document may be proved in "another way"?

Q17: If you answered "yes" to Q16, should the certification and other requirements imposed by s 45 of the *PAA* be relaxed so that a complete photocopy is sufficient to prove an enduring document?

Issue 7 – Emergency treatment and advance health directives

7.1 The problem

A person who executes an AHD directing that he or she not be given life-sustaining measures in specified circumstances does so in the expectation that those directions will be respected. However, health providers can be placed in a difficult position when called upon to give emergency treatment and are then told by a third party that the patient does not want life-sustaining measures to be initiated. This situation can potentially raise the following issues:

- What should be the course of action for a health provider in an emergency situation when advised of a patient's AHD directing that treatment be withheld?
- What protection is afforded to a health provider who, unsure of the validity or content of an AHD, nevertheless administers life-sustaining measures to the patient?

Case study O illustrates the issue.

Case study O

Gary is an ambulance officer. He received a call to a residential address having been advised that an elderly woman, Margaret, collapsed and was not breathing. Gary arrived within minutes and was about to intubate Margaret but before he could do so, her daughter intervened, declaring that Margaret had executed an AHD. (The daughter was holding a document at the time.) She said that Margaret was dying of cancer and she didn't want to be revived. The daughter explained that she had simply panicked when Margaret stopped breathing and that she shouldn't have called for assistance. If Gary does not initiate life-sustaining measures immediately, Margaret will sustain severe brain damage. There is no time to check the validity and details of the AHD.

7.2 The common law

At common law, a health provider owes his or her patient a duty under the law of negligence to act with reasonable care and skill.[113] In the case of a life-threatening

[113] *Rogers v Whitaker* (1992) 175 CLR 479. Although note that in this context of emergency, it is unlikely that a health provider will owe a legal duty to provide medical care to someone who is not an existing patient; compare *Lowns v Woods* (1996) Aust Torts Rep 81-376.

emergency, this duty would generally require the treating health provider to administer appropriate treatment.[114] If the treatment is considered to be one of the "necessaries of life" (as it may be in such a situation), then a health provider who is in charge of the patient's care would also be under a duty imposed by the criminal law to provide that treatment.[115]

As for all treatment, consent should be obtained before providing care,[116] but in the case of an emergency this may not be possible if the person has lost capacity. In such circumstances, the common law doctrine of necessity allows medical assistance to be provided, where it is necessary to act, where medical assistance is a reasonable response and where the treating health provider does "no more than is reasonably required".[117] A limit on this, however, is that necessity cannot justify the giving of treatment where the patient has clearly refused it in advance of losing capacity.[118]

7.3 The *PAA* and *GAA*

The *GAA* interposes upon the doctrine of necessity. Section 63 permits urgent health care[119] to be given without obtaining consent if the health care "should be carried out urgently to meet imminent risk to the adult's life or health".[120] As at common law, a limit on the ability to treat without consent in this situation is if the adult's "health provider knows the adult objects to the health care in an advance health directive".[121]

Knowledge

The major difficulty from a health provider's perspective is raised by the phrase "knows the adult objects" because it is unclear when a health provider will be considered to *know* of an objection. The legal uncertainty surrounding the meaning of the term "know" was raised earlier in different contexts.[122] Although similar issues arise here, because the treatment is being provided in an emergency context, there is less scope for a health provider to take steps to satisfy him or herself whether a valid AHD was in existence and whether it applied to the situation with which he or she may be confronted.

---

114 There are, of course, exceptions. For example, at common law, a health provider is not obliged to provide futile treatment as it is not in a patient's best interests: *Airedale NHS Trust v Bland* [1993] AC 789; *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061.

115 The phrase "necessaries of life" comes from s 285 of the *Criminal Code 1899* (Qld) but the common law also recognises this duty: *R v Stone* [1977] QB 354. This duty to provide the necessaries of life under the *Criminal Code 1899* (Qld) is discussed further in Issue 14.

116 *In re F (mental patient: sterilisation)* [1990] 2 AC 1, 72; *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 233.

117 *In re F (mental patient: sterilisation)* [1990] 2 AC 1, 77.

118 *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649; *Malette v Shulman* (1990) 67 DLR (4th) 321.

119 Other than special health care: *GAA*, s 63(1). "Special health care" is defined in *PAA* and *GAA*, sch 2 s 7.

120 *GAA*, s 63(1)(b)(i). The section also applies to health care that "should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent" under the statutory regime: s 63(1)(b)(ii). See also s 63A of the *GAA* which permits a life-sustaining measure to be withheld or withdrawn in an acute emergency.

121 *GAA*, s 63(2).

122 See Issues 3 and 4 above.

If the health provider had actual knowledge that an AHD had been executed and covered the current situation, the treatment should not be provided. However, as considered above, the issue is whether other degrees of knowledge, namely imputed knowledge or wilful blindness, will also be caught. For example, does a health provider "know" of an objection merely by *suspecting* it to be the case but he or she fails to make inquiries? Does a health provider "know" of an objection if he or she, strongly believing treatment to be appropriate, deliberately avoids checking the AHD? Finally, does a health provider "know" of an objection if he or she is aware of the existence of the AHD but does not have time to check its contents or validity because of the urgency of the situation (as in case study O)?

Turning to our case study, it is likely that Gary is protected. He has no actual knowledge of the contents or validity of the AHD and is not deliberately refraining from further enquiries. He is simply unable to check the validity and contents of the AHD because the urgency of the situation requires him to act.

Having said that, however, once treatment has commenced, the AHD should be checked for validity and content. If the preconditions to the operation of the AHD are satisfied and it is a valid document, the directions in it should be followed and treatment withdrawn.

7.4 Reform issues[123]

It is important that someone in Gary's position who provides treatment as a matter of urgency be protected and it is likely that he would currently receive the protection of s 63. This is because he does not have actual knowledge of the validity and content of the AHD as the urgency of the situation prevents him from satisfying himself of these issues.

However, the position is not clear and there may be two possible reform options. The first is that suggested in Issues 3 and 4, namely to impose an obligation on a health provider when dealing with AHDs to act in good faith and with reasonable care and skill in ascertaining the validity and content of the AHD. As s 63 deals with treatment in an emergency context, it may be reasonable in a particular fact situation for a health provider not to take any steps to check the validity or content of the AHD. But what is reasonable will depend on the facts and, in another situation, it may be reasonable to require a health provider to investigate further.

---

[123] A minor suggestion not addressed in detail is that if the section is being revised, it might also be an appropriate time to modify an aspect of s 63 which does not create problems in law, but makes the section somewhat confusing. Section 63(5) provides that "health care" does not include "withholding or withdrawal" of a life-sustaining measure. However, the section itself unquestionably does regulate the withholding or withdrawal of life-sustaining measures in s 63(2) and 63(3), as these subsections require, in certain circumstances, that such life-sustaining measures "not be carried out".

An alternative approach would be to clarify the legislation by defining "knows" for the purpose of s 63 of the *GAA*.[124] It may also be appropriate to include an example along the lines of case study O to make it clear that an individual in Gary's situation will be protected from liability.[125]

Q18: Should protection in s 63(2) of the *GAA* depend on whether the health provider "knows" that the adult objects to the health care in an AHD (as is currently the case), or on whether the health provider was acting in "good faith and with reasonable care and skill" in ascertaining whether the adult objects to the health care in an AHD?

Q19: If you think that protection should depend on what the health provider "knows" (as is currently the case), should the meaning of the term be clarified in the legislation?

Q20: If you answered "yes" to Q19, should "know" include:
(a) actual knowledge?
(b) imputed knowledge?
(c) wilful blindness?
(d) other (if so, please elaborate)?

---

[124] Although the term "know" is used elsewhere in the legislation, it may be preferable to define the term specifically for the purpose of s 63. "Wilful blindness" in an emergency context might be different from the same concept where there is more time to ascertain the existence, validity and content of an AHD.

[125] For example: "The urgency of a situation may reasonably prevent a health provider from inquiring into the truth of his or her suspicion that the patient objects."

Section 2 – General Decision Making

This section deals with six issues that are relevant when another is making the decision to withhold or withdraw life-sustaining measures on behalf of an adult with impaired capacity.

