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Law Reform Commission**

**A Review of Queensland's  
Guardianship Laws**

**Report**

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# Table of contents

<b>CHAPTER 9 .....</b>	<b>1</b>
<b>ADVANCE HEALTH DIRECTIVES.....</b>	<b>1</b>
INTRODUCTION .....	2
BACKGROUND.....	4
THE LAW IN QUEENSLAND .....	8
The key provisions .....	8
Matters about which directions may be given .....	10
The effect of a direction in an advance health directive.....	11
Limitations on the operation of a direction in an advance health directive .....	13
Appointment of an attorney under an advance health directive.....	13
Requirements for making an advance health directive .....	14
Capacity .....	14
Formal requirements.....	15
Proof of advance health directives and recognition of interstate advance health directives .....	17
THE LAW IN OTHER JURISDICTIONS .....	17
ELIGIBILITY FOR APPOINTMENT AS AN ATTORNEY UNDER AN ADVANCE HEALTH DIRECTIVE .....	18
Introduction.....	18
Eligibility of a service provider for a residential service where the principal is a resident.....	19
Issue for consideration .....	19
Discussion Paper .....	20
Submissions.....	20
The Commission's view .....	21
Eligibility of the Public Trustee .....	21
Issue for consideration.....	21
Discussion Paper .....	22
Submissions.....	22
The Commission's view .....	22
OPERATION OF A DIRECTION IN AN ADVANCE HEALTH DIRECTIVE .....	23
The law in Queensland .....	23
The law in other jurisdictions.....	23
The Commission's view .....	24
THE APPROVED FORM.....	26
Introduction.....	26
Appointment of an attorney under the approved form .....	26
Use of the approved form not mandatory .....	26
The general approach to directions under the approved form.....	26
The length of the approved form.....	28
Discussion Paper .....	29
Submissions.....	29
Appointment of an attorney under an advance health directive .....	29
The approved form.....	29
The Commission's view .....	30
Appointment of an attorney under an advance health directive .....	30
Mandatory use of the approved form.....	31
Redrafting the approved form .....	32
INFORMED DECISION-MAKING .....	34

Introduction.....	34
The position at common law .....	34
The law in Queensland .....	38
Issues for consideration .....	39
Informed decision-making.....	39
Review of an advance health directive .....	39
Discussion Paper .....	40
Submissions .....	40
Informed decision-making.....	40
Review of an advance health directive .....	41
The Commission's view .....	43
Informed decision-making.....	43
Review of an advance health directive .....	43
COPIES AND PROOF .....	44
Issue for consideration .....	44
Discussion Paper .....	45
Submissions .....	45
The Commission's view .....	46
Proof of an advance health directive .....	46
Instructions about the certification process.....	47
NOTIFICATION AND REGISTRATION .....	47
The law in Queensland .....	47
The law in other jurisdictions.....	47
South Australia.....	47
Western Australia.....	48
Other jurisdictions .....	48
Issues for consideration .....	50
Discussion Paper .....	53
Submissions .....	54
The Commission's view .....	56
Inclusion of advance health directive with adult's health records.....	56
Notification of third parties .....	60
RECOGNITION OF INTERSTATE ADVANCE HEALTH DIRECTIVES .....	60
The law in Queensland .....	60
The law in other jurisdictions.....	61
Discussion Paper .....	61
Submissions .....	62
The Commission's view .....	63
PROTECTION OF HEALTH PROVIDER: ACTING ON AN INVALID ADVANCE HEALTH DIRECTIVE OR WITHOUT KNOWLEDGE OF AN ADVANCE HEALTH DIRECTIVE .....	64
Introduction.....	64
Protection if unaware of invalidity of advance health directive .....	65
Protection if unaware of existence of advance health directive.....	66
Issues for consideration .....	66
The type of knowledge that is relevant for sections 100 and 102.....	66
A different test for protection: acting in good faith with reasonable care and skill.....	67
Discussion Paper .....	68
Submissions .....	68
The Commission's view .....	69
The meaning of an 'invalid' advance health directive under section 100 .....	69
Acting under an inoperative direction .....	70
The requirement for protection under sections 100 and 102: acting in good faith .....	71

PROTECTION OF HEALTH PROVIDER: NOT ACTING IN ACCORDANCE WITH THE ADVANCE HEALTH DIRECTIVE.....	73
Introduction.....	73
The law in Queensland .....	73
The law in other jurisdictions.....	74
Issues for consideration .....	74
Uncertainty and changed circumstances.....	74
Requirement to consult attorney.....	76
Inconsistency with good medical practice.....	76
Discussion Paper .....	78
Submissions .....	78
General comments.....	78
Uncertainty.....	79
Inconsistency with good medical practice.....	79
Changed circumstances, including advances in medical science.....	82
The Commission's view .....	82
Uncertainty.....	83
Inconsistency with good medical practice.....	84
Directions refusing health care .....	84
Directions requiring health care.....	84
Changed circumstances, including advances in medical science.....	87
The requirement for consent or authorisation of health care that is not in accordance with the direction .....	87
POWERS TO REMOVE AND REPLACE AN ATTORNEY OR CHANGE OR REVOKE AN ADVANCE HEALTH DIRECTIVE.....	89
The law in Queensland .....	89
The Commission's view .....	91
The power to appoint a new attorney under an advance health directive.....	91
The powers to change the terms of an advance health directive and revoke all or part of an advance health directive.....	92
Majority view.....	92
Minority view.....	93
Changed circumstances as a basis for change or revocation.....	95
Majority view.....	95
Minority view.....	96
THE EFFECT OF THE GUARDIANSHIP LEGISLATION ON THE OPERATION OF A CONSENT OR REFUSAL THAT WOULD OTHERWISE BE EFFECTIVE AT COMMON LAW.....	96
Introduction.....	96
The law in Queensland .....	99
The law in other jurisdictions.....	103
Discussion Paper .....	103
Submissions.....	104
Recognition of common law directives generally.....	104
Recognition of common law directives in relation to the withholding or withdrawal of life-sustaining measures .....	106
The Commission's view .....	106
RECOMMENDATIONS .....	109
<b>CHAPTER 10 .....</b>	<b>119</b>
<b>STATUTORY HEALTH ATTORNEYS .....</b>	<b>119</b>
INTRODUCTION.....	119
BACKGROUND.....	120

THE LAW IN QUEENSLAND .....	122
THE LAW IN OTHER JURISDICTIONS .....	124
ACHIEVING THE RIGHT BALANCE AND UNDERSTANDING THE ROLE .....	126
Discussion Paper .....	127
Submissions .....	127
The Commission's view .....	128
IDENTIFYING THE STATUTORY HEALTH ATTORNEY.....	128
Spouse .....	129
Discussion Paper .....	131
Submissions.....	131
The Commission's view .....	131
Carer .....	131
Discussion Paper .....	132
Submissions.....	133
The Commission's view .....	133
Close friend or relation .....	133
Relation .....	133
Close friend.....	135
Discussion Paper .....	136
Submissions.....	137
Relation.....	137
Close friend.....	137
The Commission's view .....	138
Relation.....	138
Close friend.....	138
EXCLUSIONS AND LIMITATIONS .....	139
Discussion Paper .....	140
Submissions .....	140
The Commission's view .....	141
READILY AVAILABLE AND CULTURALLY APPROPRIATE.....	141
Discussion Paper .....	142
Submissions .....	143
Readily available.....	143
Culturally appropriate.....	143
The Commission's view .....	143
AN ORDER OF PRIORITY .....	144
Discussion Paper .....	144
Submissions .....	145
The Commission's view .....	146
SCOPE OF STATUTORY HEALTH ATTORNEY'S POWER .....	147
Discussion Paper .....	148
Submissions .....	148
The Commission's view .....	149
THE EFFECTIVENESS OF A DECISION MADE BY A STATUTORY HEALTH ATTORNEY. 150	
Background .....	150
The Commission's view .....	151
RECOMMENDATIONS .....	152
<b>CHAPTER 11 .....</b>	<b>155</b>
<b>THE WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING MEASURES ...</b>	<b>155</b>
INTRODUCTION .....	156
BACKGROUND.....	157

The emergence of legal and ethical issues in relation to life-sustaining measures .....	157
The common law .....	161
OVERVIEW OF THE QUEENSLAND LEGISLATION .....	167
Withholding or withdrawal: a 'health matter' .....	167
Withholding or withdrawal under an advance health directive .....	167
Withholding or withdrawal by an adult's substitute decision-maker .....	169
The priority for decisions about the withholding or withdrawal of life-sustaining measures .....	169
Withholding or withdrawal of a life-sustaining measure in an acute emergency .....	170
Certification in clinical records .....	171
The Adult Guardian's role in relation to the withholding or withdrawal of life-sustaining measures .....	172
THE DEFINITION OF 'HEALTH CARE' .....	173
The law in Queensland .....	173
Submissions .....	174
The Commission's view .....	174
THE DEFINITION OF 'LIFE-SUSTAINING MEASURE' .....	175
The law in Queensland .....	175
The law in other jurisdictions .....	176
Discussion Paper .....	177
Submissions .....	177
The Commission's view .....	178
WITHHOLDING OR WITHDRAWAL OF A LIFE-SUSTAINING MEASURE UNDER AN ADVANCE HEALTH DIRECTIVE .....	179
The law in Queensland .....	179
The requirement that the adult's medical condition falls within one of four categories.....	181
Issues for consideration .....	181
The law in other jurisdictions.....	182
Jurisdictions with restrictions relating to the gravity of the adult's medical condition.....	183
Jurisdictions without restrictions relating to the gravity of the adult's medical condition.....	185
Discussion Paper .....	185
Submissions.....	186
The Commission's view .....	187
The requirement that the commencement or continuation of artificial nutrition or hydration would be inconsistent with good medical practice .....	190
Issue for consideration.....	192
Discussion Paper .....	192
Submissions.....	192
The Commission's view .....	193
The requirement that the adult has no reasonable prospect of regaining capacity for health matters .....	194
Issue for consideration.....	194
Discussion Paper .....	195
Submissions.....	195
The Commission's view .....	196
The requirement that the commencement or continuation of the life-sustaining measure would be inconsistent with good medical practice .....	197
Issue for consideration.....	197
The law in other jurisdictions.....	199
Discussion Paper .....	199
Submissions.....	200

The Commission's view .....	201
CONSENT TO THE WITHHOLDING OR WITHDRAWAL OF A LIFE-SUSTAINING MEASURE BY AN ADULT'S SUBSTITUTE DECISION-MAKER.....	203
The law in Queensland .....	203
Limitation on the operation of a consent by a substitute decision-maker or the Tribunal .....	204
Good medical practice .....	205
The law in other jurisdictions.....	206
Australian Capital Territory .....	207
South Australia.....	208
Victoria .....	209
Issue for consideration .....	211
Discussion Paper .....	212
Submissions .....	212
The Commission's view .....	214
The limitation in section 5(2) of the definition of 'health care' .....	214
The limitation in section 66A of the <i>Guardianship and Administration Act</i> 2000 (Qld) .....	215
Majority view .....	217
Minority view .....	220
THE EFFECT OF THE CONSENT REQUIREMENTS WHERE THE LIFE-SUSTAINING MEASURE IS 'MEDICALLY FUTILE' .....	223
Background .....	223
The meaning of 'futile' .....	227
Whether the withholding and withdrawal of a life-sustaining measure should be treated in an identical manner.....	231
Discussion Paper .....	232
Submissions .....	232
The Commission's view .....	236
Withholding of a 'futile' life-sustaining measure.....	236
Withdrawal of a 'futile' life-sustaining measure.....	238
Majority view .....	238
Minority view .....	238
THE EFFECT OF AN ADULT'S OBJECTION TO THE COMMENCEMENT OR CONTINUATION, OR WITHHOLDING OR WITHDRAWAL, OF A LIFE-SUSTAINING MEASURE .....	239
Non-urgent health care .....	240
Urgent health care .....	242
The law in other jurisdictions.....	243
Non-urgent health care .....	243
Urgent health care .....	244
Discussion Paper .....	244
Submissions .....	245
The Commission's view .....	245
Objection to the commencement or continuation of a life-sustaining measure .....	245
Non-urgent health care .....	245
Urgent health care .....	246
Objection to the withholding or withdrawal of a life-sustaining measure .....	247
Non-urgent health care .....	247
Urgent health care .....	252
THE TRIBUNAL'S POWERS IN RELATION TO THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING MEASURES.....	252
Background .....	252

The current provisions.....	253
Discussion Paper .....	255
Submissions .....	256
The Commission's view .....	256
The need for the Tribunal's function of consenting to the withholding or withdrawal of life-sustaining measures .....	257
Issue for consideration.....	257
Discussion Paper .....	258
Submissions.....	259
The Commission's view .....	259
<b>POTENTIAL CRIMINAL RESPONSIBILITY FOR WITHHOLDING OR WITHDRAWING A LIFE-SUSTAINING MEASURE .....</b>	<b>260</b>
Introduction.....	260
The law in Queensland .....	260
Guardianship legislation.....	260
Criminal Code (Qld) .....	261
Section 285: Duty to provide necessaries .....	262
Section 296: Acceleration of death.....	268
Section 311: Aiding suicide.....	269
The law in other jurisdictions.....	270
Australian Capital Territory .....	270
Northern Territory.....	272
South Australia.....	272
Victoria .....	273
Discussion Paper .....	274
Submissions .....	274
The Commission's view .....	274
Amendment of the Criminal Code (Qld).....	274
Civil liability.....	277
<b>RECOMMENDATIONS .....</b>	<b>278</b>
<b>CHAPTER 12 .....</b>	<b>285</b>
<b>THE EFFECT OF AN ADULT'S OBJECTION TO HEALTH CARE .....</b>	<b>285</b>
INTRODUCTION .....	286
THE EFFECT OF AN ADULT'S OBJECTION AT COMMON LAW .....	286
AN OVERVIEW OF THE LAW IN QUEENSLAND .....	286
<i>Guardianship and Administration Act 2000</i> (Qld).....	286
Definition of 'object' .....	287
Order of priority for dealing with 'special health matters' and 'health matters' .....	288
OBJECTION TO HEALTH CARE GENERALLY .....	290
The law in Queensland .....	290
The law in other jurisdictions.....	295
Issues for consideration .....	297
Discussion Paper .....	298
Submissions .....	300
The Commission's view .....	301
Health matters other than life-sustaining measures .....	301
Special health matters: Sterilisation and termination of pregnancy.....	302
OBJECTION TO TISSUE DONATION AND SPECIAL MEDICAL RESEARCH OR EXPERIMENTAL HEALTH CARE .....	305
The law in Queensland .....	305
Removal and donation of tissue .....	305
Special medical research or experimental health care.....	307

The Commission's view .....	309
OBJECTION TO URGENT HEALTH CARE .....	309
The law in Queensland .....	309
Health care to meet imminent risk to the adult's life or health: section 63(1)(b)(i) ...	311
Health care to meet significant pain or distress to the adult: section 63(1)(b)(ii).....	312
The law in other jurisdictions.....	312
Discussion Paper .....	313
Submissions .....	314
The Commission's view .....	315
Health care to meet imminent risk to the adult's life or health: section 63(1)(b)(i) ...	315
Health care to prevent significant pain or distress: section 63(1)(b)(ii) .....	316
Knowledge that an adult objects to the health care in an advance health directive .....	316
The relationship between section 63(2) of the <i>Guardianship and Administration         Act 2000</i> (Qld) and section 103 of the <i>Powers of Attorney Act 1998</i> (Qld) .....	317
OBJECTION TO MINOR AND UNCONTROVERSIAL HEALTH CARE.....	320
The law in Queensland .....	320
The law in other jurisdictions.....	321
Discussion Paper .....	322
Submissions .....	322
The Commission's view .....	322
PRESENT AND PREVIOUS OBJECTIONS .....	323
The law in Queensland .....	323
Discussion Paper .....	328
Submissions .....	328
The Commission's view .....	328
RECOMMENDATIONS .....	328
<b>CHAPTER 13 .....</b>	<b>331</b>
<b>CONSENT TO PARTICIPATION IN MEDICAL RESEARCH .....</b>	<b>331</b>
INTRODUCTION .....	331
BACKGROUND.....	332
THE LAW IN QUEENSLAND .....	332
Terminology.....	332
Participation in special medical research or experimental health care .....	333
Requirements for the Tribunal's consent .....	333
The effect of an adult's objection .....	337
Data about Tribunal consents .....	338
Participation in approved clinical research.....	338
Requirements for the Tribunal's approval of clinical research.....	339
The effect of an adult's objection .....	340
Data about Tribunal approvals.....	341
THE LAW IN OTHER JURISDICTIONS .....	342
Jurisdictions with specific consent mechanisms for medical research .....	342
New South Wales .....	342
Special treatment.....	343
Clinical trials.....	344
Victoria .....	346
Other Australian jurisdictions .....	350
THE CURRENT REQUIREMENT FOR TRIBUNAL CONSENT OR APPROVAL.....	350
Issues for consideration .....	350
Participation in special medical research or experimental health care.....	350

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Participation in an approved clinical research .....	351
Discussion Paper .....	352
Submissions .....	353
Threshold issue .....	353
Tribunal oversight of special medical research or experimental health care and clinical research .....	353
Consent mechanism for special medical research or experimental health care .....	355
Consent mechanism for approved clinical research .....	355
General comments .....	356
The Commission's view .....	356
Participation of adults in medical research .....	356
Consent mechanism for special medical research or experimental health care .....	357
Participation in approved clinical research .....	358
Information available to substitute decision-maker .....	359
The effect of an adult's objection .....	359
THE SCOPE OF THE DEFINITIONS OF 'HEALTH CARE' AND 'SPECIAL HEALTH CARE' .....	360
Issue for consideration .....	360
The law in other jurisdictions .....	362
Discussion Paper .....	362
Submissions .....	363
The Commission's view .....	363
RECOMMENDATIONS .....	363



# Chapter 9

## Advance health directives

INTRODUCTION .....	2
BACKGROUND.....	4
THE LAW IN QUEENSLAND .....	8
The key provisions .....	8
Matters about which directions may be given .....	10
The effect of a direction in an advance health directive.....	11
Limitations on the operation of a direction in an advance health directive .....	13
Appointment of an attorney under an advance health directive.....	13
Requirements for making an advance health directive .....	14
Proof of advance health directives and recognition of interstate advance health directives .....	17
THE LAW IN OTHER JURISDICTIONS .....	17
ELIGIBILITY FOR APPOINTMENT AS AN ATTORNEY UNDER AN ADVANCE HEALTH DIRECTIVE .....	18
Introduction.....	18
Eligibility of a service provider for a residential service where the principal is a resident...	19
Eligibility of the Public Trustee .....	21
OPERATION OF A DIRECTION IN AN ADVANCE HEALTH DIRECTIVE .....	23
The law in Queensland .....	23
The law in other jurisdictions.....	23
The Commission's view .....	24
THE APPROVED FORM.....	26
Introduction.....	26
Discussion Paper .....	29
Submissions .....	29
The Commission's view .....	30
INFORMED DECISION-MAKING .....	34
Introduction.....	34
The position at common law .....	34
The law in Queensland .....	38
Issues for consideration .....	39
Discussion Paper .....	40
Submissions .....	40
The Commission's view .....	43
COPIES AND PROOF .....	44
Issue for consideration .....	44
Discussion Paper .....	45
Submissions .....	45
The Commission's view .....	46
NOTIFICATION AND REGISTRATION .....	47
The law in Queensland .....	47
The law in other jurisdictions.....	47
Issues for consideration .....	50
Discussion Paper .....	53
Submissions .....	54

The Commission's view .....	56
RECOGNITION OF INTERSTATE ADVANCE HEALTH DIRECTIVES .....	60
The law in Queensland .....	60
The law in other jurisdictions.....	61
Discussion Paper .....	61
Submissions.....	62
The Commission's view .....	63
PROTECTION OF HEALTH PROVIDER: ACTING ON AN INVALID ADVANCE HEALTH DIRECTIVE OR WITHOUT KNOWLEDGE OF AN ADVANCE HEALTH DIRECTIVE .....	64
Introduction.....	64
Issues for consideration .....	66
Discussion Paper .....	68
Submissions.....	68
The Commission's view .....	69
PROTECTION OF HEALTH PROVIDER: NOT ACTING IN ACCORDANCE WITH THE ADVANCE HEALTH DIRECTIVE.....	73
Introduction.....	73
The law in Queensland .....	73
The law in other jurisdictions.....	74
Issues for consideration .....	74
Discussion Paper .....	78
Submissions.....	78
The Commission's view .....	82
POWERS TO REMOVE AND REPLACE AN ATTORNEY OR CHANGE OR REVOKE AN ADVANCE HEALTH DIRECTIVE.....	89
The law in Queensland .....	89
The Commission's view .....	91
THE EFFECT OF THE GUARDIANSHIP LEGISLATION ON THE OPERATION OF A CONSENT OR REFUSAL THAT WOULD OTHERWISE BE EFFECTIVE AT COMMON LAW.....	96
Introduction.....	96
The law in Queensland .....	99
The law in other jurisdictions.....	103
Discussion Paper .....	103
Submissions.....	104
The Commission's view .....	106
RECOMMENDATIONS .....	109

## INTRODUCTION

9.1 The Commission's terms of reference direct it to review the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld), including the law relating to advance health directives.<sup>1</sup> An advance health directive is one of the two types of 'enduring document' for which the guardianship legislation makes provision.<sup>2</sup>

<sup>1</sup> The terms of reference are set out in Appendix 1.

<sup>2</sup> *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of 'enduring document'); *Powers of Attorney Act 1998* (Qld) s 28. The other type of enduring document is an enduring power of attorney. Enduring powers of attorney are considered in Chapter 16 of this Report.

9.2 This chapter gives an overview of the current scheme for advance health directives in Queensland, as well as the law in relation to advance health directives (or their equivalent) in other jurisdictions. It also makes recommendations about a number of specific issues that arise under the legislation.

9.3 As explained below, legislative provision for advance health directives is an important part of the advance care planning process. The Commission recognises, however, that the effectiveness of the broader process of advance care planning also depends on a range of additional factors, such as good communication between health providers and their patients:<sup>3</sup>

Creating a legal structure for advance directives is only the first step in making advance directives useful tools for patients and health professionals. What is needed in addition to a legal structure is a culture of advance care planning, where patients and health professionals 'engage in a process of reflection, discussion and communication of treatment preferences for end-of-life care that proceeds, and may lead to, an advance directive.'<sup>4</sup> (note in original)

9.4 Recently, the National Health and Hospitals Reform Commission has also referred to the importance of funding and implementing advance care planning on a national basis and of adopting a national approach to the education and training of health professionals:<sup>5</sup>

We recommend that advance care planning be funded and implemented nationally, commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

9.5 While these other considerations are important factors in improving the effectiveness of advance care planning processes, the Commission's review is specifically concerned with 'the law relating to advance health directives'. As a result, the Commission's recommendations are necessarily confined to the legal issues that arise under the guardianship legislation in relation to advance health directives. The review does not extend to an examination of the wider range of non-legislative issues, such as the development of policies regarding the training of health professionals or the practices of health professionals in communicating with patients and their families.

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<sup>3</sup> C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal of Ageing* (June Supplement) S28.

<sup>4</sup> DMcD Taylor and PA Cameron, 'Advance care planning in Australia: overdue for improvement' *International Medicine Journal* 32 (2002) 475–80.

<sup>5</sup> National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Final Report (June 2009) 23, Recommendation 57.

## BACKGROUND

9.6 Medical treatment ordinarily requires patient consent.<sup>6</sup> Consistent with the concept of individual autonomy, every competent adult has the right to decide whether to consent to, or refuse, medical treatment. If a patient lacks capacity to give consent, a mechanism is needed to determine whether or not particular treatment can be given.

9.7 One such mechanism is the advance health directive. Advance health directives 'are decisions made by patients about what medical treatments they would like in the future, if at some point, they cannot make decisions for themselves'.<sup>7</sup> Advance health directives were developed as a response to the recognition of patient autonomy and self-determination, and to concerns about the possible indignities of artificial prolongation of life by new medical technologies.<sup>8</sup> In some jurisdictions, they have also been used in relation to psychiatric treatment.<sup>9</sup>

9.8 Legislative provision for advance health directives overcame three perceived problems.<sup>10</sup>

9.9 First, there was some uncertainty at common law about whether an 'advance directive'<sup>11</sup> about health care would be binding on health practitioners or would simply be taken into account as evidence of the patient's wishes, and whether doctors would be protected from potential liability if they complied, or failed to comply, with such a directive. A legislative scheme provides greater certainty and minimises the need for such questions to be resolved on an individual basis by the courts.

9.10 Secondly, legislative provision for advance health directives enables an adult to make certain health care decisions in advance where the adult may not wish to use an enduring power of attorney for that purpose. Enduring powers of attorney allow people to appoint attorneys to give or refuse consent on their behalf.

<sup>6</sup> Eg *Airedale NHS Trust v Bland* [1993] AC 789, 891 (Lord Mustill); *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218, 232–4 (Mason CJ, Dawson, Toohey and Gaudron JJ); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102 (Lord Donaldson MR). In Queensland, see also *Guardianship and Administration Act 2000* (Qld) s 79; Criminal Code (Qld) ss 245 (Definition of assault), 246 (Assaults unlawful).

<sup>7</sup> C Stewart, 'Advance directives: Disputes and dilemmas' in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 38.

<sup>8</sup> Law Reform Commission of Ireland, *Bioethics: Advance Care Directives*, Consultation Paper No 51 (2008) [1.06]; South Australia Government, *South Australian Advance Directives Review*, Background Paper (2007) 7; R Tobin, 'The incompetent patient's right to die: time for legislation allowing advance directives?' (1993) *New Zealand Law Review* 103.

<sup>9</sup> T Foukas, 'Psychiatric advance directives: Part 1' (1999) 8(1) *Australian Health Law Bulletin* 13.

<sup>10</sup> See generally Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 346–8; D Lanham and B Fehlberg, 'Living wills and the right to die with dignity' (1991) 18(2) *Melbourne University Law Review* 329, 331–5.

<sup>11</sup> In this context, the term 'advance directive' is used to refer to a decision about health care the effectiveness of which is determined by the common law rather than by statute. Other terms that are also commonly used to refer to such decisions are 'common law directive' and 'advance care directive'. Generally, these decisions are made more remotely in time from when the need for the decision arises than is usually the case. See the discussion of 'advance directives' and their effectiveness at [9.377]–[9.384] below.

However, some people might not have a trusted family member or friend to appoint as attorney or they might not wish to burden other people with the difficulties of making such decisions.<sup>12</sup> Provision for an adult to make legally binding directions about these matters in advance provides an alternative and minimises the risk that a chosen, or default, decision-maker might make decisions that are inconsistent with the adult's wishes.

9.11 Thirdly, the scheme for advance health directives overcame the limitations of existing legislative provisions in other jurisdictions for 'living wills'. By a living will a person could direct that, in the event that the person became terminally ill and lost decision-making capacity, life-sustaining treatment be withheld.<sup>13</sup> Provision for living wills did not allow directions to be given about other health care or treatment. In contrast, the legislative schemes in Queensland and some other jurisdictions<sup>14</sup> apply to a wider range of health care matters and in a wider range of circumstances — namely, in any circumstance in which the person's decision-making capacity for the relevant matter is impaired. In Queensland, the scheme also encompasses and extends the concept of a 'Ulysses agreement' or 'advance psychiatric directive'<sup>15</sup> by allowing directives to be made with respect to care or treatment for a person's mental condition and special health care matters such as electroconvulsive therapy or psychosurgery and experimental health care.<sup>16</sup>

9.12 It has been suggested that advance directives are 'a logical extension of the right to self-determination',<sup>17</sup> and that:<sup>18</sup>

Without this logical extension, the right to self-determination would become a nonsense. A doctor would only have to wait for a patient to fall into unconsciousness before they could proceed with treatments which had been refused by the patient. Conversely a doctor could cease to provide agreed upon treatments as soon as the patient became incompetent.

12 Such concerns were raised, for example, by participants in a South Australian study: M Brown, 'Who would you choose? Appointing an agent with a medical power of attorney' (1997) 16(4) *Australasian Journal on Ageing* 147, 149–50.

13 The concept of the 'living will' was developed in the United States of America and was reflected in the statutory provision for anticipatory directions for the refusal of life-sustaining treatment in the Northern Territory and South Australia: Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-Making for People who Need Assistance Because of Mental or Intellectual Disability*, Discussion Paper, WP No 38 (1992) 144. See *Natural Death Act* (NT); *Natural Death Act 1983* (SA), repealed by *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

14 Eg *Guardianship and Administration Act 1990* (WA); *Mental Capacity Act 2005* (Eng) s 24(1); *Health Care Directives Act*, CCSM 1992 c H27 (Manitoba). See also [9.51] below.

15 Ulysses agreements and psychiatric advance directives are used to provide advance refusal or consent to psychiatric treatment that survives the person's subsequent incapacity: see eg A Macklin, 'Bound to freedom: The Ulysses contract and the psychiatric will' (1987) 45 *University of Toronto Faculty of Law Review* 37, 38. See also eg JA Dunlap, 'Mental health advance directives: Having one's say?' (2000) 89(2) *Kentucky Law Journal* 327, 351–4.

16 *Powers of Attorney Act 1998* (Qld) s 35(1), sch 2 ss 4–5, 6–7.

17 C Stewart, 'Advance directives: Disputes and dilemmas' in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 39.

18 *Ibid.*

9.13 Importantly, the legislation in Queensland is not limited to the refusal of treatment but also enables an adult to provide advance consent to treatment. This is an especially important measure given that lack of access to treatment, rather than over-treatment, is often a more pressing concern for people with disabilities.<sup>19</sup>

9.14 Advance health directives therefore have a number of advantages:<sup>20</sup>

Arguably, the right now given to Queenslanders to execute an advance health directive or living will under the *Powers of Attorney Act 1998* is a right based on the principle of self-determination.

Individuals are provided with a mechanism of planning for their own incapacity with respect to important health care decisions, including whether or not to withhold or withdraw life-sustaining treatment at the end of their lives.

These directives have the advantage of removing the decision-making burden from the shoulders of family members and friends, who are often called on to take responsibility for, or at least be involved in, critical decisions about life-sustaining treatment.

...

Perhaps the most significant advantage of the advance health directive is that it encourages discussion between the principal, family members and health care professionals about death and dying.

9.15 Advance health directives give effect to the principles of decision-making autonomy and least restrictive interference with adults' rights. They can safeguard patients' right of choice, self-determination and dignity at times when their preferences and human rights may otherwise be overlooked.<sup>21</sup> For example, one respondent to the Commission's review commented:<sup>22</sup>

Nobody knows what the adult's best interests are better than the adult. I am 87 years of age, I have an Advance Health Directive also I wear a plaque around my neck that states — DO NOT RESUSCITATE. Signed by my Doctor and myself. I am in good health at the moment and life is good, but if something goes wrong I want to be allowed to die not patched up and spend the rest of my life in a nursing home. I have stated in my Advance Health Directive I wish to have pain killing drugs even if this hastens my death.

<sup>19</sup> Queensland Advocacy Incorporated, *Submission on 'Rethinking Life-Sustaining Measures: Questions for Queensland'* (4 July 2005) 5 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 23 August 2010.

<sup>20</sup> G Clarke, 'Living wills and the *Powers of Attorney Act 1998*: an opportunity to die with dignity' (1999) 19(1) *Proctor* 18, 20. See also Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-Making for People who Need Assistance Because of Mental or Intellectual Disability*, Discussion Paper, WP No 38 (1992) 143; and, in the context of mental illness, T Foukas, 'Psychiatric advance directives: Part 1' (1999) 8(1) *Australian Health Law Bulletin* 13.

<sup>21</sup> Eg D Porter, 'Advance directives and the persistent vegetative state in Victoria: A human rights perspective' (2005) 13 *Journal of Law and Medicine* 256. See also Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 29.

<sup>22</sup> Submission 65.

9.16 Advance directives can also help prevent abuse, neglect or exploitation that might arise from inadequate decision-making arrangements; further, their statutory recognition may contribute to wider community respect for the autonomy of people with disabilities or mental illness.<sup>23</sup>

9.17 This is consistent with the United Nations *Convention on the Rights of Persons with Disabilities*, which recognises the importance of autonomy and least restrictive means of intervention, the inherent right to life of every human being, the right of persons with disabilities to enjoy the highest attainable standard of health without discrimination on the basis of disability, and the need to protect people with disabilities from exploitation and abuse.<sup>24</sup>

9.18 As with enduring powers of attorney, there is always a risk that advance health directives may involve abuse. This may occur, for example, if a person executes an advance health directive under undue pressure from a family member or other person and without understanding the nature or consequences of the document. There is also a risk that over-emphasis on the use of advance directives to refuse life-sustaining treatment may contribute to social pressures on people with aged-related or other disabilities 'not to be a burden'.<sup>25</sup> For example, Right to Life Australia has suggested that advance health directives seem to exemplify the view that the sick are routinely being grossly over-burdened with unnecessary and/or unhelpful treatment from which they need to be protected, when under-servicing, rather than over-servicing, is much more likely to be the case.<sup>26</sup>

9.19 It is important for the legislative scheme for advance health directives to balance the need for safeguards against misuse with the desirability of providing an accessible and convenient means of advance planning. It is also important to balance the need for clarity and certainty with the flexibility that is necessary to make advance health directives a workable option.

9.20 Reliable information about the use of advance health directives is scarce. Available research suggests that they are not commonly used.<sup>27</sup> For example, Queensland research reported in 2002 suggests that relatively few people have executed an advance health directive compared with enduring powers of

23 The preservation of decision-making autonomy for people with a mental illness, for example, is arguably of particular importance, given that psychiatry has been said to be 'an area traditionally fraught with benevolent paternalism': T Foukas, 'Psychiatric advance directives: Part 1' (1999) 8(1) *Australian Health Law Bulletin* 13, 13.

24 United Nations, *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 13 December 2006, arts 3(a), 12(4), 16, 25. The Convention is considered in Chapter 3 of this Report. See also eg United Nations, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, 17 December 1991; United Nations, *Principles for Older Persons*, GA Res 46/91, 16 December 1991.

25 See eg Queensland Advocacy Incorporated, *Submission on 'Rethinking Life-Sustaining Measures: Questions for Queensland'* (4 July 2005) 12 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 23 August 2010.

26 Submission 149.

27 C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal of Ageing* S25, S28.

attorney.<sup>28</sup> This is consistent with earlier research in other Australian jurisdictions.<sup>29</sup>

9.21 The low uptake of advance health directives may be a consequence of a lack of awareness, although it may be that some people prefer informal options even when they know about advance directives.<sup>30</sup> Other barriers to the uptake of advance directives include the time involved in making a directive, people's reluctance to consider end-of-life issues, and difficulties in predicting future scenarios.<sup>31</sup> It has been said, however, that even if it is not widely exercised, the right to make an advance directive remains important.<sup>32</sup>

## THE LAW IN QUEENSLAND

### The key provisions

9.22 The *Powers of Attorney Act 1998* (Qld) makes provision for advance health directives. Sections 35 and 36 provide:

#### **35 Advance health directives**

- (1) By an **advance health directive**, an adult principal may—
- (a) give directions, about health matters and special health matters, for his or her future health care; and
  - (b) give information about his or her directions; and
  - (c) appoint 1 or more persons who are eligible attorneys to exercise power for a health matter<sup>35</sup> for the principal in the event the directions prove inadequate; and
  - (d) provide terms or information about exercising the power.

<sup>28</sup> CM Cartwright et al, *Community and Health/Allied Health Professionals' Attitudes to Euthanasia: What are the Driving Forces?* Report to the National Health and Medical Research Council (August 2002), cited in Alzheimer's Australia, *Submission to the House of Representatives Legal and Constitutional Affairs Committee Inquiry into Older People and the Law* (30 November 2006) 10 <<http://www.aph.gov.au/house/committee/laca/olderpeople/subs/sub55.pdf>> at 23 August 2010.

<sup>29</sup> C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal of Ageing* S25, S28.

<sup>30</sup> The results of a small study in New South Wales suggest that people prefer informal advance care planning options even after they have been informed about advance health directives: J Mador, 'Advance care planning: Should we be discussing it with our patients?' (2001) 20(2) *Australasian Journal on Ageing* 89, 91. It has also been suggested that, even with large scale education initiatives, it is possible that advance directives will be used by only a small class of adults 'such as patients with chronic conditions, or those with specific religious objections to types of treatments': C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal of Ageing* S25, S28.

<sup>31</sup> Eg Law and Justice Foundation of New South Wales (S Ellison et al), *Access to Justice and Legal Needs: The Legal Needs of Older People in NSW* (2004) vol 1, 158–9.

<sup>32</sup> C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal of Ageing* S25, S28.

- (2) Without limiting subsection (1), by an advance health directive the principal may give a direction—
- (a) consenting, in the circumstances specified, to particular future health care of the principal when necessary and despite objection by the principal when the health care is provided; and
  - (b) requiring, in the circumstances specified, a life-sustaining measure to be withheld or withdrawn; and
  - (c) authorising an attorney to physically restrain, move or manage the principal, or have the principal physically restrained, moved or managed, for the purpose of health care when necessary and despite objection by the principal when the restraint, movement or management is provided.
- (3) A direction in an advance health directive has priority over a general or specific power for health matters given to any attorney.
- (4) An advance health directive is not revoked by the principal becoming a person with impaired capacity.

35 Note this does not include a special health matter.

### **36 Operation of advance health directive**

- (1) A direction in an advance health directive—
- (a) operates only while the principal has impaired capacity for the matter covered by the direction; and
  - (b) is as effective as if—
    - (i) the principal gave the direction when decisions about the matter needed to be made; and
    - (ii) the principal then had capacity for the matter.<sup>36</sup>
- (2) A direction to withhold or withdraw a life-sustaining measure<sup>37</sup> can not operate unless—
- (a) 1 of the following applies—
    - (i) the principal has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a doctor treating the principal and another doctor, the principal may reasonably be expected to die within 1 year;
    - (ii) the principal is in a persistent vegetative state, that is, the principal has a condition involving severe and irreversible brain damage which, however, allows some or all of the principal's vital bodily functions to continue, including, for example, heart beat or breathing;
    - (iii) the principal is permanently unconscious, that is, the principal has a condition involving brain damage so

severe that there is no reasonable prospect of the principal regaining consciousness;<sup>38</sup>

- (iv) the principal has an illness or injury of such severity that there is no reasonable prospect that the principal will recover to the extent that the principal's life can be sustained without the continued application of life-sustaining measures; and
  - (b) for a direction to withhold or withdraw artificial nutrition or artificial hydration—the commencement or continuation of the measure would be inconsistent with good medical practice; and
  - (c) the principal has no reasonable prospect of regaining capacity for health matters.
- (3) An attorney's power for a health matter under an advance health directive is exercisable during any or every period the principal has impaired capacity for the matter and not otherwise.<sup>39</sup>
- (4) While power for a health matter is exercisable under an advance health directive, the directive gives the attorney for the matter power to do, for the principal, anything in relation to the matter the principal could lawfully do if the principal had capacity for the matter.
- (5) However, the power given is subject to the terms of the advance health directive and this Act.
- (6) A person dealing with the attorney may ask for evidence, for example, a medical certificate, to establish that the principal has impaired capacity for the matter.