The first three issues in this section focus on the criteria that are considered in these decisions, and in particular, on the role of "good medical practice". The first issue, Issue 8, considers the difficulties of assessing what are the requirements of good medical practice. The next issue queries whether the power (a veto based on good medical practice) given to health providers to prevent decisions to withhold or withdraw life-sustaining measures from operating is appropriate. Issue 10 then raises the more general matter of the different principles that the legislation requires decision makers to have regard to when making these sorts of decisions. It highlights the need for further guidance in situations where different principles suggest different outcomes.

The final three issues in this section raise some problems with definitions in the legislation. The first of these issues explores the possibility that the legislation might require a health provider to provide futile treatment unless consent to stop or not commence treatment is obtained. The next issue, Issue 12, then reveals that the definition of "health care" may inadvertently require all decisions to withhold or withdraw life-sustaining measures to be driven by good medical practice. Issue 13 asks whether the protection attached to treatment considered to be "life-sustaining measures" will apply to all care that is needed to keep a person alive.

Issue 8 – "Good medical practice": what does it mean?

8.1 The problem

The term "good medical practice" is used in the legislation in connection with decisions to withhold or withdraw life-sustaining measures. However, there are currently no guidelines that are available in Queensland to guide decision makers and health providers alike in determining whether or not particular treatment is consistent with good medical practice.

Case studies P and Q illustrate this issue.

Case study P

Violet is 75 years old and is very ill. She suffered a massive stroke 18 months ago which caused significant brain damage. As a result, she lost her swallowing reflex and a percutaneous endoscopic gastrostomy ("PEG") was inserted to provide her with artificial nutrition and hydration. Violet makes no meaningful response to visual, auditory, tactile or painful stimuli but the doctors are not in agreement regarding whether Violet could be regarded as being in a persistent vegetative state. Violet's family wants the PEG withdrawn as they do not want her to endure any further indignity.

Dr Walsh understands their request, but is concerned about whether such action would be lawful as it is certain to result in Violet's death.

Case study Q

James is 75 years old and is very ill. He suffered a massive stroke 18 months ago which caused significant brain damage. As a result, he lost his swallowing reflex and a percutaneous endoscopic gastrostomy ("PEG") was inserted to provide him with artificial nutrition and hydration. James makes no meaningful response to visual, auditory, tactile or painful stimuli but the doctors are not in agreement regarding whether James could be regarded as being in a persistent vegetative state. James has a son and a daughter. The son wants the PEG continued but the daughter wants it terminated. The matter is referred to the Adult Guardian.

The Adult Guardian talks to James' treating doctor, Dr Nelty about the matter. He advises that he has liaised with a number of his colleagues about James' condition and medical opinion is divided about the appropriate treatment in this case.

8.2 Good medical practice under the *PAA* and *GAA*

The role played by good medical practice under the legislation differs depending on whether a decision to withhold or withdraw life-sustaining measures is made by an adult through an AHD before losing capacity, or by someone on behalf of an adult. It is clear, however, from the following discussion that the notion of good medical practice plays a significant role in decisions to withhold or withdraw life-sustaining measures.

Advance health directive

If an adult has made an AHD before losing capacity, and the AHD deals with the situation that arises, that document will govern the matter. However, the legislation places a number of restrictions on the operation of an AHD in relation to a direction to withhold or withdraw a life-sustaining measure. Firstly, the adult must be very sick before the direction can operate.[126] Secondly, the adult must have no reasonable prospect of regaining capacity for health matters.[127] Thirdly, if the direction relates to withholding or withdrawing artificial nutrition and hydration (which would include the PEG in case studies P and Q), commencing or continuing the treatment must be inconsistent with good medical practice.[128] The effect of this third restriction is that directions in an AHD to refuse artificial nutrition and hydration (but not other kinds of life-sustaining measures, such as artificial respiration or CPR) cannot operate without having regard to what constitutes good medical practice.

Substituted decision maker

If an adult has not completed an AHD, the legislation authorises another to make the decision on his or her behalf.[129] In making a decision about withholding or withdrawing a life-sustaining measure (as in case studies P and Q), the decision maker must have regard to the general principles and health care principle that are set out in Schedule 1 to the *PAA* and the *GAA*.[130] That is not where the matter ends, however, because any consent given to withhold or withdraw a life-sustaining measure cannot operate *"unless the adult's health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice"*.[131]

8.3 What constitutes good medical practice?

Good medical practice is defined in Schedule 2.[132]

---

[126] *PAA*, s 36(1)(a). As to whether these limits on the operation of AHDs are desirable, see further Issue 2 above**.**

[127] *PAA*, s36(1)(c).

[128] *PAA*, s36(1)(b).

[129] The identity of that person will be determined by the adult's personal circumstances: *GAA* s 66 and *PAA* s 63. See Part 2 for a discussion of the law in Queensland on end of life decision making.

[130] These principles and how they operate in this context are discussed further in Issue 10 below.

[131] *GAA*, s 66A.

[132] *PAA* and *GAA*, sch 2 s 5B.

> ***5B Good medical practice***
>
> *"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.*

Formal national guidelines that embody the recognised medical and ethical standards, practices and procedures regarding circumstances in which life-sustaining measures can properly be withheld or withdrawn do not exist.[133] This is not the case in all jurisdictions. In England, for example, detailed guidelines exist regarding decision making in this context.[134] There is some work, however, currently in progress in New South Wales to develop some guidelines to assist health providers and decision makers.[135]

Such guidance would have assisted Dr Walsh in case study P and the substitute decision maker (the Adult Guardian) in case study Q in deciding whether to withdraw or consent to the withdrawal respectively of treatment.

8.4 Reform issues

The above material raises at least the following issues for consideration.

Test regarding good medical practice

In the context of both a direction in an AHD (if it relates to artificial nutrition and hydration) and a decision made by a substituted decision maker, withholding or withdrawal of life-sustaining measures can occur only if *commencing or continuing treatment is inconsistent with good medical practice.*

Medicine is not an exact science. There may be more than one legitimate and acceptable course of treatment in a particular situation. In case study Q, for example, Dr Nelty's investigations found that there was a body of medical opinion which considered it sound treatment to continue PEG feeding while another body considered it sound to withdraw it.

As the legislation is currently drafted, treatment can only be withheld or withdrawn if continuing or commencing treatment is *inconsistent* with good medical practice. This is a very high hurdle to satisfy. Arguably it means that if a responsible body of

---

[133] Although note that there is other guidance available to medical practitioners making these decisions. See, for example, guidelines produced by the Australian and New Zealand Society of Palliative Medicine (available at http://www.anzspm.org.au/guidelines/index.html) or the Australian Medical Association *Position Statement on the Care of Severely and Terminally Ill Patients* (available at http://www.ama.com.au/web.nsf/doc/SHED-5FK3DB).

[134] British Medical Association, *Withholding and Withdrawing Life Prolonging Medical Treatment: Guidance for Decision Making* (2nd ed, 2001).

[135] New South Wales Health, *Dying with Dignity: Revised Draft Guidelines for Clinical Decision Making at the End of Life* (2000), available at http://www.health.nsw.gov.au/health-public-affairs/publications/dwd/. See also New South Wales Health, *Using Advance Care Directives* (2004), available at http://www.health.nsw.gov.au/pubs/2004/adcare_directives.html.

medical opinion believes treatment should commence or continue (even if this body does not represent the majority medical view), withholding or withdrawing treatment will be unlawful.

Perhaps the legislation could strike a better balance and would be more reflective of medical opinion if the test permitted withholding or withdrawing of life-sustaining measures provided such action was consistent with good medical practice.

Guidance regarding what constitutes good medical practice

Over recent years, there have been repeated and consistent calls to develop guidelines to assist health providers and substitute decision makers in making decisions about withholding or withdrawing life-sustaining measures.[136]

As yet, there is no indication that progress is being made in Queensland to develop guidance in this regard.

Q21: Should the test be reformulated so that it would be lawful to withhold or withdraw life-sustaining measures provided such a course is consistent with good medical practice?

Q22: Should guidelines be developed to assist health providers and substitute decision makers in making decisions about withholding or withdrawing life-sustaining measures?

---

[136] See for example, *Re MC* [2003] QGAAT 13 at [71] and Adult Guardian, *Annual Report* (2000-2003) 31-32.

Issue 9 – "Good medical practice": a right of veto?