36 See also section 101 (No less protection than if adult gave health consent).

37 Defined in schedule 2, section 5A.

38 This is sometimes referred to as 'a coma'.

39 However, the priority of an attorney's power for a health matter is decided by the *Guardianship and Administration Act 2000*, section 66 (Adult with impaired capacity—order of priority in dealing with health matter). See, in particular, section 66(4).

## Matters about which directions may be given

9.23 A principal may give directions in an advance health directive about health matters, such as the treatment of a physical or mental condition, or about special health matters, such as tissue donation or participation in experimental health care.<sup>33</sup>

9.24 A principal may also give a direction requiring the withholding or withdrawal of a life-sustaining measure.<sup>34</sup>

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

34 The withholding and withdrawal of life-sustaining measures is considered in Chapter 11 of this Report.

9.25 The fact that the *Powers of Attorney Act 1998* (Qld) enables a principal to give a direction consenting to health care (and not just a direction refusing health care) is a positive feature of the Queensland legislation. It means that it is possible for an adult to authorise health care directly by way of his or her advance health directive. This avoids the need for a health provider to seek consent for the health care from the adult's substitute decision-maker. It also means that the decision to receive the health care is the adult's decision, rather than that of the adult's substitute decision-maker.

### The effect of a direction in an advance health directive

9.26 Section 36(1) of the *Powers of Attorney Act 1998* (Qld) provides that a direction in an advance health directive operates only while the principal has impaired capacity for the matter covered by the direction, and is as effective as if the principal gave the direction, and had capacity for the matter, when the decisions about the matter needed to be made.<sup>35</sup> If a principal has given a direction about a health matter or a special health matter, the health matter or special health matter must be dealt with in accordance with the direction.<sup>36</sup> A direction in an advance health directive takes priority over a power given to an attorney.<sup>37</sup>

9.27 By providing that an adult's direction is as effective as if the principal gave the direction when decisions about the matter needed to be made and the principal then had capacity for the matter, section 36(1) does not elevate the effect of the principal's direction above the effect that a decision made by a competent adult would have.

9.28 It is clear that a competent adult may refuse medical treatment even if that decision will result in the adult's death.<sup>38</sup> However, the effect of a competent adult's decision requiring medical treatment is more complex. This question was considered by the English Court of Appeal in *R (Burke) v General Medical Council*.<sup>39</sup> Mr Burke, who was competent, had a degenerative illness. It was likely that, as his illness progressed, he would need artificial nutrition and hydration ('ANH') to survive. He was concerned that, in the final stages of his illness, doctors might withdraw ANH. He sought judicial review of guidelines published by the General Medical Council in relation to the withholding and withdrawal of life-prolonging treatments.

9.29 The Court of Appeal considered it important to 'distinguish between the withdrawal of ANH in circumstances where this will shorten life and the withdrawal of ANH where it will not have this effect because it is no longer sustaining life'.<sup>40</sup>

<sup>35</sup> *Powers of Attorney Act 1998* (Qld) s 36(1). See also *Powers of Attorney Act 1998* (Qld) s 101; *Guardianship and Administration Act 2000* (Qld) s 80 (No less protection than if adult gave health consent).

<sup>36</sup> *Guardianship and Administration Act 2000* (Qld) ss 65(1)–(2), 66(1)–(2).

<sup>37</sup> *Powers of Attorney Act 1998* (Qld) s 35(3).

<sup>38</sup> See [11.20] below.

<sup>39</sup> [2006] QB 273.

<sup>40</sup> *Ibid* 290.

The Court stated that, if Mr Burke feared that ANH might be withdrawn before the final stages of his disease, there 'are no grounds for thinking that those caring for a patient would be entitled to or would take a decision to withdraw ANH in such circumstances'.<sup>41</sup>

9.30 The Court emphasised, however, that the duty to provide ANH did not arise because a patient demanded it:<sup>42</sup>

Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.

So far as ANH is concerned, there is no need to look far for the duty to provide this. Once a patient is accepted into a hospital, the medical staff come under a positive duty at common law to care for the patient. ... A fundamental aspect of this positive duty of care is a duty to take such steps as are reasonable to keep the patient alive. Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH. This duty will not, however, override the competent patient's wish not to receive ANH. Where the competent patient makes it plain that he or she wishes to be kept alive by ANH, this will not be the source of the duty to provide it. The patient's wish will merely underscore that duty.

9.31 The Court also considered and rejected the argument that a competent patient is entitled to insist on a treatment that is not offered:<sup>43</sup>

So far as the general proposition is concerned, we would endorse the following simple propositions advanced by the GMC. (i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated (ie will provide overall clinical benefit) for his patient. (ii) He then offers those treatment options to the patient in the course of which he explains to him/her the risks, benefits, side effects, etc involved in each of the treatment options. (iii) The patient then decides whether he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases [the patient] will, of course, decide which treatment option he considers to be in his best interests and, in doing so, he will or may take into account other, non-clinical factors. However, he can, if he wishes, decide to accept (or refuse) the treatment option on the basis of reasons which are irrational or for no reasons at all. (iv) If he chooses one of the treatment options offered to him, the doctor will then proceed to provide it. (v) If, however, [the patient] refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (ie he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.

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41 Ibid.

42 Ibid 296–7.

43 Ibid 301.

The relationship between doctor and patient usually begins with diagnosis and advice. The doctor will describe the treatment that he recommends or, if there are a number of alternative treatments that he would be prepared to administer in the interests of the patient, the choices available, their implications and his recommended option. In such circumstances, the right to refuse proposed treatment gives the patient what appears to be a positive option to choose an alternative. In truth the right to choose is no more than a reflection of the fact that it is the doctor's duty to provide a treatment that he considers to be in the interests of the patient and that the patient is prepared to accept.

### Limitations on the operation of a direction in an advance health directive

9.32 Section 36(2) of the *Powers of Attorney Act 1998* (Qld) sets out a number of limitations on the operation of a direction to withhold or withdraw a life-sustaining measure.<sup>44</sup> Generally, the limitations require that, for the direction to operate, the adult's condition must be sufficiently poor, there must be no reasonable prospect that the adult will regain capacity and, additionally, for a direction to withhold or withdraw artificial nutrition or artificial hydration, the commencement or continuation of the measure would be inconsistent with good medical practice. The appropriateness of these limitations is considered in detail in Chapter 11 of this Report.

### Appointment of an attorney under an advance health directive

9.33 Section 35(1)(c) of the *Powers of Attorney Act 1998* (Qld) enables a principal, by an advance health directive, to appoint one or more persons who are eligible attorneys to exercise power for a health matter for the principal in the event that the directions in the advance health directive prove inadequate. The appointment of an attorney in an advance health directive operates in a similar fashion to an appointment made in an enduring power of attorney. The attorney's power is exercisable only during a period when the principal has impaired capacity for the matter.<sup>45</sup>

9.34 Section 36(4) of the Act provides that, while power is exercisable under an advance health directive, the attorney has authority to do anything in relation to the health matter that the principal could lawfully do if the principal had capacity for the matter. However, section 36(5) provides further that the attorney's power is subject to the terms of the advance health directive<sup>46</sup> and the *Powers of Attorney Act 1998* (Qld). One effect of the second of these limitations is that an attorney appointed under an advance health directive may exercise power only in relation to health matters and has no authority in relation to special health matters.<sup>47</sup>

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44 *Powers of Attorney Act 1998* (Qld) s 36 is set out at [9.22] above.

45 *Powers of Attorney Act 1998* (Qld) s 36(3).

46 A principal may, by an advance health directive, provide terms or information about the exercise of the attorney's powers: *Powers of Attorney Act 1998* (Qld) s 35(1)(d). To the extent the advance health directive does not state otherwise, the attorney will be taken to have the maximum power that could be given by the directive: s 77.

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

9.35 The provisions that apply to attorneys generally also apply to attorneys appointed under an advance health directive.<sup>48</sup> Those issues are considered in Chapter 16 of this Report.

### Requirements for making an advance health directive

9.36 The *Powers of Attorney Act 1998* (Qld) includes requirements about the capacity that an adult must have in order to make an advance health directive, as well as formal requirements in relation to the execution of an advance health directive. These requirements are considered in detail in Chapter 8 of this Report.

### Capacity

9.37 Section 42(1) of the *Powers of Attorney Act 1998* (Qld) provides that a principal may make an advance health directive only if the principal understands the following matters:

- the nature and the likely effects of each direction in the advance health directive;
- that a direction in an advance health directive operates only while the principal has impaired capacity for the matter covered by the direction;
- that the principal may revoke a direction at any time the principal has capacity for the matter covered by the direction; and
- that at any time the principal is not capable of revoking a direction, the principal is unable to effectively oversee the implementation of the direction.

9.38 To have the capacity to make an advance health directive, it is not sufficient that the principal is *capable* of understanding these matters — the section requires that the principal *actually* understands these matters.

9.39 Further, section 42(2) of the Act provides that, to the extent that an advance health directive gives power to an attorney, a principal may make an advance health directive only if the principal also understands the matters necessary to make an enduring power of attorney giving the same power.<sup>49</sup>

9.40 In Chapter 8 of this Report, the Commission has made two recommendations to strengthen the requirements for capacity to make an advance health directive.

9.41 The first recommendation is that section 42 of the *Powers of Attorney Act 1998* (Qld) be amended to provide that a principal has capacity to make an advance health directive only if, in addition to the matters currently listed in section

<sup>48</sup> These provisions deal with matters such as the appointment of multiple attorneys, the duties imposed on attorneys and the circumstances in which an attorney who breaches his or her duties may be protected from liability for the breach.

<sup>49</sup> The matters that a principal must understand to make an enduring power of attorney are set out in s 41 of the *Powers of Attorney Act 1998* (Qld). Those matters are considered in Chapter 8 of this Report.

42(1), the principal understands the nature and effect of the advance health directive and is capable of making the advance health directive freely and voluntarily.<sup>50</sup>

9.42 The second recommendation is that section 42 of the Act be amended so that the list of the matters that must be understood by a principal in order to make an advance health directive is expressed as a non-exhaustive list.<sup>51</sup>

### **Formal requirements**

9.43 The *Powers of Attorney Act 1998* (Qld) also includes a number of formal requirements relating to the execution of an advance health directive. These requirements are intended to ensure, as far as possible, the integrity of the process of making an advance health directive. These include requirements that an advance health directive must:

- be made in writing;<sup>52</sup>
- be signed by the principal or, if the principal instructs, be signed for the principal and in the principal's presence by an 'eligible signer';<sup>53</sup>
- be signed and dated by an eligible witness<sup>54</sup> — that is, by a justice, commissioner for declarations, notary public or lawyer;<sup>55</sup>
- if it is signed by the principal, include a certificate signed by the witness stating that:<sup>56</sup>
  - the principal signed the advance health directive in the witness's presence; and
  - the principal, at the time, appeared to the witness to have the capacity necessary to make the advance health directive;
- if it is signed by a person for the principal, include a certificate signed by the witness stating that:<sup>57</sup>

50 See Recommendation 8-3 of this Report. Note that the Supreme Court or the Tribunal may declare that an advance health directive is invalid if it is satisfied that the principal did not have the capacity to make it or it is invalid for another reason, for example, the principal was induced to make it by dishonesty or undue influence: *Powers of Attorney Act 1998* (Qld) s 113(2)(a), (c).

51 See Recommendation 8-4 of this Report.

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

53 *Powers of Attorney Act 1998* (Qld) s 44(3)(a).

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

55 *Powers of Attorney Act 1998* (Qld) s 31(1)(a). But see [9.44] below.

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

57 *Powers of Attorney Act 1998* (Qld) s 44(5).

- the principal, in the witness's presence, instructed the person to sign the advance health directive for the principal;
  - the person signed the advance health directive in the presence of the principal and the witness; and
  - the principal, at the time, appeared to the witness to have the capacity necessary to make the advance health directive; and
- include a certificate signed and dated by a doctor stating that the principal, at the time of making the advance health directive, appeared to the doctor to have the capacity necessary to make it.<sup>58</sup>

9.44 In Chapter 8, the Commission noted that, while justices of the peace (magistrates court) and justices of the peace (qualified) are required to attain a particular level of competence to carry out their duties, commissioners for declarations are not subject to a similar requirement. The Commission therefore recommended, with a view to having a more rigorous witnessing requirement, that the definition of 'eligible witness' in section 31(1)(a) of the *Powers of Attorney Act 1998* (Qld) be amended to omit the reference to a commissioner for declarations.<sup>59</sup> That recommendation, in combination with section 29(5) of the *Justices of the Peace and Commissioners for Declarations Act 1991* (Qld), will also have the effect that a justice of the peace (commissioner for declarations) will not be able to witness an enduring document.<sup>60</sup> Accordingly, the Commission further recommended that, where the approved form for an advance health directive refers to a 'justice of the peace', it should be amended to refer to a 'justice of the peace other than a justice of the peace (commissioner for declarations)'.<sup>61</sup>

9.45 An advance health directive may be made in the approved form although that is not currently a requirement for its validity.<sup>62</sup> However, an advance health directive that is not made in the approved form must still comply with all the execution requirements of the Act to be valid.

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

59 See Recommendation 8-8 of this Report.

60 *Justices of the Peace and Commissioners for Declarations Act 1991* (Qld) s 29(5) provides that a justice of the peace (commissioner for declarations) is limited to the exercise of the powers of a commissioner for declarations. Section 42 of that Act provides for the office of a justice of the peace (commissioner for declarations). A justice of the peace who, at 30 June 2000, remained in office as a justice of the peace under s 41(a) (that is, a justice of the peace who was appointed under the previous Act and who was never appointed as a justice of the peace (qualified) or as a justice of the peace (magistrates court)) ceased to hold that office and instead became a justice of the peace (commissioner for declarations).

61 See Recommendation 8-10 of this Report.

62 *Powers of Attorney Act 1998* (Qld) s 44(2). See, however, the Commission's recommendation at [9.109]–[9.113] and Recommendation 9-5 below.

9.46 An advance health directive may be revoked in the same way as an enduring power of attorney, with the exception that a revocation by the principal need not be in the approved form.<sup>63</sup>

### **Proof of advance health directives and recognition of interstate advance health directives**

9.47 The *Powers of Attorney Act 1998* (Qld) also provides for proof of an advance health directive and for the recognition of similar documents made in other Australian jurisdictions.<sup>64</sup> However, it does not provide for the registration of advance health directives. These issues are discussed later in this chapter.

## **THE LAW IN OTHER JURISDICTIONS**

9.48 With the exception of New South Wales and Tasmania,<sup>65</sup> every other Australian jurisdiction has legislation dealing with advance directions about medical treatment.

9.49 Provision is made for 'health directions' in the ACT,<sup>66</sup> 'directions' in the Northern Territory,<sup>67</sup> 'anticipatory directions' in South Australia,<sup>68</sup> 'decisions to refuse treatment' in Victoria,<sup>69</sup> and 'advance health directives' in Western Australia.<sup>70</sup> There is considerable variation between the jurisdictions.

9.50 Like Queensland, the legislation in South Australia and Western Australia allows a person to make an advance direction consenting to, or refusing, certain treatment. In contrast, advance directions in the ACT, the Northern Territory and Victoria are limited to the refusal or withdrawal of particular treatment.

9.51 There are also differences in the type of treatment for which an advance direction can be made. The provisions in the ACT, South Australia and Western Australia apply in relation to medical, surgical and dental treatment, including life-sustaining measures. In Victoria, the provision applies to operations, the

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63 *Powers of Attorney Act 1998* (Qld) ss 48, 49(2), 51–56, 58.

64 *Powers of Attorney Act 1998* (Qld) ss 40, 45.

65 In New South Wales and Tasmania, the common law applies. This is also the case in New Zealand: see *Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996* (NZ) reg 2 sch cl 2, Right 7(5).

66 *Medical Treatment (Health Directions) Act 2006* (ACT) ss 7–9.

67 *Natural Death Act* (NT) ss 3 (definition of 'extraordinary measures'), 4.

68 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ss 4 (definition of 'medical treatment'), 7.

69 *Medical Treatment Act 1988* (Vic) ss 3 (definition of 'medical treatment'), 5.

70 *Guardianship and Administration Act 1990* (WA) ss 3(1) (definition of 'treatment'), 110P–110RA, 110S.

administration of drugs and other medical procedures. The Northern Territory provision applies only in relation to ‘extraordinary measures’.<sup>71</sup>

9.52 Other limitations also apply. In the Northern Territory and South Australia, advance directions apply only if the person is suffering from a terminal illness and there is no real prospect of recovery.<sup>72</sup>

9.53 Significantly, in Victoria, a statutory refusal of treatment can be made only in relation to a person’s current condition.<sup>73</sup>

9.54 The jurisdictions differ in other details as well, such as the formalities for making an advance direction, the circumstances in which a direction is revoked, and provisions for proof and registration of advance directions.

9.55 Although there is little uniformity between the legislative schemes of the jurisdictions, in most cases, the statutes expressly preserve, and operate alongside, the common law.<sup>74</sup>

## ELIGIBILITY FOR APPOINTMENT AS AN ATTORNEY UNDER AN ADVANCE HEALTH DIRECTIVE

### Introduction

9.56 Section 29 of the *Powers of Attorney Act 1998* (Qld) specifies those persons who are eligible for appointment as an attorney under an enduring power of attorney or an advance health directive.<sup>75</sup> It provides:

#### 29 Meaning of *eligible attorney*

- (1) An **eligible attorney**, for a matter under an enduring power of attorney, means—
- (a) a person who is—
- (i) at least 18 years; and

<sup>71</sup> Extraordinary measures are defined as ‘medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation’: *Natural Death Act* (NT) s 3. This is similar to the definition of ‘life-sustaining measure’ in the Queensland guardianship legislation.

<sup>72</sup> *Natural Death Act* (NT) s 4(3); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 7(3). However, the South Australian Advance Directives Review Committee has recommended that ‘the personal advance directive not be limited to the terminal phase of a terminal illness or a persistent vegetative state but allow for instructions to be written to apply to any period of lost or diminished capacity’: Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: First Report of the Review of South Australia’s Advance Directives, Proposed Changes to Law and Policy* 43 <[http://www.aqd.sa.gov.au/news/pdfs/2009/AG\\_Report\\_1\\_final\\_300808.pdf](http://www.aqd.sa.gov.au/news/pdfs/2009/AG_Report_1_final_300808.pdf)> at 24 August 2010.

<sup>73</sup> *Medical Treatment Act 1988* (Vic) s 5.

<sup>74</sup> See [9.401]–[9.403] below.

<sup>75</sup> Issues relating generally to the eligibility of attorneys appointed under enduring documents, such as the relevance of a person’s criminal history, are considered in Chapter 16 of this Report.

- (ii) not a paid carer, or health provider, for the principal;<sup>28</sup> and
  - (iii) not a service provider for a residential service where the principal is a resident; and
  - (iv) if the person would be given power for a financial matter—not bankrupt or taking advantage of the laws of bankruptcy as a debtor under the *Bankruptcy Act 1966* (Cwlth) or a similar law of a foreign jurisdiction; or
- (b) the public trustee; or
  - (c) a trustee company under the *Trustee Companies Act 1968*; or
  - (d) for a personal matter only—the adult guardian.
- (2) An eligible attorney, for a matter under an advance health directive, means—
- (a) a person who has capacity for the matter who is—
    - (i) at least 18 years; and
    - (ii) not a paid carer, or health provider, for the principal,<sup>29</sup> or
  - (b) the public trustee; or
  - (c) the adult guardian.

<sup>28</sup> *Paid carer and health provider* are defined in schedule 3 (Dictionary).