9.1 The problem

The *PAA* and the *GAA* create a mechanism whereby another can consent for an adult with impaired decision making capacity. However, in the case of most decisions to withhold or withdraw life-sustaining measures, that consent cannot operate unless the adult's health provider considers that commencing or continuing the treatment is inconsistent with good medical practice. The issue raised here is whether it is appropriate for a doctor to be able to prevent that consent from taking effect unless he or she regards the treatment as being inconsistent with good medical practice.

Case study R

Ruth, a 75 year old woman, had a stroke and was admitted to a hospital. She had difficulty swallowing so a nasogastric tube was inserted through which she could be provided with artificial nutrition and hydration. It is now two weeks later and Ruth's condition has been assessed by her medical team. Their view is that her condition is such that she will almost certainly require a high level of care in a nursing home. Although she is not in a vegetative state, she appears to have very limited cortical activity. She is able to watch people with her eyes as they move around her room. However, it is impossible to elicit any other response. She does not vocalise and does not respond to moderately painful stimuli. There are times when she appears to be awake. She remains incapable of swallowing by herself and complications with the nasogastric tube mean that she will require artificial nutrition and hydration through a PEG to continue living.

Ruth has always been a very independent person. Up until the stroke, she had lived in her own home, managed all of her affairs and was assertive in expressing her needs. In terms of her medical care, Ruth has always been very independent as well, and she has been clear in directing health providers and the rest of her family as to the care she wanted. She is also an active member of a community group called Older Consumers, which is an advocacy group for the economic rights of older people as consumers. At a number of meetings of this group, she has said in discussion with different people: "If I can't live independently, without being hooked up to machines to survive, or things like that, I would rather they just let me go. Life is for living."

The medical evidence as to her future is divided. Some doctors think it unlikely that her mental condition will improve (but think that PEG feeding should be instituted for three months to monitor her condition). Others think that Ruth may regain some capacity, although she would not have the same level of mental functioning as in the past, and certainly would not be capable of making decisions about her future medical treatment. There is no disagreement, however, about the continued need for artificial nutrition and hydration. Even if Ruth recovers some mental capacity, she will always need to be fed in this way.

Ruth has a son (Jim) who she appointed as her attorney for health matters. Jim wants to stop the PEG feeding because that is what his mother wanted. Ruth also has a daughter (Margaret) who wants to see how her mother's condition settles before deciding (although she agrees with Jim's view of what her mother would have wanted). The doctor in charge of the medical team treating Ruth, Dr Efat, believes the PEG feeding should be started as he is of the opinion that good medical practice requires it. His view is that he may be happy to withhold this treatment at a later stage, but he wants to wait for Ruth's condition to settle so he can ascertain how much mental capacity Ruth will have before making the decision.

9.2 The common law

The person who makes the decision to withhold or withdraw life-sustaining measures at common law is the treating doctor.[137] They are required to make that decision based on their assessment of what is in the "best interests of the patient".[138] Although the phrase "best interests" is necessarily vague, the early English cases in the area indicated that the primary factor considered under this test is responsible medical opinion, that is, whether from a medical perspective it is appropriate to continue treatment. Other factors taken into account to varying degrees under the best interests test include the views and values of the adult (to the extent that they can be ascertained) and the views of the family. Sometimes these other factors have been assigned weight as criteria independent from responsible medical opinion,[139] although at other times they have been taken into account as part of making an informed medical decision.[140]

More recently, there has been a shift for an adult's "best interests" to be informed more by non medical considerations than had been the case in the past.[141] Criticisms are still made, however, that undue weight is given to the medical aspects of a person's best interests[142] and it has been suggested that doctors are unlikely to withhold or withdraw life-sustaining measures unless they conclude that it is

---

137 Of course, if there is an application before the court about the matter, that court is the appropriate decision maker: see Part 2 above.

138 This "best interests" test has been adopted widely in the common law world. The seminal English decision of *Airedale NHS Trust v Bland* [1993] AC 789 has already been discussed in Part 2, although note also proposals to enact a version of the best interests test in statute: *Mental Incapacity Bill* 2004, cl 4. Best interests is also the test in New Zealand (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235; *Re G* [1997] 2 NZLR 201) and Ireland (*In the Matter of a Ward of Court* [1995] 2 ILRM 401).

139 For example, *Re G* [1997] 2 NZLR 201, 210-212. See also *Re G (Persistent Vegetative State)* [1995] 2 FCR 46 (Fam Div) 46, 51 in relation to the views of the family, although cf the comments of I Kennedy and A Grubb, *Medical Law* (3rd ed, 2000) 2141.

140 *Airedale NHS Trust v Bland* [1993] AC 789, 871 (Lord Goff); *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 250-251.

141 See, for example, the often quoted statement by Butler-Sloss P in *Re A (Male Sterilisation)* [2000] 1 FLR 549, 555: "best interests encompasses medical, emotional and all other welfare issues."

142 For example, some commentators have criticised the best interests test as being "medicalised" (JK Mason, RA McCall Smith and GT Laurie, *Law and Medical Ethics* (6th ed, 2002) 513-514) while others are critical of the paternalism (which they describe as "doctor knows best") as being "endemic in English medical law" (I Kennedy and A Grubb, *Medical Law* (3rd ed, 2000) 2105).

medically appropriate to do so. This means that decisions made to continue or commence life-sustaining measures may be contrary to the likely wishes of the adult and the opinions of his or her family.

Accordingly, under the common law, the decision would be made by Dr Efat in case study R, although he would consider the views of Ruth and her children. It is likely, however, that his decision would be to continue PEG feeding until Ruth's situation has settled.

9.3 The *PAA* and *GAA*

The regime established under the *PAA* and the *GAA* makes two major changes to how these decisions were made at common law, the first being who makes the decision. Instead of the decision resting with the treating doctor, section 66 of the *GAA* sets out (in order) another set of potential decision makers:[143]

- the adult (through an AHD);
- a guardian appointed by the Tribunal, or the Tribunal itself through an order;
- an attorney appointed under an enduring power of attorney or an AHD; or
- a "statutory health attorney".

Such an approach departs from the common law as it is clear than none of these potential decision makers is the treating doctor.

The second major change made by the legislation is the criteria upon which the decision maker must decide. At common law, a patient's best interests govern whether life-sustaining measures are withheld or withdrawn. A medical assessment of a patient's best interests, albeit informed by non medical factors, has tended to be the primary consideration taken into account. Under the *PAA* and *GAA*, decision makers must apply the general principles and the health care principle which include a wide array of factors, one of which is a patient's best interests. How these principles interact is discussed below in Issue 10.

So rather than Dr Efat making a decision based on Ruth's best interests, under the *PAA* and *GAA*, Jim as Ruth's attorney will be the appropriate decision maker and he will be required to apply the general principles and the health care principle.

However, the issue raised here is that the legislation also provides for a further role for the adult's health provider. Section 66A of the *GAA* requires that before Jim's consent can operate, Dr Efat must reasonably consider that the commencement or continuation of the PEG feeding would be inconsistent with good medical practice. In case study R, Dr Efat is not of this view and so Jim's consent cannot operate.[144]

---

[143] See Part 2 where this was considered in more detail.

[144] Although as mentioned earlier, it would be possible for Jim to approach the Guardianship and Administration Tribunal to determine the matter.

9.4 Reform issues

The question raised here is whether it is appropriate for an adult's health provider to be able to veto a decision made to withhold or withdraw life-sustaining measures under the legislation. Although the decision maker (who is Jim in our case study) could seek to overcome the doctor's objection by pursuing the matter further before the Guardianship and Administration Tribunal, this is a limit on the ability of a decision maker, either appointed by the adult or by the legislation, to consent on behalf of the adult.

There are competing considerations in having an adult's health provider play such a role. On one hand, the safeguard of good medical practice may be warranted to protect adults with impaired capacity from relatives who would withhold or withdraw life-sustaining measures in inappropriate circumstances. On the other hand, a lesser role for an adult's health provider might be justified by the fact that the legislation has deliberately moved away from a best interests test, which has been criticised for being too heavily driven by medical considerations rather than what the adult wants. Another criticism might be that it gives significant power to a single health provider to assess what he or she thinks is good medical practice.[145] It could also be argued that there are already sufficient safeguards to deal with potential abuse. For example, under the legislation an individual (such as a doctor, nurse or relative) who is concerned about the welfare of the adult can bring the matter before the Tribunal for its consideration. This is a safeguard to prevent relatives from making a decision based upon improper motives.

Q23: Should an adult's health provider be able to prevent a decision maker's consent from operating if they are not satisfied that commencing or continuing life-sustaining measures is inconsistent with good medical practice?

---

[145] Although the requirement for Dr Efat to "reasonably consider" that view means that he cannot base his opinion on idiosyncratic factors. Rather he must have reached his conclusion based on an informed assessment, including consulting colleagues, guidelines or other literature if appropriate.

Issue 10 – General principles and the health care principle: a need for further guidance?

10.1 The Problem

The *PAA* and *GAA* provide substitute decision makers with principles that they must consider when exercising a power conferred on them by the legislation.[146] These principles are contained in Schedule 1. They are separated into "general principles" and the "health care principle". The 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 relevant to health related decisions only, which obviously includes the sorts of decisions being discussed.

The principles are intended to provide guidance to a person or entity who is making a decision for an adult, for example, whether to withhold or withdraw a life-sustaining measure. However, a decision maker may have difficulty deciding upon the appropriate course of action if the different principles that must be considered suggest conflicting outcomes.

Case study S illustrates this issue.

Case study S

Trevor is a 40 year old man who is married with two young children. He is a high school physical education teacher and also competes in marathons. Trevor has been training for the 2006 Commonwealth Games. He and his wife have discussed each of their wishes should either be involved in an accident which would require invasive medical treatment to recover. They pledged to each other that they would ensure that the other would never have to incur what they perceived to be the unacceptable indignity of being on life-sustaining measures if there was only a limited prospect of making a full recovery.

Trevor's family is involved in a car accident. Most of the family escapes serious injury but Trevor sustains severe head injuries and is placed on life-support. Trevor's wife, Amanda, is advised of his condition – that he has suffered significant brain damage, cannot currently breathe on his own and that he will need to be on life-support until his condition stabilises and staff can more accurately assess his prognosis. At this stage, however, the prospect of Trevor ever being able to live independently again is extremely remote.

---

146 *PAA*, s 76; *GAA* s 11.

10.2 Guidance provided by general principles ("GP") and health care principle ("HCP")

The provision of principles to guide decision making as currently drafted in the legislation raises a number of issues.

Principles provide uncertain and potentially conflicting guidance

The principles that are likely to be particularly relevant to a decision to withhold or withdraw life-sustaining measures are:

- An adult's right to respect for his or her human worth and dignity as an individual must be recognised and taken into account;[147]
- The principle of substituted judgment must be used so that if, from an adult's previous actions, it is reasonably practicable to work out what his or her views and wishes would be, a person in performing a function or exercising a power under the legislation must take those views and wishes into account;[148]
- A power for a health matter should be exercised in the way that is least restrictive of an adult's rights;[149]
- A power for a health matter should only be exercised if –
    - It is necessary and appropriate to maintain or promote an adult's health or wellbeing;[150] or
    - It is, in all the circumstances, in an adult's best interests.[151]

Other principles that may also be relevant (although possibly less directly) are:

- An adult has the same basic human rights regardless of their capacity and this must be recognised and taken into account.[152] This could refer to an adult's ability to determine whether they want or do not want particular treatment;
- A power for a matter should be exercised in a way that is appropriate to an adult's characteristics and needs.[153]

The decision made, guided by these principles, will depend heavily on the circumstances of each case. In our case study, a number of these principles (particularly the principle of substituted judgment) suggest that the life-support should be terminated immediately. On the other hand, medical opinion suggests that life-support should continue until Trevor's condition stabilises and an assessment can be

---

147 GP 3.

148 GP 7(4). But note that in performing a function or exercising a power under the legislation, a person must do so in a way consistent with the adult's proper care and protection: GP 7(5).

149 HCP 12(1)(a).

150 HCP 12(1)(b)(i). In deciding whether the exercise of a power is appropriate, a person must consider the adult's views and wishes, and the information given by the adult's health provider: HCP 12(2).

151 HCP 12(1)(b)(ii).

152 GP 2.

153 GP 10.

made of his prognosis. The legislation gives no guidance as to which of these principles should take precedence.

Relevance of adult's views and wishes within the health care principle[154]

Under health care principle 12, one factor that a decision maker must consider is that a power for a health matter should be exercised only if:

- it is necessary and appropriate to maintain or promote the adult's health or wellbeing; *or*
- in all the circumstances, it is in the adult's best interests (emphasis added).

The use of the word "or" means that only one of these requirements needs to be satisfied. In determining whether the power is "appropriate" within (i), the decision maker is directed to seek the adult's views and wishes.[155] Although a contrary argument has been put forward,[156] the legislation does not impose the same requirement in determining whether the exercise of the power would be "in the patient's best interests".[157]

It is suggested that the legislation should be altered to make clear that an adult's views and wishes must be considered as part of assessing his or her best interests. It may already be the case, as the law is currently drafted, that an adult's views and wishes should be considered when assessing best interests. This is because at common law, the determination of best interests should include considering what an adult wants (or would have wanted).[158] Nevertheless, a change in legislation might still be warranted to strengthen the weight given to an adult's views and wishes in that a legislative duty is imposed upon a decision maker to specifically seek this information. An amendment also seems logical in that there seems to be no justification for considering the adult's views and wishes in determining whether treatment is "necessary and appropriate" but not when making an assessment as to "best interests".

10.3 Reform issues

The preceding commentary raises three issues that may require further consideration.

---

154 An argument similar to that outlined below, can also be made in relation to the requirement, which is also imposed under HCP 12(2), to "take the information given by the adult's health provider into account". This parallel argument is not pursued further here, partly because the views of an adult's health provider are already so strongly entrenched as part of the best interests test that there is no need to reaffirm their relevance to an assessment of best interests.

155 HCP 12(2).

156 That argument suggests that HCP 12(2) applies to both HCP 12(1)(b)(i) and (ii). It argues that the use of the word "appropriate" in HCP 12(2) is coincidental and does not refer to the use of the same word in the previous subsection.

157 This interpretation of the legislation is supported by the fact that HCP 12(1)(b)(ii) was inserted by a later amendment (the *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld)). This argument is not explored further here but is outlined in greater detail in L Willmott and B White, "Charting a Course Through Difficult Legislative Waters: Tribunal Decisions on Life-Sustaining Measures" (2005) *Journal of Law and Medicine* (forthcoming).

158 See the above discussion of the content of the best interests test in Issue 9 and also in Part 2.

The first issue is whether clearer guidance is required concerning a decision about withholding or withdrawing life-sustaining measures. When considering a health matter involving such a decision, many (if not most) of the general principles will not be relevant. If that is the case, perhaps consideration should be given to whether **only** the health care principle should guide decision making. Another alternative is to continue to apply the general principles to these decisions, but state that they should yield to the health care principle in case of conflict.[159]

Secondly, even if only the health care principle governed such decision making, there may need to be further guidance regarding priority given to those factors within this principle. If there is potential for conflict as outlined earlier, it should be considered whether the health care principle (or another provision) should contain a direction that, for example, the best interests test should prevail over a substituted judgment test (or vice versa).

Thirdly, it is difficult to understand the way in which the health care principle treats an adult's views and wishes. There does not appear to be any justification for requiring an adult's views and wishes to be taken into account in determining whether the treatment is "necessary and appropriate", but not impose a similar duty if making a decision based on the alternate ground of "best interests".

Q24: Should both the general principles and the health care principle, or just the health care principle, guide decision making in relation to withholding or withdrawing life-sustaining measures?

Q25: Should more direction be given to a decision maker regarding which principle (or principles) are more important in making a decision about withholding or withdrawing a life-sustaining measure if those principles suggest different outcomes?

Q26: Should the legislation provide that the adult's views and wishes apply equally in determining "best interests" as in determining what treatment is "necessary and appropriate" in the health care principle?

---

[159] This is probably already the law because the specific provision dealing with health care is likely to take priority over the more general provisions that apply to decision making in general.

Issue 11 – A requirement to provide futile treatment?

11.1 The problem

At common law, a health provider does not have an obligation to provide life-sustaining measures that are futile.[160] This is because receiving treatment that is futile is not in an adult's best interests. Under the *PAA* and the *GAA*, a decision to withhold or withdraw life-sustaining measures requires consent so it may be more difficult for a health provider to refuse to provide futile treatment in Queensland.