<sup>29</sup> *Paid carer and health provider* are defined in schedule 3 (Dictionary).

## **Eligibility of a service provider for a residential service where the principal is a resident**

### ***Issue for consideration***

9.57 Section 29(1) of the *Powers of Attorney Act 1998* (Qld), which deals with eligible attorneys for a matter under an enduring power of attorney, provides that a person is not eligible for appointment if the person is 'a service provider for a residential service where the principal is a resident'.<sup>76</sup> However, section 29(2) of that Act, which deals with the eligibility requirements for appointment as an attorney for a matter under an advance health directive, does not contain a similar exclusion.

9.58 The exclusion in section 29(1) of a person who is a service provider for a residential service where the principal is a resident resulted from an amendment to

<sup>76</sup>

*Powers of Attorney Act 1998* (Qld) s 29(1)(a)(iii).

the *Powers of Attorney Act 1998* (Qld) in 2004.<sup>77</sup> The Explanatory Notes for the Justice and Other Legislation Amendment Bill 2004 (Qld) state:<sup>78</sup>

Clause 91 amends section 29 (Meaning of eligible attorney) to exclude residential service providers from being eligible attorneys for the purposes of the Act.

9.59 This suggests that the intention was for the exclusion to apply generally to the eligibility of a person to be an attorney under an enduring document, although the exclusion as enacted applies only to the eligibility of a person to be an attorney under an enduring power of attorney.

9.60 The *Justice and Other Legislation Amendment Act 2004* (Qld) also amended the *Powers of Attorney Act 1998* (Qld) by inserting section 59AA,<sup>79</sup> which provides:

**59AA Service provider**

If the attorney becomes the service provider for a residential service where the principal is a resident, the enduring document is revoked to the extent it gives power to the attorney.

9.61 In referring to ‘the attorney’, section 59AA appears to apply to both an attorney under an enduring power of attorney, as well as to an attorney under an advance health directive, even though, in the latter case, the service provider is not excluded from being appointed as an attorney. This would tend to suggest that the exclusion of a residential service provider from appointment as an eligible attorney under section 29(1), but not under section 29(2), was a drafting oversight.

**Discussion Paper**

9.62 In the Discussion Paper, the Commission sought submissions on whether section 29(2)(a) of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that an eligible attorney for a matter under an advance health directive means, in addition to the matters mentioned in section 29(2)(a)(i) and (ii), a person who is not a service provider for a residential service where the principal is a resident.<sup>80</sup>

**Submissions**

9.63 A number of respondents, including the Adult Guardian, the former Acting Public Advocate and the Department of Communities, were of the view that section 29(2)(a) of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that an eligible attorney for a matter under an advance health directive does not

<sup>77</sup> See *Justice and Other Legislation Amendment Act 2004* (Qld) s 91.

<sup>78</sup> Explanatory Notes, *Justice and Other Legislation Amendment Bill 2004* (Qld) 20.

<sup>79</sup> *Justice and Other Legislation Amendment Act 2004* (Qld) s 92.

<sup>80</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 247.

include a person who is a service provider for a residential service where the principal is a resident.<sup>81</sup>

### ***The Commission's view***

9.64 The eligibility requirements for appointment as an attorney under an advance health directive should be consistent with the requirements for appointment as an attorney for a personal matter under an enduring power of attorney. Section 29(2)(a) of the *Powers of Attorney Act 1998* (Qld) should therefore be amended to provide that an eligible attorney for a matter under an advance health directive means, in addition to the categories of person currently mentioned in section 29(2)(a), a person who is not a service provider for a residential service where the principal is a resident.

## **Eligibility of the Public Trustee**

### ***Issue for consideration***

9.65 Section 29(2)(b) of the *Powers of Attorney Act 1998* (Qld) provides that the Public Trustee is an eligible attorney for a matter under an advance health directive. When so appointed, the Public Trustee may:

- exercise power for a health matter for the principal in the event that the directions contained in the advance health directive prove inadequate;<sup>82</sup> and
- subject to the terms of the advance health directive and the *Powers of Attorney Act 1998* (Qld), do anything in relation to a health matter for the principal that the principal could lawfully do if he or she had capacity for the matter.<sup>83</sup>

9.66 The inclusion of the Public Trustee as an eligible attorney for appointment under an advance health directive is inconsistent with the scope of the Public Trustee's powers under the *Guardianship and Administration Act 2000* (Qld). Under that Act, the Public Trustee may be appointed as an administrator to make financial decisions for an adult,<sup>84</sup> but may not be appointed as a guardian to make personal decisions (including decisions about health matters) for an adult.<sup>85</sup>

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81 Submissions 160, 161, 164, 165, 169.

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

83 *Powers of Attorney Act 1998* (Qld) s 36(4)–(5).

84 *Guardianship and Administration Act 2000* (Qld) s 14(1)(b)(ii).

85 *Guardianship and Administration Act 2000* (Qld) s 14(1)(a).

9.67 The current provision is also inconsistent with the draft provision recommended in the Commission's original 1996 report. Clause 80 of the draft Bill that was included in that report provided:<sup>86</sup>

**Eligibility to be chosen—health care decision**

80. A person may be chosen by an advance health care directive as a chosen decision maker for a health care decision for an adult only if the person is—
- (a) an individual who is at least 18 years old and not a paid carer, or health care provider, for the adult; or
  - (b) the adult guardian.

9.68 Although section 29(2)(b) of the *Powers of Attorney Act 1998* (Qld) provides that the Public Trustee is an eligible attorney for a matter under an advance health directive, the Commission has been informed that it is not the practice of the Public Trustee to accept an appointment as an attorney under an advance health directive. The Commission has also been informed that the drafting of advance health directives is not one of the services presently offered by the Public Trust Office.<sup>87</sup>

**Discussion Paper**

9.69 In the Discussion Paper, the Commission sought submissions on whether section 29(2)(b) of the *Powers of Attorney Act 1998* (Qld) should be omitted so that the Public Trustee is not an eligible attorney for appointment under an advance health directive.<sup>88</sup>

**Submissions**

9.70 A number of respondents, including the Adult Guardian, the former Acting Public Advocate and the Department of Communities, were of the view that section 29(2)(b) of the *Powers of Attorney Act 1998* (Qld) should be amended so that the Public Trustee is not an eligible attorney for appointment under an advance health directive.<sup>89</sup>

**The Commission's view**

9.71 In the Commission's view, the Public Trustee should not be eligible for appointment as an attorney under an advance health directive. The expertise of the Public Trustee is in relation to financial management and it is not appropriate

<sup>86</sup> Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 2, Draft Assisted and Substituted Decision Making Bill 1996 cl 80.

<sup>87</sup> Information provided by the Public Trust Office, 18 September 2009.

<sup>88</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 248.

<sup>89</sup> Submissions 160, 161, 164, 165, 169.

for the Public Trustee to be eligible for appointment as an attorney to make health care decisions for a principal under an advance health directive.

9.72 Section 29(2)(b) of the *Powers of Attorney Act 1998* (Qld) should therefore be omitted so that the Public Trustee is not an eligible attorney for a matter under an advance health directive. This recommendation is consistent with the approach taken under the *Guardianship and Administration Act 2000* (Qld), which provides that the Public Trustee is eligible for appointment as an administrator but not as a guardian. It also reflects the Public Trustee's own practice in this regard.<sup>90</sup>

## OPERATION OF A DIRECTION IN AN ADVANCE HEALTH DIRECTIVE

### The law in Queensland

9.73 Although section 36(2) of the *Powers of Attorney Act 1998* (Qld) contains specific limitations that govern the operation of a direction to withhold or withdraw a life-sustaining measure, the Act does not contain any requirements for the operation generally of a direction in an advance health directive.

9.74 However, the Act provides in section 103(1)–(2) that a health provider who has reasonable grounds to believe that:<sup>91</sup>

- a direction in an advance health directive is uncertain;
- a direction in an advance health directive is inconsistent with good medical practice; or
- circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate;

does not incur any liability, either to the adult or anyone else, if the health provider does not act in accordance with the direction.

9.75 Section 103(3) further provides that, 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. This provision ensures that, if the meaning of the direction is capable of clarification by the attorney, a health provider who does not act in accordance with the direction will not have the protection of the section.

### The law in other jurisdictions

9.76 In Victoria, the *Medical Treatment Act 1988* (Vic) provides that a refusal of treatment certificate ceases to apply to a person if the medical condition of the

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<sup>90</sup> See [9.68] above.

<sup>91</sup> *Powers of Attorney Act 1998* (Qld) s 103 is considered at [9.277]–[9.293] below.

person has changed to such an extent that the condition in relation to which the certificate was given is no longer current.<sup>92</sup>

9.77 In Western Australia, the *Guardianship and Administration Act 1990* (WA) provides that, in specified circumstances, a treatment decision in an advance health directive does not operate. Section 110S(3) provides:

- (3) Subject to subsection (4), a treatment decision in an advance health directive does not operate if circumstances exist or have arisen that—
  - (a) the maker of that directive would not have reasonably anticipated at the time of making the directive; and
  - (b) would have caused a reasonable person in the maker's position to change his or her mind about the treatment decision.

9.78 Section 110S(4) requires a number of matters to be taken into account in determining whether section 110S(3) applies.<sup>93</sup>

### The Commission's view

9.79 While section 103 of the *Powers of Attorney Act 1998* (Qld) protects a health provider who, in specified circumstances, does not act in accordance with a direction in an advance health directive, nothing in the Act actually limits the operation of the direction in these circumstances. Accordingly, a health provider who, for example, has reasonable grounds to believe that circumstances have changed to the extent that the terms of the direction are inappropriate will be protected from liability if he or she does not act in accordance with a direction. However, the direction is still operative and the health provider could equally choose to act in accordance with the direction.

9.80 In the Commission's view, with the exception of a direction that is inconsistent with good medical practice, the circumstances mentioned in section 103(1) are so significant that their existence should not simply provide a ground of defence for a non-complying health provider. The existence of those circumstances goes to the heart of whether there is an effective direction and, subject to the matters mentioned below, those circumstances should constitute a limitation on the operation of a direction.

9.81 First, unlike the protection given under section 103, the provision dealing with the operation of a direction in an advance health directive should not be framed in terms of a health provider having reasonable grounds to believe specified matters; rather, it should be a question of fact whether the particular circumstance applies.

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<sup>92</sup> *Medical Treatment Act 1988* (Vic) s 7(3).

<sup>93</sup> These matters are set out at [9.286] below.

9.82 Secondly, the circumstances in which a direction does not operate should be consistent with the changes recommended later in this chapter to section 103.<sup>94</sup>

9.83 Section 36 of the *Powers of Attorney Act 1998* (Qld) should therefore be amended to provide that a direction in an advance health directive does not operate if:

- the direction is uncertain; or
- circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

9.84 The section should also be amended to provide that a direction in an advance health directive is not uncertain if its meaning can be ascertained by consultation with:

- an attorney appointed under the advance health directive; or
- if an attorney is not appointed under the advance health directive, but the advance health directive names an attorney for health matters appointed under the adult's enduring power of attorney — the named attorney.

9.85 By providing that, in the specified circumstances, a direction does not operate, the Commission's recommendation to amend section 36 of the *Powers of Attorney Act 1998* (Qld) overcomes the problem that can arise where a direction in relation to health care is uncertain or inappropriate in light of changed circumstances, but section 66(2) of the *Guardianship and Administration Act 2000* (Qld) prevents the adult's guardian, attorney or statutory health attorney from exercising power for the matter because there is still an operative direction dealing with the matter.

9.86 Because a direction in an advance health directive may, as a result of this recommendation, be inoperative (whether in relation to a particular situation or generally), it is desirable to ensure that the Tribunal and the Supreme Court have an express power to determine whether a direction is operative. Accordingly, section 113 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that the court<sup>95</sup> may decide whether a direction in an advance health directive is operative and may make a declaration to that effect.

<sup>94</sup> Later in this chapter, the Commission has recommended that s 103 of the *Powers of Attorney Act 1998* (Qld) be amended in several respects (see [9.316]–[9.336] below). The main changes that are recommended are:

- the amendment of s 103(1) to omit the reference to a direction that is inconsistent with good medical practice;
- the amendment of s 103(1) to clarify that the reference to a direction that is inappropriate in light of changed circumstances is to be considered from the principal's perspective; and
- the amendment of s 103(3) so that, if the advance health directive does not appoint an attorney but it nevertheless identifies the attorney for health matters appointed under the principal's enduring power of attorney, the section will require consultation with the attorney appointed under the enduring power of attorney.

<sup>95</sup> Note that s 109A of the *Guardianship and Administration Act 2000* (Qld) confers on the Tribunal the same jurisdiction and powers for enduring documents that the Supreme Court has.

## THE APPROVED FORM

### Introduction

#### ***Appointment of an attorney under the approved form***

9.87 Section 35(1)(c) of the *Powers of Attorney Act 1998* (Qld) provides that a principal may, by an advance health directive, appoint one or more persons who are eligible attorneys ‘to exercise power for a *health matter* for the principal in the event the directions prove inadequate’ (emphasis added).

9.88 However, section 7 of the approved form for an advance health directive makes provision for the appointment of an attorney for ‘personal/health matters’.<sup>96</sup> While personal matters include health matters, they also include a range of other matters such as where and with whom the principal lives, whether, and if so, where, the principal works, what education or training the principal undertakes, and day-to-day issues such as diet and dress.<sup>97</sup>

#### ***Use of the approved form not mandatory***

9.89 Section 44(2) of the *Powers of Attorney Act 1998* (Qld) provides that an advance health directive must be made in writing and may be in the approved form.<sup>98</sup> Use of the approved form is not mandatory.

#### ***The general approach to directions under the approved form***

9.90 It has been suggested that ‘there is no such thing as a perfect “living will” form’:<sup>99</sup>

The evidence from previous research indicates that written directives (living will forms) for refusing medical treatment in advance, whether legal documents or not, are difficult to design and very few people actually use them. There is no such thing as a perfect ‘living will’ form that will cover all contingencies and cater to people’s personal preferences. These forms are difficult to write, interpret and implement.

9.91 As noted above, different jurisdictions impose different formal requirements for making an advance health directive. The Federal Parliament’s Standing Committee on Legal and Constitutional Affairs has recommended ‘the development of straightforward, nationally-consistent and user-friendly advance

<sup>96</sup> See Department of Justice and Attorney-General, Guardianship, Forms and publications, Advance Health Directive (Form 4) Section 7: Appointing an attorney for personal/health matters, cl 28–34 <[http://www.justice.qld.gov.au/\\_data/assets/pdf\\_file/0007/15982/advance-health-directive.pdf](http://www.justice.qld.gov.au/_data/assets/pdf_file/0007/15982/advance-health-directive.pdf)> at 24 August 2010.

<sup>97</sup> *Powers of Attorney Act 1998* (Qld) sch 2 s 2.

<sup>98</sup> See Department of Justice and Attorney-General, Guardianship, Forms and publications, Advance Health Directive (Form 4) <[http://www.justice.qld.gov.au/\\_data/assets/pdf\\_file/0007/15982/advance-health-directive.pdf](http://www.justice.qld.gov.au/_data/assets/pdf_file/0007/15982/advance-health-directive.pdf)> at 24 August 2010.

<sup>99</sup> M Brown, ‘The law and practice associated with advance directives in Canada and Australia: Similarities, differences and debates’ (2003) 11(1) *Journal of Law and Medicine* 59, 72.

care directive documentation' as part of the national harmonisation of advance care planning legislation.<sup>100</sup>

9.92 It is important for the approved form to strike an appropriate balance between the need for flexibility on the one hand, and specificity on the other. While there is provision in the current approved form for the principal to give general instructions about his or her future health care, the form also directs considerable attention to specific life-sustaining treatments in specific situations.<sup>101</sup> This part of the form is set out in a 'tick-a-box' fashion, and provides for the principal to indicate the type of treatment that he or she does, or does not, want to receive in those situations.

9.93 While this may help to ensure that the principal's instructions are reasonably clear and specific, the perceived inflexibility of the form could deter some people from making an advance health directive. For example, people may not wish to give specific instructions on some matters but may think that they need to answer all the questions in the form in order for it to be properly completed. The specificity of the questions in the form may also limit the effectiveness of the directive, for example, if particular treatments become irrelevant or new techniques are developed.<sup>102</sup> Striking an appropriate balance is important.<sup>103</sup>

Language may be too difficult or technical for non-medical people to understand, and forms may be too general or vague to guide treatment decisions, if limited to statements of values without specific examples for guidance. On the other hand, forms may be too rigid or prescriptive, and leave no room for reasonable interpretation in unforeseen situations.

9.94 The South Australian Advance Directives Review Committee has recommended that, while advance directives should still allow for specific medical treatment directions and refusals to be given:<sup>104</sup>

advance directives for health care ... [should] not require instructions to be written in medically-based terms, but rather encourage a person's instructions to be written in outcomes-based terms.

100 Parliament of Australia, House of Representatives, Standing Committee on Legal and Constitutional Affairs, *Older People and the Law*, Report (2007) [3.179].

101 Advance Health Directive (Form 4) Section 3: Terminal, incurable, or irreversible conditions. This section of the form includes the following situations: if the principal is in the terminal phase of an incurable illness, if the principal is permanently unconscious, if the principal is in a persistent vegetative state or if the principal is so seriously ill or injured that he or she is unlikely to recover to the extent that he or she can live without the use of life-sustaining measures. These situations correspond to the circumstances listed in s 36(2) of the *Powers of Attorney Act 1998* (Qld) in which a direction to withhold or withdraw a life-sustaining measure will operate.

102 Government of South Australia, *South Australian Advance Directives Review*, Background Paper (2007) 10–11.

103 M Parker and C Cartwright, 'Mental capacity in medical practice and advance care planning: Clinical, ethical and legal issues' in B Collier, C Coyne and K Sullivan (eds), *Mental Capacity: Powers of Attorney and Advance Health Directives* (2005) 56, 84. See also J Blackwood, 'I would rather die with two feet than live with one: The status and legality of advance directives in Australia' (1997) 19(2) *University of Queensland Law Journal* 270, 292.

104 Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: First Report of the Review of South Australia's Advance Directives, Proposed Changes to Law and Policy* 45 <[http://www.agd.sa.gov.au/news/pdfs/2009/AG\\_Report\\_1\\_final\\_300808.pdf](http://www.agd.sa.gov.au/news/pdfs/2009/AG_Report_1_final_300808.pdf)> at 24 August 2010.

9.95 The Committee considered that people who make advance directives 'are not so much seeking to control all treatment decisions, but rather seeking to live well and die with dignity in accord with their personal values'.<sup>105</sup> It suggested that:<sup>106</sup>

Rather than specifying medical treatments consented to or refused, an outcomes-based approach encourages people to consider and record:

- their personal values and life-goals
- levels of functioning they consider intolerable or unacceptable and
- interventions they would find burdensome and intrusive.

...

People can generally describe their wishes in these non-medical terms, and studies suggest that while medical instructions change over time, values and life goals remain consistent and can be applied not only to end-of-life care but to any period of lost or diminished capacity.

An outcomes-based model enables autonomy and dignity to be respected without requiring an understanding of the likely result of medical interventions in a range of circumstances.

It does not limit treatment interventions to those available at the time the [advance directive] was written, but permits a range of interventions that might achieve the person's life goals and respect their values. With an outcomes-based [advance directive], the clinical team can advise agents and relatives whether the medical interventions contemplated are likely to leave the patient in a condition they have described as personally unacceptable or intolerable, and decisions which respect the person's values can be made in the light of that advice. This model supports a best-practice collaborative team approach.

### ***The length of the approved form***

9.96 The approved form for making an advance health directive is 24 pages long, and includes some four pages of explanatory information. The length and complexity of the current form have been criticised as a disincentive to making an advance health directive:<sup>107</sup>

in Queensland the advance care plan for the elderly is significantly impeded by the legislated Queensland advance health directive, which is a complex 24-page document that does not get completed even by those who are very keen to document their wishes and to appoint a surrogate decision maker.

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105 Ibid 44.

106 Ibid. See also Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 38.

107 Evidence to Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, Brisbane, 16 July 2007 [LCA 33] (Dr William Silvester).

## Discussion Paper

9.97 In the Discussion Paper, the Commission sought submissions on whether:<sup>108</sup>

- the approved form should allow a principal to appoint an attorney for personal matters as well as for health matters; and
- the approved form appropriately balances the need for flexibility and specificity.

## Submissions

### *Appointment of an attorney under an advance health directive*

9.98 The Adult Guardian commented that it should not be possible for a principal, under an advance health directive, to appoint an attorney for personal matters as well as health matters. In her view, the inclusion of the option for appointment of an attorney for personal matters is confusing.<sup>109</sup>

9.99 Another respondent was also of the view that the approved form should not allow a principal to appoint an attorney for personal matters as well as health matters.<sup>110</sup>

### *The approved form*

9.100 The Adult Guardian referred to the difficulty that some people have in anticipating the circumstances in which their advance health directive should operate.<sup>111</sup> However, she considered that this situation could be improved by redrafting the form to place greater emphasis on the quality of life that the adult wishes to achieve:

The experience of the Adult Guardian is that most adults who have capacity are easily able to relate the quality of life they wish to enjoy in certain circumstances. However they are often unable to relay that quality into a particular response to the questions asked in the Advance Health Directive. In part this is because the anticipatory nature of the document means that it is unable to anticipate the progression of the particular illness or diagnosis.

9.101 Several respondents commented on the length and complexity of the approved form.

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<sup>108</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 251.

<sup>109</sup> Submission 164.

<sup>110</sup> Submission 161.

<sup>111</sup> Submission 164.

9.102 The Adult Guardian was generally critical of the approved form:<sup>112</sup>

The form is overly complex, lengthy and circular in the organisation of its content. ... In the experience of the Adult Guardian most frequently the form is used by adults who are either aged or who have an extremely poor medical diagnosis. Generally these adults propose to use the document so that they can relieve their families of some of the burden of responsibility involved in making difficult decisions about their health care at this time. The Adult Guardian often hears at community forums that the adult has abandoned use of the form because of its unwieldy form and complexity.

9.103 In the Adult Guardian's view, the form requires redrafting by a properly constituted committee to make it user-friendly:

A properly constituted committee including community members, medical staff, lawyers and representatives of the relevant statutory authorities and a person experienced in drafting forms needs to re-draft the form so that it is user-friendly. Incorporation of tick-a-boxes, clear instructions, and progressive questions are needed.

9.104 Caxton Legal Centre Inc also commented that the approved form is confusing and badly worded and should be rewritten.<sup>113</sup>

9.105 The Brisbane South Palliative Care Collaborative suggested that the length of the current form reduces its efficacy.<sup>114</sup>

Currently, the length of the form is excessive, and we believe this creates a barrier, both to patients who are considering the need to document their wishes but also for clinical staff, as locating the salient information within the 24 page document reduces the clinical efficacy of the document.

9.106 Another respondent commented that the approved form should be kept simple and not exceed two pages in length.<sup>115</sup>

## **The Commission's view**

### ***Appointment of an attorney under an advance health directive***

9.107 In the Commission's view, it is appropriate that a principal may, by an advance health directive, appoint an attorney for health matters. While it is arguable that an advance health directive should be confined to an expression of the principal's own directions about his or her future health care, it is unlikely that the directions in an advance health directive will be sufficiently comprehensive that the principal will not also need a substitute decision-maker for those health care decisions that are not the subject of a specific direction. The Commission therefore considers that any potential for confusion that arises from the fact that an attorney

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112 Ibid.

113 Submission 174.

114 Submission 102.

115 Submission 161.

may be appointed under either an enduring power of attorney or an advance health directive is outweighed by the flexibility afforded to a principal who may wish to appoint an attorney for health matters only. Accordingly, section 35(1)(c) of the *Powers of Attorney Act 1998* (Qld) should continue to provide that a principal may, by an advance health directive, appoint an attorney for health matters.

9.108 However, if a principal wishes to appoint an attorney for personal matters generally and not just for health matters, that should be done by making an enduring power of attorney. An advance health directive should not be used as a means for conferring authority to make decisions that do not relate to the principal's health care. Accordingly, section 7 of the approved form for an advance health directive should be amended so that it refers to the appointment of an attorney for health matters only.

### **Mandatory use of the approved form**

9.109 Although the submissions were critical of various aspects of the approved form, the form nevertheless includes useful explanatory notes and instructions about making and revoking an advance health directive, as well as other important information about the implications of making an advance health directive. The approved form also assists in guiding decision-making about different types of health care. The use of the approved form is therefore an important means of maximising the likelihood that an adult who completes an advance health directive appreciates the significance of making the advance health directive and is able to give clear and specific directions.

9.110 Given the significance of the directions that may be given by an advance health directive, it is important that this information and assistance is available to a person making an advance health directive. While it can never be guaranteed that a person will read the entire form, the use of the approved form is still the best way to ensure that this information is brought to the person's attention. The Commission is therefore of the view that section 44 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that an advance health directive must be made in the approved form. This is consistent with the approach taken in section 44(1) of the Act, which requires an enduring power of attorney to be made in the approved form.

9.111 Because of section 49(1) of the *Acts Interpretation Act 1954* (Qld),<sup>116</sup> it will be sufficient compliance with this requirement if a person makes an advance health

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*Acts Interpretation Act 1954* (Qld) s 49 provides in part:

**49 Forms**

- (1) If a form is prescribed or approved under an Act, strict compliance with the form is not necessary and substantial compliance is sufficient.
- (2) If a form prescribed or approved under an Act requires—
  - (a) the form to be completed in a specified way; or
  - (b) specified information or documents to be included in, attached to or given with the form; or
  - (c) the form, or information or documents included in, attached to or given with the form, to be verified in a specified way;
 the form is not properly completed unless the requirement is complied with.

directive that is in substantial compliance with the approved form. However, it will still be necessary, as is currently the case where an advance health directive is not made in the approved form, for the execution of the advance health directive to comply with the requirements of section 44(3)–(8) of the *Powers of Attorney Act 1998* (Qld) in relation to the signing and witnessing of the document, certification of the principal's capacity and, where the advance health directive appoints an attorney, the attorney's acceptance of the appointment.<sup>117</sup>

9.112 The requirement for an advance health directive to be made in the approved form should apply only to an advance health directive made after the commencement of the legislation that gives effect to this recommendation. If the requirement applied to all advance health directives, it is likely that many advance health directives would be invalidated on the ground that they have not been made in the approved form.

9.113 While it may be said that people who have an existing advance health directive that is not in the approved form should make a new one in the approved form, those people would need to be made aware of the need to do so. In the absence of a significant education campaign, it is likely that they would simply not be aware of the need to make a new advance health directive. Moreover, there will inevitably be people who have lost capacity since making their advance health directive. The invalidation of their advance health directive on the ground that it is not made in the approved form would be a significant erosion of their autonomy when it is not possible for them to make a new directive.

### **Redrafting the approved form**

9.114 In view of the concerns that have been raised about the length and complexity of the approved form, the Commission is of the view that the approved form should be redrafted.

9.115 The redrafting of the approved form for an advance health directive should be undertaken by a multidisciplinary team with expertise and experience in relation to the users of the forms, as well as the law. The Commission notes in this regard that academics from the School of Social Work and Human Services at the University of Queensland and from the School of Law at the Queensland University of Technology hold a grant from the Legal Practitioner Interest on Trust Accounts Funds Grants Fund for 2009–10 to undertake research into the improvement of the forms and outcomes in relation to enduring documents.<sup>118</sup>

9.116 Although the Commission is not undertaking the redrafting of the approved form, there are nevertheless several matters in relation to the form that should be addressed when it is redrafted.

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<sup>117</sup> *Acts Interpretation Act 1954* (Qld) s 49(2).

<sup>118</sup> See Department of Justice and Attorney-General, Legal Practitioner Interest on Trust Accounts Funds Grants Fund recipients 2009–10 <<http://www.justice.qld.gov.au/corporate/sponsorships-and-grants/?a=650>> at 24 August 2010. See, generally, Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 33–4.

9.117 Section 3 of the form sets out a number of situations and makes provision for the principal to tick whether or not, in those situations, the principal wants to receive particular life-sustaining measures. Those situations are framed in terms of the four circumstances mentioned in section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld). At present, section 36(2) provides that at least one of the circumstances in section 36(2)(a) must be satisfied for a direction to withhold or withdraw a life-sustaining measure to operate. However, in Chapter 11, the Commission has recommended that the operation of a direction to withhold or withdraw a life-sustaining measure should not be confined to those circumstances and that section 36(2)(a) should therefore be omitted.<sup>119</sup> While it may still be desirable for the approved form to encourage decision-making about specific end-of-life situations, the review of the approved form should take account of the fact that, under the Commission's recommendations, a direction to withhold or withdraw a life-sustaining measure will be able to operate outside the circumstances presently mentioned in section 36(2)(a) of the Act.

9.118 In addition, when the approved form is redrafted, it should include questions that draw the adult's attention to whether a direction refusing particular health care is intended to operate in unforeseen circumstances, where the need for the health care does not arise as a result of an existing condition of the adult or the natural progression of such a condition. For example, an adult with a degenerative illness might give a direction refusing assisted ventilation knowing that an inability to breathe independently is part of the ordinary progression of the illness. If circumstances later arise where the adult requires assisted ventilation, not because of the progression of the illness, but because of an unforeseen event that is not related to the adult's illness, such as an injury sustained in a motor vehicle accident, the issue is whether the direction was intended to operate in that circumstance. It is to be expected that some adults would not want their direction to operate in that circumstance while others would be adamant that it should.

9.119 As well as making continued provision for a principal to give specific directions about specific health care, consideration should also be given to incorporating the 'outcomes-based' approach recommended by the South Australian Advance Directives Review Committee.<sup>120</sup> That approach, which is currently reflected to some extent in the 'Personal statement' in section 4 of the approved form, has the potential to maximise the certainty of a direction in an advance health directive by giving the principal the opportunity to explain the context in which a direction is given.

9.120 Finally, it is noted that the principal's personal statement in section 4 of the approved form for an advance health directive does not make provision for the principal to sign or initial that page.<sup>121</sup> This is in contrast to the remainder of the form where such provision is made. The redrafted form should make provision for the principal to sign or initial each page that includes a statement or direction of the principal.

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119 See Recommendation 11-3 of this Report.

120 See [9.94]–[9.95] above.

121 Advance Health Directive (Form 4) 13.

## INFORMED DECISION-MAKING

### Introduction

9.121 One of the major criticisms of advance health directives is that, because they are made in advance of the circumstances in which they are to apply, they may involve uninformed treatment decisions:<sup>122</sup>

The very nature of the document — an *advance* directive — that is to come into effect at some unforeseeable date in the future, means that in some cases, especially those concerning end of life decisions, the person making the directive must try and predict medical problems not yet in existence. It is impossible for a person to contemplate every treatment choice and provide instructions regarding them. (emphasis in original)

9.122 It has been suggested that:<sup>123</sup>

Only if the decision is made at the time of treatment is there a real opportunity to question the medical practitioner, to ask about the implications of the decision, to understand the consequences, and to decide whether to seek another opinion or pursue alternatives. (emphasis in original)

### The position at common law

9.123 It is not entirely clear whether, at common law, an advance direction refusing health care is effective only if the decision is fully informed.

9.124 In *Hunter and New England Area Health Service v A*,<sup>124</sup> McDougall J observed that ‘a factor that has been suggested to vitiate a refusal of treatment is the absence of, or failure to provide, adequate information’.<sup>125</sup> His Honour rejected that proposition:<sup>126</sup>

I do not accept the proposition that, in general, a [competent] adult’s clearly expressed advance refusal of specified medical procedures or treatment should be held to be ineffective simply because, at the time of statement of the refusal, the person was not given adequate information as to the benefits of the procedure or treatment (should the circumstances making its administration desirable arise) and the dangers consequent upon refusal. As I have said, a valid refusal may be based upon religious, social or moral grounds, or indeed upon no apparent rational grounds; and is entitled to respect (assuming of course that it is given freely, by a competent adult) regardless.

<sup>122</sup> J Blackwood, ‘I would rather die with two feet than live with one: The status and legality of advance directives in Australia’ (1997) 19(2) *University of Queensland Law Journal* 270, 275. See also eg D Lanham and B Fehlberg, ‘Living wills and the right to die with dignity’ (1991) 18(2) *Melbourne University Law Review* 329, 335; Queensland Advocacy Incorporated, *Submission on ‘Rethinking Life-Sustaining Measures: Questions for Queensland’* (4 July 2005) 10 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 24 August 2010.

<sup>123</sup> Queensland Advocacy Incorporated, *Submission on ‘Rethinking Life-Sustaining Measures: Questions for Queensland’* (4 July 2005) 10 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 24 August 2010.

<sup>124</sup> (2009) 74 NSWLR 88.

<sup>125</sup> *Ibid* 94.

<sup>126</sup> *Ibid*.

9.125 McDougall J considered the reasons for differentiating between the requirements for a valid consent to treatment and a valid refusal of treatment:<sup>127</sup>

In circumstances where it is practicable for a medical practitioner to obtain consent to treatment, then, for the consent to be valid, it must be based on full information, including as to risks and benefits. But the question with which I am concerned is whether an advance refusal of consent to certain specified forms of medical treatment equally needs to be supported by the provision of all adequate information. The reason for obtaining consent to treatment is to justify in law what would otherwise be a battery (I leave aside the emergency situation where consent cannot be obtained). A consent that is based on misleading information is clearly of no value; and a consent based on insufficient information is not much better. But once it is accepted that religious, social or moral convictions may be of themselves an adequate basis for a decision to refuse consent to medical treatment, it is clear that there is no reason that a decision made on the basis of such values must have taken into account the risks that may follow if a medical practitioner respects and acts upon that decision. This is so *a fortiori* where there is no discernible rational basis for the decision. No question arises of justifying what would otherwise be unlawful, and factors to be taken into account in determining whether something is or is not unlawful do not have application by analogy.

9.126 In *Brightwater Care Group (Inc) v Rossiter*,<sup>128</sup> which concerned the effect of a contemporaneous refusal of treatment, as distinct from an advance refusal, Martin CJ considered ‘the extent to which the decision to refuse to consent to treatment must be an informed decision’.<sup>129</sup> Martin CJ noted that, in *Hunter and New England Area Health Service v A*, McDougall J:<sup>130</sup>

rejected the notion that a refusal to consent had to be informed to be effective in the context of an advance directive given by a person who, at the time of the court hearing, lacked the capacity to receive further information or make any further decision.

9.127 However, Martin CJ considered the circumstances of the case before him to be ‘quite different’.<sup>131</sup>

Mr Rossiter has the capacity to receive and consider information he is given, and to make informed decisions after weighing that information. ...

Also it is clearly established that medical service providers have a legal duty to inform patients of all aspects and risks associated with any medical procedure before seeking their consent to that procedure. With respect to McDougall J, in the circumstances of this case, where it is perfectly feasible to ensure that Mr Rossiter is given full information as to the consequences of any decision to discontinue treatment before he makes that decision, I can see no reason why his medical service providers should not be under a similar obligation. This view is consistent with the views expressed in the English and Canadian cases

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127 Ibid 94–5.

128 [2009] WASC 229.

129 Ibid [28].

130 Ibid.

131 Ibid [29].

to which I have referred, where emphasis is placed on the need for an informed decision to discontinue life support: *Airedale NHS Trust v Bland*, 864 and *Nancy B v Hôtel-Dieu de Québec*. There will obviously be cases in which it is not possible to obtain such a decision, but this is not one of them, and I will refrain from proffering any view as to what should be required in such cases.

9.128 In *Airedale NHS Trust v Bland*,<sup>132</sup> Lord Goff referred, in obiter,<sup>133</sup> to the principle that ‘a patient of sound mind may, if properly informed, require that life support be discontinued’, citing *Nancy B v Hôtel-Dieu de Québec*.<sup>134</sup> However, the latter case was not a decision about the effect of a refusal of treatment at common law, but was a decision about the effect of provisions of the *Civil Code of Lower Canada* and the *Quebec Code of Ethics of Physicians*.<sup>135</sup> The plaintiff, who was competent, had Guillain-Barré syndrome. She sought an injunction to require the hospital where she was a patient to comply with her decision that she did not want to be artificially ventilated. At issue was the effect of article 19.1 of the Code, which provided:

No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.

9.129 In *Nancy B v Hôtel-Dieu de Québec*, Dufour J observed that the ‘courts have indicated in their judgments that the patient’s consent must be freely given and informed’.<sup>136</sup> This was a reference to the consent required of a person who consented to undergo treatment. Dufour J held that the ‘logical corollary of this doctrine of informed consent is that the patient generally has the right not to consent, that is the right to refuse treatment and to ask that it cease where it has already been begun’.<sup>137</sup> His Honour also held that the ‘terminology employed in art 19.1 is sufficiently broad to encompass the act of placing a person on a respirator by a third person’.<sup>138</sup> Accordingly, such an act would require the informed consent of the patient. In the present case, however, the plaintiff was refusing continued respiratory support.

9.130 Dufour J held that:<sup>139</sup>

putting a person on a respirator and constantly keeping her on it without her consent surely constitutes intrusion and interference which violates the person of Nancy B.

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132 [1993] AC 789.

133 Anthony Bland was in a persistent vegetative state and had never expressed any views about the treatment that he would want to receive, or would not want to receive, in the circumstances that arose: *ibid* at 797 (Sir Stephen Brown P) at first instance.

134 [1993] AC 789, 864.

135 RRQ, 1981, c M-9.

136 (1992) 86 DLR (4th) 385, 389.

137 *Ibid* 390.

138 *Ibid* 391.

139 *Ibid* 391–2.

*It therefore clearly follows from our civil law that Nancy B, whose consent in this regard was freely given and informed, is entitled to require that the respiratory treatment being given her cease. (emphasis in original).*

9.131 While Dufour J held that Nancy B was fully informed, he did not state that it was necessary for her to be fully informed to refuse treatment — only that it was necessary that a person be fully informed to consent to treatment.

9.132 The other decision that has considered whether a refusal of treatment must be fully informed in order to be effective is *Malette v Shulman*.<sup>140</sup> In that case, Mrs Malette was given a blood transfusion by Dr Shulman after she sustained life-threatening injuries in a car accident. He was aware that she was carrying a signed card in which she identified herself as a Jehovah's Witness and refused a blood transfusion in any circumstances. Mrs Malette survived and successfully sued Dr Shulman for damages for battery.

9.133 On appeal, it was argued that a card refusing a blood transfusion cannot be effective if the doctor is unable to provide the patient with the information she would need before making a decision to withhold consent in this specific emergency situation.<sup>141</sup>

9.134 The Ontario Court of Appeal held that it was 'unnecessary to determine in this case whether there is a doctrine of informed refusal as distinct from the doctrine of informed consent'.<sup>142</sup> The Court dismissed the appeal, holding that:<sup>143</sup>

In the particular doctor-patient relationship which arose in these emergency circumstances it is apparent that the doctor could not inform the patient of the risks involved in her prior decision to refuse consent to blood transfusions in any circumstances. It is apparent also that her decision did not emerge out of a doctor-patient relationship. Whatever the doctor's obligation to provide the information needed to make an informed choice may be in other doctor-patient relationships, he cannot be in breach of any such duty in the circumstances of this relationship. The patient manifestly made the decision on the basis of her religious convictions. It is not for the doctor to second-guess the reasonableness of the decision or to pass judgment on the religious principles which motivated it. The fact that he had no opportunity to offer medical advice cannot nullify instructions plainly intended to govern in circumstances where such advice is not possible. Unless the doctor had reason to believe that the instructions in the Jehovah's Witness card were not valid instructions in the sense that they did not truly represent the patient's wishes, in my opinion he was obliged to honour them. He has no authorization under the emergency doctrine to override the patient's wishes. In my opinion, she was entitled to reject in advance of an emergency a medical procedure inimical to her religious values.