Case studies T, U and V illustrate the issue.

Case study T

James is 35 years old, single and a senior associate in a big law firm. He is the only child of Rupert and Charlotte. He has been involved in a car accident and suffered severe and irreversible brain damage. He was rushed to hospital and immediately put on life support as he had stopped breathing. Two weeks later his position has stabilised but he has no prospect of recovery. The medical staff at the hospital wants to stop the life support as they regard the treatment as futile. This prognosis has been supported by two independent consultants who have assessed James' case. Rupert and Charlotte refuse to consent to withdrawal of treatment.

Case study U

Frances is 95 years old and very ill. She is suffering from end stage dementia, and has a number of other medical conditions including cerebral lymphoma, diverticulitis and osteoporosis. Frances' condition has just deteriorated and she has been taken by ambulance from her nursing home to a hospital. Frances is diagnosed with pneumonia. The treatment proposed by her doctor, Dr Wells, is that Frances be made comfortable and be treated for her pain. Dr Wells has not prescribed antibiotics as he regards this treatment as futile. This course of action is consistent with good medical practice. Frances' family is insisting that antibiotics be given to her.

---

[160] Determining when treatment is futile is an extremely difficult exercise and is not considered further in this Issues Paper. For a discussion of this problem, see I Kerridge, K Mitchell and J McPhee, "Defining Medical Futility in Ethics, Law and Clinical Practice: An Exercise in Futility?" (1997) 4 *Journal of Law and Medicine* 235.

Case study V

Anne is a 40 year old woman who has been admitted to hospital for a minor procedure. An adverse event occurs regarding her anaesthetic and Anne suffers severe and irreversible brain damage. Although she is not clinically dead, there is only minimal core brain activity. Her breathing is laboured and it is likely that she will have to be put on a respirator (and certainly other life-sustaining measures) to survive.

Anne's family is told that she has no prospect of recovery and that life-sustaining measures should not be provided to her. Anne's family do not agree with this approach and insist that all life-sustaining measures be given as needed.

11.2 The common law

At common law, a medical practitioner is under no duty to treat a patient where "no benefit at all would be conferred…".[161] Treatment that is futile is not in a patient's best interests and so need not be provided. This decision is going to be made at the first instance by the treating doctor in charge of the patient who must make an assessment of his or her best interests.[162]

It is, of course, open to those who are close to the patient to challenge that the treatment is futile and to assert instead that a patient's best interests warrant that treatment.[163] If a court is called upon to adjudicate in such a dispute, it is not bound by the views of the medical profession and will reach its own independent assessment of what the patient's best interests require.[164] However, the courts have said, in the context of futility, that the "decision as to appropriate treatment … is principally a matter for the expertise of professional medical practitioners".[165] Again, if the court concludes (as the doctor did) that the treatment is futile and therefore not in a patient's best interests, that treatment need not be continued.[166]

In all three case studies, then, the common law would allow the medical staff to withdraw treatment because in each case, the treatment – whether existing or proposed – is apparently futile. In case study T, the medical team may withdraw life support. In case studies U and V, the treating doctors may refuse to administer life-

---

[161] *Airedale NHS Trust v Bland* [1993] AC 789, 858-859 (Lord Keith of Kinkel), 869 (Lord Goff of Chieveley), 884-885 (Lord Browne-Wilkinson), 898 (Lord Mustill). See also *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 251 and the recent Australian decision *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061.

[162] *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554.

[163] This is what happened in *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 and in *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061.

[164] This can be contrasted with the position in England where it appears that more weight is given to the views of medical profession: *Airedale NHS Trust v Bland* [1993] AC 789, 858-859 (Lord Keith of Kinkel), citing *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. See also *Re J (A Minor) (Wardship: Medical Treatment)* [1992] 4 All ER 614.

[165] See *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061, [25].

[166] *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061, [28].

sustaining measures. It may be that the family objections result in the matter being decided by a court in which case, provided the medical evidence supports the action proposed by the treating doctor, the judge is likely to reach the same conclusion as to futility and best interests.

11.3 The *PAA* and *GAA*

The extent to which futile treatment must be provided is a little more complex under the *PAA* and *GAA*. The following issues are relevant:

- Section 79 of the *GAA* makes it an offence for a health provider to carry out health care for an adult with impaired capacity unless the appropriate consent is obtained.
- "Health care" is defined to include the withholding or withdrawal of a life-sustaining measure if its commencement or continuation would be inconsistent with good medical practice.[167]
- A "health matter" is a matter relating to "health care"[168] and section 66 of the *GAA* sets out who can make the decision about a health matter on behalf of an adult with impaired capacity. (This section would be relevant for case studies T, U and V above and in each case, the consent to withhold or withdraw treatment would need to be given by the decision maker empowered by the legislation. In these case studies, that decision maker will be a member of the adults' family, not the treating doctor.)

The conclusion from this is that a health provider must obtain consent for a decision to withhold or withdraw a life-sustaining measure, or he or she will commit an offence under s 79 of the *GAA*.

This causes a problem for the health providers in case studies T, U and V. The necessary consent is being withheld by the substitute decision makers (the family members) so the health providers would be unable to withdraw the treatment in case study T, and may be required to provide the antibiotics in case study U and the life support in case study V. On this interpretation, the health providers would be compelled to provide futile treatment, which is a significant shift from the common law.

There are, however, two ways in which this difficulty can be avoided. The first is for the Adult Guardian to give consent on behalf of the adult. The *GAA* authorises the Adult Guardian to do this in cases where there is disagreement about a health matter that cannot be resolved through mediation[169] or where a decision maker is acting contrary to the health care principle.[170] The second potential way to avoid this

---

[167] *PAA* and *GAA*, sch 2 s 5(2). The difficulty with this definition (particularly the reference to good medical practice) is dealt with in Issue 12.

[168] *PAA* and *GAA*, sch 2 s 4.

[169] *GAA*, s 42.

[170] *GAA*, s 43.

difficulty is for the matter to be brought before the Tribunal, which can also consent on behalf of an adult with impaired capacity.[171]

11.4 Reform issues

The outcome of the above reasoning is that there may be two reasons to consider reform. The first is that a health provider who withholds or withdraws life-sustaining measures may still commit an offence even if a court or Tribunal subsequently determines that the treatment was futile. Because the lawfulness of a decision turns on consent rather than best interests (and futility), if that consent not to provide the treatment was not obtained, an offence under s 79 of the *GAA* has been committed. This is regardless of the appropriateness of the treatment.

This is different from the common law. Although in cases of disagreement it may be prudent to seek the guidance of a court, at common law a doctor who does not will only be liable for a decision to withhold or withdraw treatment if subsequent prosecution or civil litigation shows the doctor's assessment of futility has been wrong.

A second reason to consider reform is that it requires a health provider, in the case of a disagreement, to go through an additional procedural hurdle of seeking consent either from the Adult Guardian or the Tribunal. There may be an argument for requiring external approval of a medical decision in some circumstances where a decision to withhold or withdraw life-sustaining treatment is in dispute. However, if the proposed or current treatment is clearly futile, it is perhaps inappropriate to insist on this additional requirement.

Q27: Should health providers be required to obtain consent from a substitute decision maker before they can withhold or withdraw life-sustaining measures that are medically futile?

---

[171] *GAA*, s 82(1)(f).

Issue 12 – "Health care": a problematic definition

12.1 The problem

Under Queensland's legislative regime, some decisions to withhold or withdraw life-sustaining measures can only be taken if commencing or continuing the treatment would be inconsistent with good medical practice. For example, as discussed in Part 2, decisions made by statutory health attorneys must meet this requirement before they can take effect.[172] On the other hand, AHDs (apart from directions to withhold or withdraw artificial nutrition and hydration) can operate without regard to good medical practice. Presumably, because the decision is actually being made by the adult him or herself rather than another on their behalf, the legislation gives effect to the right to self-determination.

A problem arises, however, in the *PAA* and *GAA* regarding the definition of "health care". "Health care" includes withholding or withdrawing life-sustaining measures *if commencing or continuing such treatment would be inconsistent with good medical practice*.[173] Defining "health care" in this way raises two potential interpretations, both of which are unsatisfactory:

- The most likely interpretation is that the definition may mean that a decision to withhold or withdraw life-sustaining measures, where commencing or continuing this treatment is not inconsistent with good medical practice, is not a decision about an adult's "health care", and so falls outside the legislation altogether.[174] This would mean that such a decision could not be authorised by the legislation.
- An alternative, although less plausible, interpretation is that the definition may mean that a decision to withhold or withdraw life-sustaining measures, where commencing or continuing this treatment is not inconsistent with good medical practice, is not a decision about an adult's "health care", but rather a "personal matter".[175]

Case studies W and X illustrate the problems that this definition can cause.

---

172 *GAA*, s 66A.

173 *PAA* and *GAA*, sch 2 s 5.

174 Unfortunately, for this sentence to be legally accurate, the wording is difficult to follow. In essence, the point being made is that "health care" includes a decision to withhold or withdraw life-sustaining measures only if it is consistent with good medical practice to do so.

175 Again, the legislation makes expressing this point clearly quite difficult. In essence, the point being made is that a decision to withhold or withdraw life-sustaining measures that is not consistent with good medical practice will be a "personal matter" and not "health care".

Case study W

Katarina is terminally ill with cancer and is expected to die within a year. When she was first diagnosed with this illness, she executed a valid AHD which states that she does not want life-sustaining measures, including antibiotics. More recently, Katarina has also developed dementia with the result that although she still has some awareness of her surroundings, for example, she still recognises people, she does not have capacity to make her own medical decisions.

Katarina has been receiving some palliative chemotherapy and recently she developed an infection at the point at which the medication was being administered. Her immune system is such that if the infection is left without treatment, it is highly likely that she will die. However, the infection can be treated cheaply and easily by common antibiotics. Dr Godfrey is aware of the AHD but decides that treatment is likely to resolve her immediate condition and so orders that the antibiotics should be given.

Case study X

Assume the same factual scenario, except instead of an AHD, Katarina had executed a power of attorney for personal matters in favour of Abdul. Katarina and Abdul had discussed at length Katarina's views on the sorts of medical treatment she wants and does not want. She was of the view that even if her life is still comfortable, she does not want to linger forever. Accordingly, in one of these discussions, Katarina told Abdul that regardless of what the doctors might say, she does not want to receive medical treatment needed to keep her alive if she gets that ill "because her body knows when it is time to go".

12.2 Decision is a personal matter only

The less likely of the two interpretations (second bullet point above) is that the definition of "health care" may lead to the absurd result that a decision to withhold or withdraw life-sustaining measures is not regarded as a decision about a health matter, but rather about a personal matter. This would mean that in case study W, because the decision is not a health matter, it cannot be governed by Katarina's AHD.[176] The position is different though in case study X where Abdul has been given a power of attorney for personal matters. His refusal of the antibiotics on behalf of Katarina is contrary to medical advice, so it could not be a health matter. It could, however, be a decision about the adult's "care" and so potentially be considered a personal matter.[177] If this was so, he could therefore make the decision to withhold antibiotics under his power of attorney for personal matters.

---

[176] *PAA*, s 35(1).
[177] *PAA* and *GAA*, sch 2 s 2.

Such an interpretation is clearly undesirable and would also have a number of other absurd results including:

- A statutory health attorney could not make such a decision as they are unable to make personal decisions.
- The health care principle could not apply (even though it is arguably the most important principle to consider for health issues) because it applies only to health matters.
- There would be fewer safeguards for more controversial and difficult decisions. This arises because a decision to withhold or withdraw life-sustaining measures only becomes a personal matter if the commencement or continuation of the treatment is not inconsistent with good medical practice. Arguably, these are the sorts of cases where there should be stricter criteria for when treatment should not be given. However, the effect of becoming a personal matter is that there are fewer safeguards. One example is that decisions about personal matters do not need to take account of whether or not they are inconsistent with good medical practice.

Although such an interpretation is open to the Tribunal and to the courts, its absurdity means that they will probably avoid taking such an approach.

12.3 Decision falls outside legislation

The more plausible interpretation (but one that is still problematic) discussed above was that a decision to withhold or withdraw life-sustaining measures can only be health care if commencing or continuing the treatment would be inconsistent with good medical practice. Accordingly, if such a decision is not, then it is not "health care". Under this interpretation, the alternative view of treating such a decision as being a personal matter is rejected because it is so clearly and obviously a decision about an adult's health. Rather, it must have been the intention of the legislature that if such a decision did not fall within the definition of "health care", it is not one that is capable of being made under the legislation. In short, this means that health care decisions in this area, whether made pursuant to an AHD or by a substituted decision maker, can only be made if they are not inconsistent with good medical practice.

In case study W, the direction in Katarina's AHD could not operate unless it complied with the good medical practice requirement, because it is not health care as regulated by the legislation. It is difficult to reconcile this with s 36(2)(b) of the *PAA* which imposes this requirement of good medical practice only in relation to directions in AHDs that relate to artificial nutrition and hydration. It would seem illogical for Parliament to have included this specific safeguard that applies only to artificial nutrition and hydration, but then render it obsolete by defining health care so as to require all medical treatment given to comply with the good medical practice requirement. Perhaps the answer to this lies with the fact that the definition of health care was amended in 2001.[178] It seems that in making these changes, Parliament has unintentionally created this inconsistency.

---

[178] *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld), s 17.

In case study X, Abdul would be unable to make this decision if it is inconsistent with good medical practice because it is not a health matter. Again, it seems unlikely that such a result was intended because it leaves no room for the operation of s 66A of the *GAA* which already imposes this requirement of good medical practice.

Q28: Should the definition of "health care" in sch 2 s 5(2) of the *PAA* and *GAA* retain the requirement that commencing or continuing life-sustaining measures be inconsistent with good medical practice?

Issue 13 – "Life-sustaining measure": too narrow a definition?[179]

13.1 The problem

The *PAA* and *GAA* treat decisions to withhold and withdraw life-sustaining measures differently from other kinds of health care. This is because of the grave consequences of such decisions. However, it may be that at least one kind of treatment needed to keep a person alive, the hand feeding of patients who are unable to feed themselves, does not fall within the definition of "life-sustaining measure". This means that a decision to cease such treatment is not subject to the same scrutiny as is the case for similar life-sustaining measures such as artificial nutrition and hydration.

Case studies Y and Z illustrate this issue.

Case study Y

Helga is 80 years old and, since suffering a stroke 12 months ago, has been in a persistent vegetative state ("PVS"). Despite this diagnosis, Helga is still able to swallow. The nursing staff of the aged care facility in which she lives hand feed her all of her meals.

Helga's daughter is her statutory health attorney and asks the nursing staff to stop feeding her mother. Helga's doctor, Dr Khan considers that continuing the hand feeding is not inconsistent with good medical practice, so instructs the nurses to continue feeding Helga.

Case study Z

David is 65 years old and he suffers from advanced dementia. While he is still mobile, he lacks capacity to make medical decisions. David has been fed by hand at his nursing home since his admission some years ago. His condition has deteriorated recently, and he no longer shows any interest in being fed. The food that does go in his mouth is not chewed and simply remains there until he later spits it out.

David's wife (his statutory health attorney) requests that David should no longer receive food, and that no artificial nutrition or hydration should be provided. She has been informed that the medical evidence shows that David's passing will be more comfortable if this approach is taken. However, David's treating doctor, Dr Millhouse, does not believe that this approach is consistent with good medical practice and wants to provide nutrition and hydration artificially.

---

[179] This issue was identified by Associate Professor Mal Parker during discussions after the public lecture "Lawful Withdrawal" held at QUT on 7 July 2004.

Before turning to the Queensland legislation in some detail, a preliminary comment is to distinguish the recent Victorian Supreme Court case of *Gardner; re BWV*[180] from the issue being considered here. Although both involve a comparison of artificially or naturally feeding and hydrating, the Victorian decision is of limited relevance in Queensland. In *Gardner; re BWV*, the court determined that artificial nutrition and hydration could be refused by a guardian as it was "medical treatment" rather than "palliative care" as both terms are defined by the *Medical Treatment Act 1988* (Vic). However, that decision does not help ascertain the state of Queensland law because the Victorian Act uses different terminology (with different definitions). Further, the issue being considered here, whether hand feeding of a patient who is incapable of feeding themselves falls with the definition of a "life-sustaining measure", is different from the point in question in that case.