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140 (1990) 72 OR (2d) 417.

141 Ibid 429.

142 Ibid 432.

143 Ibid 432–3.

9.135 In *Re T (Adult: Refusal of Treatment)*,<sup>144</sup> Lord Donaldson MR suggested that a refusal of treatment did not need to be fully informed to be effective, although a refusal of treatment could be vitiated by the provision of misinformation or the withholding of information that was sought by the patient.<sup>145</sup>

What is required is that the patient knew in broad terms the nature and effect of the procedure to which consent (or refusal) was given. There is indeed a duty on the part of doctors to give the patient appropriately full information as to the nature of the treatment proposed, the likely risks (including any special risks attaching to the treatment being administered by particular persons), but a failure to perform this duty sounds in negligence and does not, as such, vitiate a consent or refusal. On the other hand, misinforming a patient, whether or not innocently, and the withholding of information which is expressly or impliedly sought by the patient may well vitiate either a consent or a refusal.

### The law in Queensland

9.136 Whatever the requirement for an effective advance refusal of treatment may be at common law, the requirement under the *Powers of Attorney Act 1998* (Qld) for making an advance health directive is that the principal understands 'the nature and the likely effects of each direction in the advance health directive'.<sup>146</sup> Further, it is also a requirement for making an advance health directive that the advance health directive includes a certificate signed by the eligible witness that the principal appeared to have the capacity necessary to make the advance health directive and a certificate to similar effect signed by a doctor.<sup>147</sup>

9.137 As explained earlier in this chapter, the Commission has also made recommendations in this Report to strengthen the requirements for capacity to make an advance health directive, as well as limiting the categories of persons who may witness an advance health directive so as to exclude witnesses who do not receive any training.<sup>148</sup>

9.138 The approved form for an advance health directive also includes the following statement about doctor involvement.<sup>149</sup>

It is a requirement of the *Powers of Attorney Act 1998* (Qld) that you sign this document in the presence of a doctor. It is strongly recommended that, before completing this document, you discuss it with your general practitioner or a specialist medical practitioner who knows your medical history and views. The doctor will then be able to explain any medical terms that you are unsure about

144 [1993] Fam 95.

145 Ibid 114.

146 See *Powers of Attorney Act 1998* (Qld) s 42(1), which is discussed at [9.37]–[9.38] above.

147 See *Powers of Attorney Act 1998* (Qld) s 44, which is discussed at [9.43] above. The Draft Advance Care Directives Framework 2010 suggests that there should not be a requirement for informed consent or refusal when an 'advance care directive', such as an advance health directive is completed: see Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 17, 18, 36.

148 See [9.40]–[9.42], [9.44] above.

149 Advance Health Directive (Form 4) Section 5: Doctor involvement.

and will also be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decision you have made in the document.

## Issues for consideration

### *Informed decision-making*

9.139 The Irish Law Reform Commission has recently recommended that people should be encouraged to consult a health care professional when making an advance directive.<sup>150</sup> In the case of an advance directive refusing life-sustaining medical treatment, it also recommended that ‘the decision must be an informed decision’.<sup>151</sup> However, it did not recommend that a person making such a directive should be required to consult a doctor. In its view, a requirement to that effect may be both overly burdensome and in conflict with the principle that medical treatment may be refused on non-medical grounds.<sup>152</sup>

the Commission accepts that the emphasis should be on ensuring that a person understands what treatment they are refusing and the implications of that decision, not who or where they get the information from. The important point is that the decision is an informed decision. (note omitted)

9.140 However, a requirement for a doctor to certify that he or she has discussed the content of the directive with the person, as is presently the case in Queensland, is likely to be particularly important: the attending health professional will, for a directive made a long time in advance, be unable to assess whether the patient understood the nature and effect of making the directive at the time it was made and will, instead, need to rely on the certificate of the witness.<sup>153</sup>

### *Review of an advance health directive*

9.141 One of the difficulties identified with advance health directives is that the person’s views, the available treatment options or other circumstances may change after the directive is made.<sup>154</sup> While there is provision for a person to revoke an advance health directive while he or she retains the capacity to do so, a further issue is whether regular review of such directives should be required. Regular

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150 Law Reform Commission of Ireland, *Bioethics: Advance Care Directives*, Report No 94 (2009) [3.70], [5.27].

151 Ibid.

152 Ibid [3.68]–[3.69]. The Irish Law Reform Commission had previously proposed that medical consultation be required for advance refusals of life-sustaining treatment: Law Reform Commission of Ireland, *Bioethics: Advance Care Directives*, Consultation Paper No 51 (2008) [3.15]. In the United Kingdom, people are advised, but not required, to discuss an advance refusal of life-sustaining treatment with a doctor: Office of the Public Guardian (UK), *Mental Capacity Act (2005) Code of Practice* [9.14] <<http://www.publicguardian.gov.uk/mca/code-of-practice.htm>> at 24 August 2010.

153 Eg J Inge, ‘Advance directives’ (2000) July *Medicine Today* 121.

154 M Wallace, *Health Care and the Law* (3rd ed, 2001) [5.104]; Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-Making for People who Need Assistance Because of Mental or Intellectual Disability*, Discussion Paper, WP No 38 (1992) 145–6.

review would be consistent with the Australian Medical Association's position statement on advance care planning.<sup>155</sup>

9.142 At present, the approved form for making an advance health directive includes a specific section encouraging regular review of the document. It states:<sup>156</sup>

It is strongly recommended that you regularly review this document, as your wishes may change or there may be advances in medical technology. You would be wise to review the document every two years or if the state of your health changes significantly.

Each time you review your document and your wishes have not changed, sign and date one of the acknowledgments below. If your wishes have changed a great deal, you should complete a new document.

9.143 The recommendation to review is reiterated in the explanatory notes at the beginning of the approved form. It is not, however, a legislative requirement that an advance health directive be reviewed. This raises the issue of whether review should be mandatory and, if so, what the consequences of a failure to review should be — for example, whether a directive should automatically lapse after a given period of time unless it has been affirmed by the principal. It is important to consider the impact these options may have on the convenience of advance health directives as a means of giving effect to an adult's wishes about future medical treatment.

## Discussion Paper

9.144 In the Discussion Paper, the Commission sought submissions on:<sup>157</sup>

- how the guardianship legislation should address concerns about the potentially uninformed nature of advance decisions; and
- whether regular review of an advance health directive should be required under the legislation.

## Submissions

### *Informed decision-making*

9.145 A legal academic with expertise in health law and guardianship law commented that it might be considered desirable in some cases for a person to be

<sup>155</sup> The Australian Medical Association recommends that advance care plans be reviewed as the patient's condition and preferences change and updated regularly to ensure currency and to encourage patients to explore all advance care plan options: Australian Medical Association, Position Statement, *The Role of the Medical Practitioner in Advance Care Planning* (2006) [3.7] <<http://www.ama.com.au/node/2428>> at 24 August 2010.

<sup>156</sup> Advance Health Directive (Form 4) Section 11: Review of this document.

<sup>157</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 254.

medically informed before completing an advance health directive. However, it was observed that:<sup>158</sup>

some individuals may wish to make a binding advance directive in the absence of information being provided. There may be religious or other social grounds for their position which are not dependent on medical information. So while some may have concerns about whether information is provided at the time an advance directive is made ... others may not.

9.146 This respondent was therefore of the view that an advance health directive should be valid even if it is not based on medical (or other) information.

9.147 The Christian Science Committee on Publication for Queensland did not object to people being encouraged to consult a health provider when making an advance health directive, but was of the view that there should not be a requirement to that effect:<sup>159</sup>

We believe that there should be similar flexibility in methods to ensure that an adult producing an advance health directive is making an 'informed decision.' While we do not object to an individual being encouraged to consult a health care professional when making an advance directive, we do not feel it should be mandated. We agree that the emphasis should be on ensuring that a person understands what treatment they are refusing and the implications of that decision, not who or where they get the information from.

This is of particular concern for those who regularly turn to spiritual forms of health care and don't subscribe to a conventional medical approach to treatment. Christian Scientists or other persons who have relied upon spiritual and prayerful means for health care throughout their life (or indeed any other non-medical means of health care) may have no desire to discuss their decision and their beliefs with a medical doctor, and such a requirement could serve as an impediment to the use of an advance health directive, thereby negating the goal of giving voice to a person's wishes at a point when they are no longer able to articulate those wishes.

We believe consideration should be given to allowing for someone other than a medical doctor to ensure that an 'informed decision' has been arrived at. Examples could include a lawyer, justice of the peace, or other person qualified to explain the importance of the AHD [Advance Health Directive] document to the individual.

### ***Review of an advance health directive***

9.148 The former Acting Public Advocate commented that advance health directives should be limited in time and require review as a matter of course:<sup>160</sup>

To assist in addressing the difficulties associated with the uninformed nature of decision-making under an AHD [Advance Health Directive], their operation could be time limited, and regular review required as a matter of course. This

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158 Submission 144.

159 Submission 151.

160 Submission 160.

would ensure that if the adult's health or views/wishes in relation to health care change, they can reconsider, and where desired, revise their AHD. In doing so the AHD would arguably reflect to a greater extent the adult's most recent views. It would also enable them to potentially be better informed about their prognosis, available treatment options and other relevant matters, and would provide further opportunity for consultation with a health professional around those issues.

9.149 The Council on the Ageing Queensland was also of the view that advance health directives should be limited in the time for which they apply.<sup>161</sup>

9.150 Right to Life Australia commented generally that advance health directives are highly problematic. It suggested that advance health directives may be outdated and so fail to reflect the person's current personal views and the changes that may occur in medical treatment.<sup>162</sup> Although Right to Life Australia was generally of the view that advance health directives should not be legally binding, it commented that there should be a legislative requirement for them to be reviewed every two years.

9.151 The Adult Guardian also favoured an approach under which an advance health directive would be effective for two years:<sup>163</sup>

Given the rapidly changing nature of medical technology, understanding and treatment and the changes in attitude and lifestyle and health which may affect health care decisions, it is difficult to see how a decision made about health care should remain operative [for] more than two years. Perhaps the AHD could be binding on the treating doctor for a period of two years after it is executed, but to be binding after that period must be re-executed. If it is not re-executed, the AHD could be informative of but not binding upon the treating medical team.

9.152 However, the Department of Communities commented that, while it may be prudent to review an advance health directive regularly, it should not be mandatory.<sup>164</sup> Another respondent was of the same view.<sup>165</sup> These respondents suggested, however, that the explanatory notes on the approved form or a supporting information booklet should strongly recommend regular review of the advance health directive.<sup>166</sup>

9.153 A legal academic with expertise in health law and guardianship law was of the view that advance health directives should not be required to be reviewed 'as it would constitute an unreasonable interference with personal autonomy'.<sup>167</sup> She suggested, however, that 'the age of the advance directive may be relevant in an

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161 Submission 60.

162 Submission 149.

163 Submission 164.

164 Submission 169.

165 Submission 161.

166 Submissions 161, 169.

167 Submission 144.

assessment of whether the person would have intended it to govern the medical situation that has later arisen’.

## **The Commission’s view**

### ***Informed decision-making***

9.154 In requiring a principal to understand the nature and likely effects of each direction in an advance health directive, section 42 of the *Powers of Attorney Act 1998* (Qld) provides an important safeguard in relation to the making of an advance health directive.

9.155 Although the *Powers of Attorney Act 1998* (Qld) does not expressly require a principal to discuss the contents of the advance health directive with a doctor, section 44(6) of the Act requires an advance health directive to include a certificate signed and dated by a doctor stating that the principal, at the time of making the advance health directive, appeared to the doctor to have the capacity necessary to make it — that is, that the principal appeared to understand the nature and likely effects of each direction in the advance health directive. It would be difficult for a doctor to be satisfied of the principal’s capacity to make an advance health directive without discussing the contents of the document with the principal.

9.156 Given the significance of the directions that may be given by an advance health directive, the Commission considers that it is appropriate that the *Powers of Attorney Act 1998* (Qld) requires, in this way, informed decision-making by a principal.

### ***Review of an advance health directive***

9.157 It is clearly desirable for a principal to review his or her advance health directive periodically. However, the Commission is not persuaded that an advance health directive should operate for a specified period of time only, or that it should be necessary to review an advance health directive at regular intervals in order for it to continue to be valid. Requirements of this kind are too absolute, and would be likely to result in the invalidity of advance health directives that still reflect the principal’s wishes. Moreover, it would only be possible for a principal to review his or her advance health directive for so long as he or she retained capacity. Accordingly, a mandatory requirement for review would have the effect that an advance health directive would cease to have effect within a specified period of time after the principal lost capacity, as the principal would no longer be able to review it.

9.158 The Commission considers that a requirement for mandatory review would seriously erode an adult’s autonomy and would significantly undermine the utility of advance health directives.

9.159 Although circumstances may change, including advances in medical science, the better approach is for such changes to be accommodated by amending the *Powers of Attorney Act 1998* (Qld), as previously recommended, to provide that a direction in an advance health directive does not operate if the

direction is uncertain or circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.<sup>168</sup>

9.160 Accordingly, the Commission does not recommend a requirement for the mandatory review of an advance health directive. The approved form should, however, continue to encourage principals to review their advance health directives periodically.

## COPIES AND PROOF

### Issue for consideration

9.161 Section 45 of the *Powers of Attorney Act 1998* (Qld) deals with proof of an enduring document, including an advance health directive. It provides:

#### **45 Proof of enduring document**

- (1) An enduring document<sup>49</sup> may be proved by a copy of the enduring document certified under this section.
- (2) Each page, other than the last page, of the copy must be certified to the effect that the copy is a true and complete copy of the corresponding page of the original.
- (3) The last page of the copy must be certified to the effect that the copy is a true and complete copy of the original.
- (4) Certification must be by 1 of the following persons—
  - (a) the principal;
  - (b) a justice;<sup>50</sup>
  - (c) a commissioner for declarations;
  - (d) a notary public;
  - (e) a lawyer;<sup>51</sup>
  - (f) a trustee company under the *Trustee Companies Act 1968*;
  - (g) a stockbroker.
- (5) If a copy of an enduring document has been certified under this section, the enduring document may also be proved by a copy, certified under this section, of the certified copy.

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See [9.80]–[9.83] above and Recommendation 9-3(b)(i) below.

- (6) This section does not prevent an enduring document being proved in another way.
- 49 An enduring power of attorney made under the *Property Law Act 1974* and of force and effect before the commencement of section 163 is taken to be an enduring power of attorney made under this Act—section 163.
- 50 **Justice** means a justice of the peace—see the *Acts Interpretation Act 1954*, section 36.
- 51 **Lawyer** means a barrister, solicitor, barrister and solicitor or legal practitioner of the High Court or the Supreme Court of a State (including the Australian Capital Territory and the Northern Territory)—see the *Acts Interpretation Act 1954*, sections 33A and 36.

9.162 Without limiting the ways in which an advance health directive may be proved, section 45 enables an advance health directive to be proved by a copy certified in the prescribed manner as a true and complete copy of the original. Each page, other than the last page, of the copy must be certified to the effect that the copy is a true and complete copy of the corresponding page of the original, while the last page of the copy must be certified to the effect that the copy is a true and complete copy of the original. An advance health directive may also be proved by a certified copy of the certified copy.<sup>169</sup>

9.163 The other Australian jurisdictions do not have a provision that is similar to section 45 of the *Powers of Attorney Act 1998* (Qld).

9.164 At present, the explanatory notes in the approved form advise principals to give a *copy* of their directive to people such as their doctor, attorney, family member, friend or solicitor. However, the form does not mention the desirability of giving a certified copy.

## Discussion Paper

9.165 In the Discussion Paper, the Commission sought submissions on whether:<sup>170</sup>

- section 45 of the *Powers of Attorney Act 1998* (Qld) should clarify the ways in which a copy of an advance health directive may be proved; and
- the explanatory information provided in the approved form for making an advance health directive should advise principals to provide certified copies of the document to relevant third parties.

## Submissions

9.166 A legal academic with expertise in health law and guardianship law commented that the ways in which a copy of an advance health directive may be

<sup>169</sup> *Powers of Attorney Act 1998* (Qld) s 45(5).

<sup>170</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 255.

proved should be clarified.<sup>171</sup>

9.167 The Adult Guardian noted that the other Australian jurisdictions do not have an equivalent provision dealing with the proof of an advance health directive, and suggested that consideration could be given to omitting section 45 of the *Powers of Attorney Act 1998* (Qld):<sup>172</sup>

A matter for consideration is what mischief overly prescriptive methods of proving this document are designed to achieve, given that similar provisions don't exist in other States. Unless there seems to be a history of misuse, perhaps consideration should be given to the provisions about more formal proof of the document [being] deleted from the legislation.

9.168 A number of respondents were of the view that the explanatory information provided in the approved form for an advance health directive should advise principals to provide certified copies of the document to relevant third parties.<sup>173</sup> The Adult Guardian commented:<sup>174</sup>

In the absence of a decision to establish a system of registration, the notice in the form should clearly state the need to notify relevant third parties and assist by providing a list of examples.

## The Commission's view

### ***Proof of an advance health directive***

9.169 A provision enabling an advance health directive to be proved by a certified copy serves two purposes. The process of certification necessarily requires the person completing the certification to examine and compare each page of the original with the copy. As a result, the process provides an assurance against the risk that the copy, whether by accident or misconduct, is not a true copy of the original. On a practical level, the provision provides useful guidance to health providers and other persons who might otherwise be unsure whether they may rely on a copy of the advance health directive or should require the production of the original.

9.170 The Commission therefore considers that the *Powers of Attorney Act 1998* (Qld) should continue to include a provision dealing with the manner of proving an advance health directive.

9.171 However, the Commission considers that the process of certification that is currently required by section 45(2) and (3) of the *Powers of Attorney Act 1998* (Qld) is too onerous. By requiring each page, including the last page, of the copy to be certified, there is a high likelihood of inadvertent non-compliance with the section. This has the potential to lead to confusion as to whether reliance can be placed on

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171 Submission 144.

172 Submission 164.

173 Submissions 144, 161, 164, 165, 169.

174 Submission 164.

a copy of an advance health directive that has been incorrectly certified. The Commission is not aware of any other statutory provision that requires certification of each individual page of the copy being certified.

9.172 The Commission is therefore of the view that section 45(2) and (3) of the *Powers of Attorney Act 1998* (Qld) should be omitted and replaced by a new subsection to the effect that the copy of the enduring document must be certified to the effect that it is a true and complete copy of the original. This change retains the benefits of certification but ensures that the requirements of the Act are not so high as to lead to error in the certification process with the resulting uncertainty that this can create.

### ***Instructions about the certification process***

9.173 In the Commission's view, the explanatory notes for the approved form for making an advance health directive should continue to recommend that a copy of the form be given to the adult's doctor, attorney, family member or friend, and solicitor. However, it would be desirable for the explanatory notes to refer to the importance of providing a *certified* copy of the advance health directive to those people. That would assist in avoiding disputes about whether a copy of an advance health directive is sufficient evidence of the document.

9.174 The approved form should also explain how a copy of the advance health directive should be certified in order to comply with section 45 of the *Powers of Attorney Act 1998* (Qld).