13.2 Life-sustaining measures and hand feeding

Whether treatment being provided to an individual falls within the definition of "life-sustaining measures" matters because of section 66A of the *GAA*. It provides that such treatment may only be withheld or withdrawn (apart from as requested in an AHD)[181] if its commencement or continuation is inconsistent with good medical practice. The rationale for this section is that it imposes an additional safeguard for such a serious health decision.

The definition of "life-sustaining measure" is as follows:[182]

> ***5A Life-sustaining measure***
>
> *(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;*
>
> *(b) assisted ventilation;*
>
> *(c) artificial nutrition and hydration.*
>
> *(3) A blood transfusion is not a "life-sustaining measure".*

The issue, then, is whether hand feeding is a "life-sustaining measure". *Artificial* nutrition is clearly a life-sustaining measure because it is listed as an example.[183] However, it is also clear that such treatment would fall within the general definition. Artificial nutrition is "intended to sustain or prolong life" and the "vital bodily function" that is "temporarily or permanently incapable of independent operation" is the function of swallowing. Artificial nutrition "supplants" that function.[184]

---

180 *Gardner; re BWV* [2003] VSC 173.

181 Although note the exception for those directions relating to withholding or withdrawing artificial nutrition and hydration: *PAA*, s 36(2)(b).

182 *PAA* and *GAA*, sch 2 s 5A.

183 *PAA* and *GAA*, sch 2 s 5A(2)(c).

184 *PAA* and *GAA*, sch 2 s 5A(1).

It seems, however, that the situation may be different with hand feeding because of doubts about whether such feeding supplants or maintains "vital bodily functions that are temporarily or permanently incapable of independent operation". Therefore, if hand feeding is *not* a life-sustaining measure, it would be regarded simply as health care. This sort of feeding would comfortably fall within the definition of that term as it is care provided under the direction or supervision of a health provider to maintain the adult's physical condition.[185]

13.3 Outcomes

If hand feeding is not a life-sustaining measure and so is not subject to the limitation of good medical practice, Dr Khan would not be entitled to rely on that practice to insist that feeding continue. It is unlikely that such an outcome was intended. The fact that Helga can swallow her own food suggests that her condition may be better than others in a PVS, yet the law imposes fewer safeguards in this case and permits treatment to be withheld or withdrawn from her more easily.

The same result ensues in case study Z, for the same reasons. If feeding by hand is not a life-sustaining measure, Dr Millhouse's opinion of good medical practice cannot operate as a veto. Accordingly, David's wife may lawfully consent to the cessation of feeding. This second case study demonstrates that this issue may arise with patients who are engaging with the world around them to some extent and are some distance away from death.

13.4 Reform issues

One way around this problem might be to include a subsection in the definition of "life-sustaining measure" that specifically includes this sort of feeding. A second option is to revise the definition of life-sustaining measure, perhaps to a more functional test that focuses on whether withholding or withdrawing treatment is likely to result in the adult's death.

13.5 Difficult ethical issues

The issue just discussed raises primarily the issue of how the legislation is drafted. It invites comment on whether the definition of "life-sustaining measure" is adequate given that it may not catch at least one scenario (a patient in a PVS who can swallow) which may be difficult to distinguish from another very similar scenario (a patient in a PVS being sustained artificially because he or she cannot swallow).

This issue does, however, raise a wider range of ethical considerations, some of which will be briefly canvassed. This paper does not take a particular view on these matters but raises them for discussion. These matters are being specifically flagged because of the strong feedback received from the Advisory Group, many of whom had particular views about food and water, whether given naturally or artificially, at the end of life.

---

[185] *PAA* and *GAA*, sch 2 s 5.

One scenario proposed was a patient with impaired capacity who was refusing food and water. This raised issues of whether it should be given anyway (presumably with some level of coercion) or whether a percutaneous endoscopic gastrostomy (a PEG, which is a tube through which artificial nutrition and hydration can be provided to the stomach) should be inserted. A third option was not to feed the patient on the grounds that the refusal of food and water is an indicator that, for example in cases of severe dementia, the terminal phase of the illness has begun.

Another question asked was whether a patient who is in a PVS and who is still capable of swallowing, should continue to be fed. It has been suggested that hand feeding in a case such as this is a form of life support and that it should be capable of being withdrawn like any other form of intervention that merely prolongs life.[186] The law is clear that those patients who are in this state do not need to be hydrated and nourished *artificially* so it was suggested that it is reasonable to ask whether their condition can be distinguished simply because food and water is taken naturally. Another issue raised was the role of technology and whether its use (for example, a PEG) is a reasonable basis for determining what medical treatment need or need not be given.

As noted above, this paper does not seek to engage with these difficult ethical issues at this early stage. Rather it raises them for consideration by the broader community, prompted mainly by the strength of views expressed from within the Advisory Group. However, as with any matter raised in this Issues Paper, comments on this issue are welcome.

Q29: Is there any reason in principle for differentiating between a PVS patient who is being hand fed and a PVS patient who is being artificially provided with nutrition and hydration in terms of the circumstances in which treatment should cease?

Q30: Should the definition of a "life-sustaining measure" be modified to more widely include those treatments needed to keep an adult alive?

---

[186] See for example, J Abbey, "Helping or Hurting? Nurses as life-support in late-stage dementia" (3rd Asia/Oceania Regional Congress of Gerontology, Hong Kong, 19-23 November 1995).

Section 3 – Criminal Law Issues

Section 3 addresses the interaction between the *PAA* and the *GAA*, and the *Criminal Code 1899* (Qld). Because withholding or withdrawing life-sustaining measures may result in a person dying, this raises the spectre of the criminal law. This section contains only one issue which explores the relationship between these two branches of law. There are concerns that the *PAA* and *GAA* might not operate to exclude all criminal responsibility for appropriate decisions made under the legislation.

Issue 14 – The *Criminal Code* and the *PAA* and *GAA*

14.1 The problem

The *Criminal Code 1899* (Qld) imposes liability on those involved in the death of a person if that death is judged to be an unlawful killing.[187] Although the *PAA* and *GAA* provide for the withholding and withdrawal of life-sustaining measures, the relationship between that legislation and the *Criminal Code* is unclear. It may be that this relationship needs to be clarified so that there can be no suggestion that health providers involved in withholding or withdrawing life-sustaining measures under the Queensland legislation could be liable under the *Criminal Code* for their actions.

Case study AA illustrates this potential problem.

Case study AA

Dr Cavalaro is treating Reginald, a 90 year old man who is lying in hospital in a persistent vegetative state. He is being artificially nourished and hydrated and medical opinion is that Reginald will never recover. Dr Cavalaro withdraws the artificial nutrition and hydration in accordance with the legislative regime and Reginald subsequently dies.

14.2 Criminal law and consent

The concern here is that there is some uncertainty about whether Dr Cavalaro may have breached the *Criminal Code*. Section 285 of the *Code* imposes a duty on a health provider to provide a patient with the necessaries of life. If a health provider fails to provide such necessaries, he or she is deemed to have caused the death of the patient. If artificial nutrition and hydration is regarded as a necessary of life in case study AA, Dr Cavalaro may be regarded as having caused Reginald's death. This raises a potential conflict between the criminal law, which may require continued treatment, and the consent mechanism created by the *PAA* and *GAA* which is designed to make appropriate decisions not to treat lawful.

It is suggested that withholding and withdrawing life-sustaining measures should be lawful in appropriate circumstances and there are potentially two ways in which it could be argued that a decision under the *PAA* and *GAA* does not contravene the criminal law. The first draws on persuasive English legal authority[188] that suggests that consent will operate to make such action lawful. Because treatment (here, the

---

[187] *Criminal Code 1899* (Qld), s 300.

[188] *Airedale NHS Trust v Bland* [1993] AC 789, 882-883 (Lord Browne-Wilkinson).

provision of life-sustaining measures) without consent is unlawful, there can be no duty to provide medical treatment where consent has not been given or where consent has been withdrawn. Therefore withholding or withdrawing life-sustaining measures, where consent to receive that treatment has not been given, must be lawful. It is probable that this is also the position under Queensland's *Criminal Code.* Section 246 creates the offence of assault, which would make treatment given without consent unlawful.[189] This result of this reasoning would be that consent to withhold or withdraw life-sustaining measures that is obtained under the *PAA* and *GAA* would render the withholding or withdrawal lawful.[190]

An alternative argument would be that in appropriate circumstances, for example, where it was no longer in a patient's best interests to receive life-sustaining measures, such treatment would not be regarded as a "necessary of life".[191] This would mean that the duty to provide such treatment under the *Criminal Code* would not arise and therefore there is no criminal liability.