## **NOTIFICATION AND REGISTRATION**

### **The law in Queensland**

9.175 The *Powers of Attorney Act 1998* (Qld) does not make provision for the registration of an advance health directive.

### **The law in other jurisdictions**

#### ***South Australia***

9.176 In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides for the voluntary registration of advance health directives.<sup>175</sup> The South Australian approach appears to have had limited success in encouraging access to advance directives:<sup>176</sup>

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175 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 14.

176 Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: Second Report of the Review of South Australia's Advance Directives, Stage 2 Proposals for implementation and communication strategies* 38 <[http://www.agd.sa.gov.au/news/pdfs/2009/Stage\\_2\\_report\\_final.pdf](http://www.agd.sa.gov.au/news/pdfs/2009/Stage_2_report_final.pdf)> at 24 August 2010.

South Australia has had a voluntary register of [medical powers of attorney] and Anticipatory Directions with MedicAlert since 1999. [Advance directives] registered with MedicAlert were reviewed in 2004 when the Chief Executive Officer advised that MedicAlert had never received a request for information about registered [advance directives] from a medical or ambulance officer. At that time, there were less than 200 [advance directives] registered, predominantly in its first two years of operation and mostly by very elderly people, so it is likely that many of the registrants are now deceased.

### **Western Australia**

9.177 In Western Australia, when the remaining provisions of the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) commence, the *Guardianship and Administration Act 1990* (WA) will provide that a register of advance health directives must be established and maintained.<sup>177</sup> The guardianship legislation will also provide that an advance health directive may be registered in the register of advance health directives, although registration will not be mandatory.<sup>178</sup>

### **Other jurisdictions**

9.178 While registration is not available in the other Australian jurisdictions, the legislation in the ACT and Victoria includes provisions that increase the likelihood that an adult's advance directive will come to the attention of his or her health providers.

9.179 In the ACT, the *Medical Treatment (Health Directions) Act 2006* (ACT) includes provisions dealing with the notification of an adult's health direction. Sections 13 and 14 provide:

#### **13 Notification of patients making or revoking health direction**

- (1) This section applies if a health professional or someone else becomes aware that a patient in a health care facility<sup>179</sup>—
  - (a) has made a health direction; or
  - (b) has revoked a health direction.
- (2) The health professional or other person must tell the person in charge of the health care facility about the making or revoking of the health direction and the circumstances in which the direction was made or revoked. (note added)

<sup>177</sup> *Guardianship and Administration Act 1990* (WA) s 110ZAA, inserted by s 11 of the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA).

<sup>178</sup> *Guardianship and Administration Act 1990* (WA) s 110RA, inserted by s 11 of the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA).

<sup>179</sup> *Medical Treatment (Health Directions) Act 2006* (ACT) dictionary defines 'health care facility' to mean 'a hospital, residential aged care facility or residential disability care facility'.

#### 14 Copy of patients making or revoking health direction

If the person in charge of a health facility is told under section 13 about a patient making or revoking a health direction, the person must take reasonable steps to ensure that—

- (a) a copy of the health direction or revocation is placed with the patient's file; or
- (b) if it is not possible to get a copy of the health direction or revocation—a note about the direction or revocation is placed with the patient's file.

9.180 The *Powers of Attorney Act 2006* (ACT) also includes a provision dealing with the duty of the person in charge of a health care facility to take reasonable steps to ascertain if an adult has a power of attorney and, if so, to place a copy with the person's records. Section 49 provides:

#### 49 Obligations on health care facilities in relation to powers of attorney

The person in charge of a health care facility<sup>180</sup> must take all reasonable steps to ensure that—

- (a) each person receiving care at the facility is asked whether the person has an enduring power of attorney for personal care matters or health care matters; and
- (b) if a person has a power of attorney of that kind—a copy of the power of attorney is kept with the person's records; and
- (c) a process is in place to periodically check the currency of powers of attorney kept. (note added)

9.181 In Victoria, the *Medical Treatment Act 1988* (Vic) also requires a patient's refusal of treatment certificate or any notification of the cancellation of such a certificate to be placed with the patient's records kept by a hospital or nursing home. Section 5E provides:

#### 5E Copies of refusal of treatment certificate

- (1) The Board of a public hospital or denominational hospital and the proprietor of a private hospital or nursing home must take reasonable steps to ensure that a copy of any refusal of treatment certificate applying to a person who is a patient in the hospital or home and of any notification of the cancellation of such a certificate—
  - (a) is placed with the patient's record kept by the hospital or home; and
  - (b) is given to the chief executive officer (by whatever name called) of the hospital or home;

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*Powers of Attorney Act 2006* (ACT) dictionary defines 'health care facility' to mean 'a hospital, residential aged care facility or residential disability care facility'.

- (c) is given to the principal registrar of the Tribunal within 7 days after the certificate is completed.
- (2) A registered medical practitioner who signs the verification in a refusal of treatment certificate for a person who is not a patient in a public hospital, denominational hospital, private hospital or nursing home must take reasonable steps to ensure that a copy of the refusal of treatment certificate is given to the principal registrar of the Tribunal within 7 days after it is made.

### Issues for consideration

9.182 Concerns have been raised about the difficulties of alerting health providers to the existence of a valid advance health directive.<sup>181</sup>

There is no provision for recording of, or access to, medical directives, which may be a critical issue where a person is not competent to determine treatment. A person who has multiple or a serious illness may be being cared for by a large number of health carers. They may or may not be in a health care facility, and may be transferred between facilities or discrete treatment areas within the same facility. There is a need to ensure that health carers are at any time aware of the existence of an advance directive.

9.183 This is likely to be particularly problematic in emergency situations, for example, when ambulance officers attend at a person's home.<sup>182</sup>

9.184 It has been suggested that one way to overcome such concerns is to provide a searchable register.<sup>183</sup>

9.185 In Ireland, the Law Reform Commission has recently recommended the establishment of a register of advance care directives,<sup>184</sup> suggesting that a register would be 'in the interests of all involved, the maker, the health care proxy (if any) and all health care professionals'.<sup>185</sup>

9.186 However, registration, whether voluntary or mandatory, has considerable resource implications and a requirement for registration could deter some people

<sup>181</sup> M Wallace, *Health Care and the Law* (3rd ed, 2001) [5.117]. The Federal Parliament's Standing Committee on Legal and Constitutional Affairs has also recommended that the Australian Government investigate ways of encouraging people to inform their health providers about their advance directives: Parliament of Australia, House of Representatives, Standing Committee on Legal and Constitutional Affairs, *Older People and the Law*, Report (2007) [3.188].

<sup>182</sup> Eg South Australia Government, *South Australian Advance Directives Review*, Background Paper (2007) 13; M Parker and C Cartwright, 'Mental Capacity in Medical Practice and Advance Care Planning: Clinical, Legal and Ethical Issues' in B Collier, C Coyne and K Sullivan (eds), *Mental Capacity: Powers of Attorney and Advance Health Directives* (2005) 56, 89. The effect of an adult's advance health directive on the authority to carry out urgent health care without consent is considered in Chapter 12 of this Report.

<sup>183</sup> B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 50.

<sup>184</sup> Law Reform Commission of Ireland, *Bioethics: Advance Care Directives*, Report No 94 (2009) [3.96].

<sup>185</sup> *Ibid* [3.95].

from making an advance directive.<sup>186</sup> These and other concerns about registration are discussed, in the context of enduring powers of attorney, in Chapter 16 of this Report.

9.187 In South Australia, the Advance Directives Review Committee considered the issue of registration of advance directives:<sup>187</sup>

Clearly the usefulness of a register relies not on the person registering their [advance directive], but on the professional who is required to abide by it seeking to affirm its existence. Establishing a register without mandating it be accessed would inappropriately raise registrants' expectations that their wishes will be known and acted upon in the future should they lose the ability to make their own decisions. It is not clear why no health professional had ever contacted MedicAlert seeking information about an [advance directive]. MedicAlert is contacted regularly about drug allergies or other medical information, but it may be that the words 'palliative care act' on a bracelet is not a meaningful prompt.<sup>188</sup> (note added)

9.188 The Review Committee recommended that South Australia not establish a State register of advance directives. The Committee preferred a model premised on making advance directives more accessible.<sup>189</sup> In its view:<sup>190</sup>

Overall, the Review Committee recommends that the benefits of a register do not outweigh the impositions. The Review Committee believes there are better means of assuring these outcomes are achieved that do not bear the cost and resource implications of a register. There is no evidence that requiring registration prevents abuse or raises the uptake of advance directives. However, adding unnecessary administrative steps risks [advance directives] being seen as overbearing government bureaucracy rather than a means of personal empowerment, and is likely to confuse the public and limit uptake; complicate decision-making by agents; complicate care by GPs, ambulance officers, hospitals and aged care services; and overload the Guardianship Board and its staff.

Evidence indicates the unreliability of requiring professionals to routinely check a register. It is better to rely on means such as wallet cards whereby the person or their agent, both of whom have a direct stake in the terms of an [advance directive] being applied, brings their [advance directive] to the attention of professionals. ... All in all, the closer the recording and retrieval

<sup>186</sup> Law Reform Commission Hong Kong, *Substitute Decision-making and Advance Directives in Relation to Medical Treatment*, Report (2006) [8.66]. That Commission recommended against the introduction of a central registry system: at [8.66].

<sup>187</sup> Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: Second Report of the Review of South Australia's Advance Directives, Stage 2 Proposals for implementation and communication strategies* 38–9 <[http://www.agd.sa.gov.au/news/pdfs/2009/Stage\\_2\\_report\\_final.pdf](http://www.agd.sa.gov.au/news/pdfs/2009/Stage_2_report_final.pdf)> at 24 August 2010.

<sup>188</sup> Registrants are issued with a bracelet or pendant inscribed 'palliative care act' (in reference to the *Consent to Medical Treatment and Palliative Care Act*): *ibid* at 38.

<sup>189</sup> Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: Second Report of the Review of South Australia's Advance Directives, Stage 2 Proposals for implementation and communication strategies* 40 <[http://www.agd.sa.gov.au/news/pdfs/2009/Stage\\_2\\_report\\_final.pdf](http://www.agd.sa.gov.au/news/pdfs/2009/Stage_2_report_final.pdf)> at 24 August 2010.

<sup>190</sup> *Ibid*.

system is to the person and their agent, the more likely it will be used, and used effectively.

9.189 The Review Committee considered a number of ways in which advance directives could be made more accessible without a formal system of registration. It noted that the 'USA Patient Self-Determination Act requires all hospitals to ask on admission whether the patient has completed an [advance directive], which has driven an increase in the uptake of health [advance directives]'.<sup>191</sup> The Review Committee also identified an international trend towards incorporating advance directives and similar documents into hospital information systems.<sup>192</sup>

There is a trend internationally towards incorporating [advance directives] and advance care plans into health and hospital information systems, and ensuring that clinical staff are alerted to their presence and contents at appropriate stages of admission and treatment. International studies show that this can increase the uptake of health [advance directives] and better ensure that treatment complies with the patient's expressed wishes.

9.190 It also referred to the potential for the computing system used in South Australian public hospitals to record a patient's advance directive with the patient's other health information:<sup>193</sup>

There are existing computing systems within the South Australian health sector with the capacity to record the existence of an [advance directive]. A computer network called OACIS records patient information across the South Australian public hospital system and is being rolled out to some GP surgeries and community health providers. OACIS allows sharing of diagnostic and prescribing information when a patient is being treated at a facility distant from their medical or hospital file. It is intended that over time OACIS will be extended to most GPs, country hospitals and the SA Ambulance Service and will permit 'alerts' to be highlighted. OACIS complements and links with other hospital-based computer networks, but does not extend into private hospitals.

A system of alerts has been developed to enable OACIS to record the existence and type of [advance directive] on admission, but is yet to be implemented throughout the health system. The facility to scan [advance directives] and call them up on screen is being investigated. It is important that completed [advance directives] are scanned rather than summarised because of the risk that a typed summary might be incomplete and misleading.

Unlike OACIS, the national HealthConnect computer network is voluntary and patients choose whether to enlist on it. It does not currently seek information about completed [advance directives]. In the future, there may be potential for all personal health information, including a person's [advance directives], to be included in a national portable electronic health record.

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191 Ibid 36.

192 Ibid.

193 Ibid 36–7.

9.191 The Review Committee therefore recommended:<sup>194</sup>

THAT the Minister for Health propose to the Australian Health Ministers' Conference that accreditation standards for health, medical and aged care facilities require that advance directives be checked on admission, are filed with the person's record and can be easily located.

THAT resources be available to ensure that hospital information systems can record the existence and contents of the health-related sections of advance directives, and these be made accessible across the broader South Australian health system.

THAT the use of a green sleeve in the front of a hospital medical record to hold [advance directives] be promoted and encouraged.

9.192 Another non-legislative option is to inform principals of the need to alert health providers and other relevant people about their advance health directive. The explanatory notes on the approved form for making an advance health directive include the following information:<sup>195</sup>

**What do I do with the completed document?**

You should keep it in a safe place, and you should give a copy to your own doctor, to your attorney for personal/health matters if you have appointed one, to a family member or friend and, if you wish, to your solicitor.

If you are admitted to hospital, make sure the hospital staff know that you have an Advance Health Directive and where a copy can be obtained.

You may also wish to carry a card in your purse or wallet stating that you have made a directive, and where it can be found.

9.193 However, as the *Powers of Attorney Act 1998* (Qld) does not currently require an advance health directive to be made in the approved form, this information may not come to the attention of a person making an advance health directive.<sup>196</sup>

## Discussion Paper

9.194 In the Discussion Paper, the Commission sought submissions on whether:<sup>197</sup>

<sup>194</sup> Ibid 37. This is consistent with the Draft Advance Care Directives Framework 2010: see Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 40.

<sup>195</sup> Advance Health Directive (Form 4) 5.

<sup>196</sup> See, however, the Commission's recommendation that the *Powers of Attorney Act 1998* (Qld) be amended to provide that an advance health directive must be made in the approved form: see [9.109]–[9.113] above and Recommendation 9-5 below.

<sup>197</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 258–9.

- the *Powers of Attorney Act 1998* (Qld) should provide for the registration of advance health directives;
- alternatively, the *Powers of Attorney Act 1998* (Qld) should impose a duty on health providers to inquire whether a patient has an advance health directive; and
- principals should be advised in the approved form or other explanatory information of the importance of taking steps to notify their health providers about their advance health directive.

## Submissions

9.195 A number of respondents were of the view that provision should be made for the registration of advance health directives.<sup>198</sup>

9.196 The Brisbane South Palliative Care Collaborative commented that the registration of advance health directives would promote patient autonomy and dignity at end-of-life.<sup>199</sup>

The lack of a state, or national, AHD registry denies clinicians access to the important knowledge of the presence of an AHD. This may result in the scenario where a patient is known to have an AHD at one facility, but if they are admitted for care at a different facility, knowledge of their end-of-life wishes may not be easily shared with the new treating clinicians in a timely manner.

Lack of access to this knowledge may be particularly salient in the emergency setting, the route that many palliative patients take on admission to hospital. In this clinical context where the doctrine of providing immediate intervention (mostly appropriately) prevails, there is anecdotal evidence that the patient's end-of-life wishes can be inadvertently overruled in this context. Ease of access to any advance planning documentation would promote patient autonomy and dignity at end-of-life in this scenario.

9.197 The former Acting Public Advocate expressed a similar view:<sup>200</sup>

The advantage in having a scheme of registration to operate in addition to a health professional's duty to inquire is that the AHD would be readily and expediently attainable, particularly in emergency/urgent health care situations. It would also enable the adult's wishes in relation to health care to be safeguarded to a greater extent, and properly carried out.

9.198 Another respondent commented that it would be very helpful to the medical profession if a doctor had access to a patient's advance health directive. He suggested that.<sup>201</sup>

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198 Submissions 20B, 60, 102, 149, 160, 161,165.

199 Submission 102.

200 Submission 160.

201 Submission 20B.

Advanced Health Directives could be stored on a database with a security code required to open the file. This security code would only be available to doctors.

This may help overcome some of the privacy issues that would need to be taken into consideration on a state or national register.

9.199 However, a legal academic with expertise in health law and guardianship law questioned whether, in light of the varied success of the registers referred to in the Discussion Paper and the resource implications of a register, the establishment of a register would be valuable.<sup>202</sup>

9.200 The Adult Guardian considered that a benefit of registration was that it would add to the perception of formality, although she acknowledged that significant resourcing would be required to establish a register that was both mandatory and free.<sup>203</sup>

One of the perceived issues with AHDs is their relative informality in comparison with the sometimes significant directions that they contain. A benefit of registration is that it would add to the perception of formality. However there are significant resourcing issues associated with establishing a register which is both mandatory and free (in line with the commentary about the elements necessary to make a register successful).

9.201 In the Adult Guardian's experience, adults with clear views tend to ensure that their treating team is informed of those views:

It is certainly the experience of the Adult Guardian that adults who have clear convictions about their health care will use letters, cards, bracelets, tattoos and various other means to ensure that the treating team is aware of their views. ... Perhaps recognition needs to be made that this is about consumer choice and that as a consumer who is exercising their choice they need to take responsibility for notifying relevant persons and organisations about that choice.

9.202 Two respondents considered that health providers should be under a duty to inquire about the existence of an advance health directive for their patients.<sup>204</sup> One of these respondents suggested that this should be part of good medical practice in any event.<sup>205</sup> This respondent also commented that it might be necessary to insert a provision to this effect in the legislation to encourage health providers to make inquiries.

9.203 The Adult Guardian commented generally that, in her experience, doctors who contact the Office of the Adult Guardian have usually identified whether the adult has an advance health directive or an enduring power of attorney.<sup>206</sup>

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202 Submission 144.

203 Submission 164.

204 Submissions 144, 165.

205 Submission 144.

206 Submission 164.

It is ... the case anecdotally that a number of adults say that AHDs are ineffective because doctors don't enquire about them and can, in certain cases, ignore their content. These reasons are often cited as the basis for their non-use. It is certainly the experience of this office when we are contacted to make decisions that medical professionals have enquired and are able to advise about whether an adult has an AHD or EPA [Enduring Power of Attorney]. However whether the enquiries were made at admission or only prior to contacting the Adult Guardian, we are unable to say.

9.204 One respondent was of the view that health providers should not be subject to a duty to inquire about the existence of an advance health directive.<sup>207</sup>

9.205 The Department of Communities suggested that there should be an obligation on the principal and the health provider to inform each other of the existence of an advance health directive.<sup>208</sup>

9.206 Another respondent was of the view that, while it sounded simple to impose a duty on health providers to inquire about the existence of an advance health directive:<sup>209</sup>

it would not be as efficient as a state or a national register accessible on a computer database to doctors. If a patient were in hospital when the advance health directive was required, it would be up to another person to try and locate it for the doctor.

9.207 Several respondents, including the Adult Guardian, were of the view that principals should be advised in the approved form or other explanatory information of the importance of taking steps to notify their health providers about their advance health directive.<sup>210</sup>

## **The Commission's view**

### ***Inclusion of advance health directive with adult's health records***

9.208 The issue to be resolved is how to maximise the likelihood that an adult's directions about his or her future health care will come to the attention of the adult's treating health provider. In the Commission's view, there are several ways to achieve this.

9.209 As part of the Council of Australian Governments' National Partnership Agreement on e-Health, the Commonwealth government has established a National Healthcare Identifier Service so that reliable healthcare-related communication can occur between individuals, providers and provider

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207 Submission 161.