Although these are potential ways that criminal liability might be avoided, there are two complicating factors. The first is that s 284 of the *Criminal Code* provides that consent is not a defence to unlawful killing. This conflicts with s 246 and there may be some doubts as to whether s 246 would prevail given that it is less specific than s 284 and also earlier in the Act. The second complicating factor is that the *PAA* and the *GAA* specifically provide that nothing in these Acts can authorise, justify or excuse killing a person and nor do they affect s 284 of the *Criminal Code.*[192] The uncertainty about how these provisions of the *PAA* and *GAA* interact the *Criminal Code* may mean that Dr Cavalaro is left open to prosecution.

Q31: Should the *PAA* and *GAA* contain a provision that clarifies the relationship between those Acts and the *Criminal Code 1899* (Qld) so as to avoid concerns about potential criminal liability?

---

189 Note also s 79 of the *GAA* which provides that if a health provider treats an adult with impaired capacity without consent, then he or she has committed an offence.

190 *GAA*, s 80.

191 *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 249-250.

192 *PAA*, s 37; *GAA*, s 238.

Section 4 – Questions for Consideration: Summary

This final section of Part 3 brings together the questions already posed so they are accessible in the one place.

Issue 1 – Wider recognition of advance directives about health care

Q1: Should the *PAA* and *GAA* recognise a valid common law advance directive as being binding on health providers?

Q2: If you answered "yes" to Q1, should there be any limitations (like those discussed in Issue 2) on the extent to which a common law advance directive can operate?

Issue 2 – Limits on the operation of advance health directives

Q3: Should the *PAA* continue to require that AHDs cannot operate unless the adult's health is sufficiently poor such that it meets one of the conditions described in s 36(2)(a) as set out above?

Q4: Should the *PAA* continue to require that AHDs cannot operate unless the adult does not have a reasonable prospect of regaining the capacity needed to make decisions about his or her health?

Q5: Should the condition discussed in Q4 (that the adult has no reasonable prospect of regaining capacity for health matters) be regarded as being met if the treatment that the AHD purports to refuse could enable the adult to recover that capacity?

Q6: Should the *PAA* continue to draw a distinction in AHDs between artificial nutrition and hydration and other kinds of life-sustaining measures by imposing a requirement of good medical practice on the former but not the latter?

Issue 3 – Protection for health providers relying on invalid advance health directives

Q7: Should the word "invalidity" as used in the context of an AHD in s 100 of the *PAA* be defined to clarify the circumstances in which the protection will apply?

Q8: Should protection in s 100 of the *PAA* depend on whether the health provider has "knowledge" of the invalidity (as is currently the case), or on whether the health provider was acting in "good faith with reasonable care and skill" in ascertaining the validity of the AHD?

Q9: If you think that protection should depend on the health provider's "knowledge" (as is currently the case), should the meaning of the term be clarified in the legislation?

Q10: If you answered "yes" to Q9, which of the following should "knowledge" include:
(a) actual knowledge?
(b) imputed knowledge?
(c) wilful blindness?
(d) other (if so, please elaborate)?

Issue 4 – Protection for health providers where no knowledge of advance health directives

Q11: Should protection in s 102 of the *PAA* depend on whether the health provider has "knowledge" that the adult has an AHD (as is currently the case), or on whether the health provider was acting in "good faith with reasonable care and skill" in ascertaining whether an AHD exists?

Q12: If you think that protection should depend on the health provider's "knowledge" (as is currently the case), should the meaning of the term be clarified in the legislation?

Q13: If you answered "yes" to Q12, which of the following should "knowledge" include:
(a) actual knowledge?
(b) imputed knowledge?
(c) wilful blindness?
(d) other (if so, please elaborate)?

Issue 5 – Deliberate non-compliance with advance health directives: a statutory excuse?

Q14: Should health providers be able to not follow AHDs if they believe that the directions in these documents are:
(a) uncertain?
(b) inconsistent with good medical practice?
(c) inappropriate because circumstances have changed since the document was executed?

Issue 6 – Proving copies of advance health directives

Q15: Would establishing a central register of AHDs be an appropriate way to resolve concerns about the authenticity of these documents? Please provide reasons for your view.

Q16: In the absence of a central register, should s 45 of the *PAA* be clarified to explain how an enduring document may be proved in "another way"?

Q17: If you answered "yes" to Q16, should the certification and other requirements imposed by s 45 of the *PAA* be relaxed so that a complete photocopy is sufficient to prove an enduring document?

Issue 7 – Emergency treatment and advance health directives

Q18: Should protection in s 63(2) of the *GAA* depend on whether the health provider "knows" that the adult objects to the health care in an AHD (as is currently the case), or on whether the health provider was acting in "good faith and with reasonable care and skill" in ascertaining whether the adult objects to the health care in an AHD?

Q19: If you think that protection should depend on what the health provider "knows" (as is currently the case), should the meaning of the term be clarified in the legislation?

Q20: If you answered "yes" to Q19, should "know" include:
(a) actual knowledge?
(b) imputed knowledge?
(c) wilful blindness?
(d) other (if so, please elaborate)?

Issue 8 – "Good medical practice": what does it mean?

Q21: Should the test be reformulated so that it would be lawful to withhold or withdraw life-sustaining measures provided such a course is consistent with good medical practice?

Q22: Should guidelines be developed to assist health providers and substitute decision makers in making decisions about withholding or withdrawing life-sustaining measures?

Issue 9 – "Good medical practice": a right of veto?

Q23: Should an adult's health provider be able to prevent a decision maker's consent from operating if they are not satisfied that commencing or continuing life-sustaining measures is inconsistent with good medical practice?

Issue 10 – General principles and the health care principle: a need for further guidance?

Q24: Should both the general principles and the health care principle, or just the health care principle, guide decision making in relation to withholding or withdrawing life-sustaining measures?

Q25: Should more direction be given to a decision maker regarding which principle (or principles) are more important in making a decision about withholding or withdrawing a life-sustaining measure if those principles suggest different outcomes?

Q26: Should the legislation provide that the adult's views and wishes apply equally in determining "best interests" as in determining what treatment is "necessary and appropriate" in the health care principle?

Issue 11 – A requirement to provide futile treatment?

Q27: Should health providers be required to obtain consent from a substitute decision maker before they can withhold or withdraw life-sustaining measures that are medically futile?

Issue 12 – "Health care": a problematic definition

Q28: Should the definition of "health care" in sch 2 s 5(2) of the *PAA* and *GAA* retain the requirement that commencing or continuing life-sustaining measures be inconsistent with good medical practice?

Issue 13 – "Life-sustaining measure": too narrow a definition?

Q29: Is there any reason in principle for differentiating between a PVS patient who is being hand fed and a PVS patient who is being artificially provided with nutrition and hydration in terms of the circumstances in which treatment should cease?

Q30: Should the definition of a "life-sustaining measure" be modified to more widely include those treatments needed to keep an adult alive?

Issue 14 – The *Criminal Code* and the *PAA* and *GAA*

Q31: Should the *PAA* and *GAA* contain a provision that clarifies the relationship between those Acts and the *Criminal Code 1899* (Qld) so as to avoid concerns about potential criminal liability?

How to make a comment or submission

The authors welcome comments and submissions on the questions raised in this Issues Paper. You are invited to contribute your views in any of the following ways:

- **Written comments and submissions can be sent to:**

  Dr Ben White and Associate Professor Lindy Willmott
  Faculty of Law
  Queensland University of Technology
  GPO Box 2434
  Brisbane QLD 4001

- **Email comments and submissions can be sent to:**

  Ben White at **bp.white@qut.edu.au** or
  Lindy Willmott at **l.willmott@qut.edu.au**

- **Comments and submissions can also be made via the project's website:**

  http://www.law.qut.edu.au/research/lifesustain/

The closing date for submissions is 30 May 2005

Further information about the project, including materials that may be useful in making a comment or submission, is also available at the project's website:

http://www.law.qut.edu.au/research/lifesustain/

If you would like your comment or submission to be treated as confidential, please indicate this clearly. However, submissions may be subject to release under the *Freedom of Information Act 1992* (Qld).