208 Submission 169.

209 Submission 20B.

210 Submissions 144, 161, 164, 165.

organisations.<sup>211</sup> The Service will underpin the development of a nationally consistent electronic health system.<sup>212</sup> Part of that electronic health system will include secure electronic summary records of a person's health history, stored and shared in a network of connected systems. When that system is created it should be possible for an adult's advance health directive to be scanned and stored electronically with the adult's other health records on the electronic system.

9.210 Because a health provider would need to consult that system in order to have access to an adult's medical records, the adult's advance health directive, if stored on that system in a prominent way, would also come to the health provider's attention. In effect, this would be an electronic version of the South Australian Advance Directives Review Committee's recommendation that a green sleeve be included in the front of a hospital medical record to hold an adult's advance directive.<sup>213</sup>

9.211 The ability to lodge an adult's advance health directive with the adult's medical records as part of an electronic health records system would avoid the need to create a parallel system for registering advance health directives and the associated costs of establishing a register. The Commission considers, however, that the greatest advantage of the proposed electronic records system is that it is more likely to be accessed by health providers than a stand-alone register of advance health directives. Further, because access to the electronic health records system will be strictly regulated, it also avoids the need to resolve the significant privacy issues that would arise if a public register for advance health directives were established. In view of the significant advantages of the system being facilitated by the Commonwealth government, the Commission does not recommend the establishment of a register for advance health directives.

9.212 However, the Commission generally favours provisions of the kind found in the ACT legislation discussed above (with the exception of section 49(c) of the *Powers of Attorney Act 2006* (ACT),<sup>214</sup> which it considers to impose too onerous a requirement given the number of adults in respect of whom it would otherwise apply).<sup>215</sup> Those provisions do not place the burden of making inquiries on the individual health provider. Instead, they impose certain duties on the person in charge of a health care facility and on a person who becomes aware that an adult has a health direction made under the *Medical Treatment (Health Directions) Act 2006* (ACT).

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211 See *Healthcare Identifiers Act 2010* (Cth); and Australian Department of Health and Ageing, eHealth, 'Healthcare Identifiers Service' <<http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-ehealth-consultation>> at 24 August 2010.

212 <[http://www.coag.gov.au/coag\\_meeting\\_outcomes/2009-12-07/docs/npa\\_e-health.pdf](http://www.coag.gov.au/coag_meeting_outcomes/2009-12-07/docs/npa_e-health.pdf)> at 24 August 2010.

213 See [9.191] above.

214 *Powers of Attorney Act 2006* (ACT) s 49(c) provides that the person in charge of a health care facility must take all reasonable steps to ensure that 'a process is in place to periodically check the currency of powers of attorney kept'.

215 See [9.179]–[9.180] above.

9.213 The *Guardianship and Administration Act 2000* (Qld) should therefore be amended to include a modified form of section 49 of the *Powers of Attorney Act 2006* (ACT) and sections 13 and 14 of the *Medical Treatment (Health Directions) Act 2006* (ACT). The new provisions should apply in relation to an advance health directive and an enduring power of attorney that applies to health matters,<sup>216</sup> either of which could be relevant to decisions about the adult's health care if the adult later loses capacity.

9.214 The *Guardianship and Administration Act 2000* (Qld) should provide that the person in charge of a health care facility (being a hospital, residential aged care facility or residential disability care facility) must take reasonable steps to ensure that:

- each person receiving care at the facility is asked whether the person has an advance health directive or an enduring power of attorney that applies to health matters; and
- if a person has either of those documents:
  - a copy of the enduring document is brought to the attention of the adult's health providers; or
  - if it is not possible to obtain a copy of the enduring document, the adult's health providers are informed of the existence of the enduring document.

9.215 The *Guardianship and Administration Act 2000* (Qld) should also provide that:

- if a health provider or another person is, or becomes, aware that an adult in a health care facility has made or revoked an advance health directive or an enduring power of attorney that applies to health matters, the health provider or other person must tell the person in charge of the health care facility about the making or revocation of the enduring document and the circumstances in which it was made or revoked; and
- if the person in charge of the health care facility is told about the making or revocation of such an enduring document, the person must take reasonable steps to ensure that:
  - a copy of the enduring document or revocation is brought to the attention of the adult's health providers; or
  - if it is not possible to obtain a copy of the enduring document or revocation, the adult's health providers are informed of the existence of the enduring document or revocation.

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This could be an enduring power of attorney that appoints an attorney specifically for health matters or one that appoints an attorney more generally for personal matters.

9.216 What will constitute reasonable steps to bring the enduring document to the attention of the adult's health providers will depend on the circumstances of the case. For example, if a hospital maintains a single medical record for each patient, placing the enduring document with adult's medical record in such a way as to draw its existence to the attention of the adult's treating doctors may well discharge the duty imposed on the person in charge of the hospital. However, if different departments of a hospital maintain separate medical records for a person, placing the enduring document with only one of those records would be unlikely to discharge that duty.

9.217 In the context of a residential facility, where a general practitioner visiting an adult at the facility would not normally have access to the file maintained by the facility in relation to the adult, placing the enduring document with the adult's file would be unlikely to discharge the duty. It would usually be necessary to take other steps to bring the existence of the enduring document to the attention of the adult's health provider.

9.218 Under these recommendations, it is possible that a health provider may be informed of the existence of an advance health directive or enduring power of attorney but not be provided with a copy of the document. Knowledge of the existence of the enduring document does not mean that the health provider has knowledge of the contents of the document. However, even if the health provider cannot be provided with a copy of the document, the Commission considers that it is still better for the health provider at least to be aware of the document's existence as this knowledge may itself affect the health provider's conduct. For example, if it is not necessary to carry out the health care immediately, it may be possible to make other inquiries that might enable the advance health directive to be located.

9.219 The Commission considered whether the legislation should also be amended to require either a health provider or a person in charge of a health care facility, where an adult has impaired capacity, to inquire of other persons whether the adult has an advance health directive or enduring power of attorney that applies to health matters. While it may be good practice to make such inquiries, the Commission is concerned not to create a duty that might have an uncertain scope and be too onerous. For example, if an adult was brought to hospital unconscious or otherwise with impaired capacity, a wider duty might require inquiries to be made more generally of the adult's family or support network. However, under the Commission's recommendations, if a health provider or another person is, or becomes, aware that the adult has an advance health directive or an enduring power of attorney that applies to health matters, the health provider or other person will have a duty to inform the person in charge of the health care facility, who will in turn have a duty to take reasonable steps to bring the existence of the document to the attention of the adult's health providers. The Commission considers that the inclusion of the recommended provisions is more effective in bringing a relevant enduring document to the attention of an adult's health provider than imposing a duty to inquire on the health provider.

### **Notification of third parties**

9.220 The approved form for an advance health directive should continue to include information about the various ways in which the principal may bring the existence of the advance health directive to the attention of relevant people.

## **RECOGNITION OF INTERSTATE ADVANCE HEALTH DIRECTIVES**

### **The law in Queensland**

9.221 Section 40 of the *Powers of Attorney Act 1998* (Qld) deals with the extent to which an enduring health care document made in another Australian jurisdiction has effect in Queensland. It provides:

**40 Recognition of enduring health care document made in other States**

If a document prescribed by regulation is made in another State<sup>217</sup> and complies with the requirements for the document in the other State, then, to the extent the document's provisions could have been validly included in an advance health directive made under this Act, the document must be treated as if it were an advance health directive made under, and in compliance with, this Act. (note added)

9.222 Recognition is limited to a document prescribed by regulation that complies with the requirements in the Australian jurisdiction in which it was made.<sup>218</sup> To the extent that the document's provisions could have been validly included in an advance health directive made under the *Powers of Attorney Act 1998* (Qld), the document will be treated as if it were an advance health directive made under that Act. To date, no documents have been prescribed by regulation for the purpose of section 40.

9.223 If a principal makes a prescribed document in another Australian jurisdiction and also makes an advance health directive under the *Powers of Attorney Act 1998* (Qld), the effect of the interstate document involves a two-step process. The first step is to determine the effect of the interstate document under section 40 of the *Powers of Attorney Act 1998* (Qld). If section 40 treats it as an advance health directive made under the *Powers of Attorney Act 1998* (Qld), the second step is to consider the effect of section 50(2) of the Act. Section 50(2) provides that a 'principal's advance health directive is revoked, to the extent of an inconsistency, by a later advance health directive'. If, for example, the interstate document refuses particular health care and a later advance health directive made

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*Acts Interpretation Act 1954* (Qld) s 33A(1) provides that a reference in an Act to a 'State' (other than a reference to Queensland or a particular State by name) includes a reference to the Australian Capital Territory and the Northern Territory.

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However, an interstate enduring health care document is not required to comply with the execution requirements of the *Powers of Attorney Act 1998* (Qld). The importance of mutual recognition of 'advance care directives' is recognised by the Draft Advance Care Directives Framework 2010: see Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 30.

under the *Powers of Attorney Act 1998* (Qld) includes a direction requesting the particular health care, the later advance health directive made under the *Powers of Attorney Act 1998* (Qld) will revoke the interstate document to the extent that it refuses the particular health care.

### The law in other jurisdictions

9.224 Western Australia is the only other Australian jurisdiction that makes provision for the recognition of interstate advance health directives. Section 110ZA of the *Guardianship and Administration Act 1990* (WA) provides:<sup>219</sup>

#### 110ZA Recognition of instrument created in another jurisdiction

- (1) The State Administrative Tribunal may make an order recognising an instrument created under a law of another jurisdiction as an advance health directive made under this Part if satisfied the instrument corresponds sufficiently, in form and effect, to an advance health directive made under this Part.
- (2) The Tribunal may revoke an order made under subsection (1).

### Discussion Paper

9.225 In the Discussion Paper, the Commission sought submissions on whether:<sup>220</sup>

- there any difficulties with section 40 of the *Powers of Attorney Act 1998* (Qld); and
- the *Powers of Attorney Act 1998* (Qld) should provide for the recognition of advance health directives made in New Zealand or in any other foreign jurisdiction.

9.226 The Commission also sought submissions on whether the recognition of interstate advance health directives should:<sup>221</sup>

- depend on the instrument having been validly made in the other jurisdiction and including provisions that could validly be included in an advance health directive made under the *Powers of Attorney Act 1998* (Qld) (which is the current Queensland approach); or
- require a declaration from the Tribunal (which is the Western Australian approach); or

219 Similar provision is made for the recognition of an instrument appointing an enduring guardian: *Guardianship and Administration Act 1990* (WA) s 110O.

220 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 259–60.

221 Ibid 260.

- depend on some other requirement.

## Submissions

9.227 A legal academic with expertise in health law and guardianship law noted that the interstate recognition of advance health directives is an issue that is raised frequently by health professionals and members of the community. She referred to the desirability of nationally consistent legislation and suggested that:<sup>222</sup>

It is likely that the most satisfactory resolution of this issue is consistent legislation throughout the Commonwealth, which of course is beyond the brief of the [Queensland Law Reform Commission]. In the meantime, it is perhaps desirable to recognise advance directives that are valid in other jurisdictions to the extent that such recognition is legally possible.

9.228 The Adult Guardian also expressed the view that interstate recognition and portability of advance health directives are significant issues.<sup>223</sup> She commented that it was difficult to see how these issues could be addressed without a national advance health directive or register of advance health directives. In her view, for an interstate or overseas advance health directive to be effective, and not merely a statement of the adult's wishes, the advance health directive should either be registered on a public register or recognised by the Tribunal.

9.229 Another respondent commented:<sup>224</sup>

people are on the move all the time. Australia needs uniform laws when we are dealing with people's lives and welfare.

9.230 Two respondents were of the view, however, that there are no difficulties with section 40 of the *Powers of Attorney Act 1998* (Qld).<sup>225</sup>

9.231 A number of respondents were of the view that the legislation should recognise an advance health directive made in New Zealand.<sup>226</sup>

9.232 The Department of Communities suggested that consideration should be given to recognising advance health directives made in New Zealand, but considered that it may not be practical to recognise advance health directives executed in a foreign language.<sup>227</sup>

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222 Submission 144.

223 Submission 164.

224 Submission 20B.

225 Submissions 161, 165.

226 Submissions 20B, 161, 164, 165.

227 Submission 169.

## The Commission's view

9.233 In the Commission's view, the two conditions that must be satisfied for an interstate advance health directive to be recognised under section 40 of the *Powers of Attorney Act 1998* (Qld) are appropriate — namely, that it complies with the requirements of the jurisdiction in which it was made and includes provisions that could validly be included in a Queensland advance health directive.

9.234 If an instrument does not satisfy the first condition because it has not been properly executed under the requirements of its 'home' jurisdiction, it would not be appropriate for it to be valid in Queensland when it is not valid in the other jurisdiction. Although the second condition necessitates a consideration of the content of the interstate instrument, the Commission considers it important that recognition is given only to a provision or direction that could be included in a Queensland advance health directive. For example, if the interstate instrument purported to appoint an attorney for what would be special health care under the *Powers of Attorney Act 1998* (Qld), the direction would not be recognised because an appointment for such a matter cannot be made under the *Powers of Attorney Act 1998* (Qld).

9.235 Earlier in this chapter, the Commission has recommended that the *Powers of Attorney Act 1998* (Qld) should be amended to provide that an advance health directive must be made in the approved form.<sup>228</sup> The main reason for that decision is that the approved form includes important information of which principals should be aware. In view of that decision, the Commission considers it appropriate that section 40 gives recognition to documents prescribed by regulation. This means that the decision about which jurisdictions' advance health directive equivalents should be recognised can be made on a jurisdiction-by-jurisdiction basis. While the more usual legislative approach would be to treat other States and Territories in a uniform manner, the decision whether to recognise instruments made in a particular jurisdiction will necessarily depend on the sufficiency of the safeguards that apply in that jurisdiction in relation to the making of an advance health directive. This would entail a consideration of matters such as the capacity required to make an advance health directive, the witnessing requirements and, if the jurisdiction has an approved form, the content of the approved form (for example, whether the form provides a satisfactory explanation of the significance of making an advance health directive).

9.236 Because section 40 applies to documents prescribed by regulation, it is effectively confined to statutory advance directives made in other jurisdictions. Because New Zealand does not make provision for statutory advance health directives,<sup>229</sup> it is not possible for section 40 to recognise advance directives made in New Zealand. If New Zealand develops a scheme for statutory advance directives, consideration should be given to whether section 40 should be amended to make provision for New Zealand instruments or those made in other countries to be prescribed by regulation.

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228 See [9.109]–[9.113] above and Recommendation 9-5 below.

229 See n 65 above.

9.237 In light of these various matters, section 40 of the *Powers of Attorney Act 1998* (Qld) should be retained in its current form.

9.238 In addition to retaining section 40, the *Powers of Attorney Act 1998* (Qld) should be amended to provide that it does not matter whether an advance health directive made under the *Powers of Attorney Act 1998* (Qld) is made in or outside Queensland.<sup>230</sup> While section 40 deals with the recognition of an instrument made interstate under the legislation of that other jurisdiction, it is important to clarify that, if a person living interstate or overseas makes an advance health directive under the *Powers of Attorney Act 1998* (Qld), the instrument will be effective in Queensland. Such a provision will be especially important for people who live in jurisdictions that do not have statutory advance directives. For example, if a person resides in New South Wales but spends a significant amount of time in Queensland, the person might wish to make an advance health directive under the *Powers of Attorney Act 1998* (Qld) to ensure that the person's directions are effective in Queensland.

## **PROTECTION OF HEALTH PROVIDER: ACTING ON AN INVALID ADVANCE HEALTH DIRECTIVE OR WITHOUT KNOWLEDGE OF AN ADVANCE HEALTH DIRECTIVE**

### **Introduction**

9.239 Section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld) provides that a direction in an advance health directive is as effective as if the principal gave the direction when a decision about the matter needed to be made and the principal then had capacity for the matter. In addition, section 101 of the Act ensures that a health provider who acts in accordance with a direction in an advance health directive 'is not liable for an act or omission to any greater extent than if the act or omission happened with the principal's consent and the principal had capacity to consent'. These provisions are relevant where the advance health directive is validly made and the health provider is aware of the existence of the advance health directive.

9.240 However, the situation may arise where a health provider relies on what appears to be a valid advance health directive but which in fact is not valid. It is also possible that a health provider may treat an adult in circumstances where the health provider is not aware that the adult has an advance health directive.

9.241 The *Powers of Attorney Act 1998* (Qld) includes provisions (sections 100 and 102) to protect a health provider in both of these situations.

9.242 Queensland Advocacy Incorporated ('QAI') has commented generally that while the need for clarity and protection for health providers is important:<sup>231</sup>

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For a similar provision in relation to powers of attorney, see s 24 of the *Powers of Attorney Act 2006* (ACT).

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Queensland Advocacy Incorporated, *Submission on 'Rethinking Life-Sustaining Measures: Questions for Queensland'* (4 July 2005) 6–7 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 25 August 2010.

this needs to be balanced by an understanding that this legislation must always give priority to the interests of people with impaired capacity, a highly vulnerable group of people.

9.243 In a submission made to this Commission, the Adult Guardian, however, has referred to the particular vulnerability of people who have had capacity but who subsequently lose it:<sup>232</sup>

Although the quote from QAI concerning the vulnerability of people who lack capacity is correct, it needs to be balanced with a recognition that AHDs are a mechanism for people who previously had capacity to make substitute decisions about their health care which they intended to be operative at a time when they lacked capacity to make those decisions. This group have different vulnerabilities from those who have never had the capacity to consider and make these decisions.

### ***Protection if unaware of invalidity of advance health directive***

9.244 Section 100 of the *Powers of Attorney Act 1998* (Qld) protects a person who acts in reliance on an invalid advance health directive without knowing it is invalid. It also protects a person who, without knowing that a power for a health matter under an enduring document (that is, an advance health directive or an enduring power of attorney) is invalid, relies on the purported exercise of the power.

9.245 Section 100 provides:

#### **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.

9.246 The second limb of protection — relying on the purported exercise of an invalid power — will be relevant where the advance health directive appoints an attorney who purports to exercise power under it. Section 96 of the Act defines what is meant by an invalid power under an enduring document and what it means to know of a power's invalidity. It provides:

#### **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.

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Submission 164.

**know**, of a power's invalidity, includes—

- (a) know of the happening of an event<sup>74</sup> that invalidates the power; or
- (b) have reason to believe the power is invalid.

74 For example, a principal's enduring power of attorney is revoked if the principal dies (section 24) or, to the extent an attorney was given power, if the attorney becomes a health provider for the principal (section 59).

9.247 Because the definition of 'invalidity, of a power under a document' includes invalidity resulting from revocation of the document, section 100 will protect a health provider who, without knowing that an advance health directive has been revoked, acts in reliance on a decision made by an attorney appointed under the advance health directive.

9.248 However, the *Powers of Attorney Act 1998* (Qld) does not include a similar definition of 'invalidity of an advance health directive'. Accordingly, it is doubtful whether the section will protect a health provider who, without knowing that an advance health directive has been revoked, acts in reliance on a direction contained in the advance health directive (as distinct from acting in reliance on a decision made by an attorney appointed under the advance health directive).

### **Protection if unaware of existence of advance health directive**

9.249 Section 102 of the *Powers of Attorney Act 1998* (Qld) deals with the situation where a health provider does not know that an adult has an advance health directive. It provides:<sup>233</sup>

#### **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 health directive.

### **Issues for consideration**

#### **The type of knowledge that is relevant for sections 100 and 102**

9.250 In the absence of a definition of knowing of the invalidity of an advance health directive or knowing that an adult has an advance health directive,<sup>234</sup> the references to 'knowing' and 'know' in sections 100 and 102 appear to be a reference to 'actual knowledge'<sup>235</sup> and not to the wider concept of constructive knowledge. A person has constructive knowledge of facts 'if he wilfully shuts his

233 Similarly, under the *Natural Death Act* (NT) s 4(3), the medical practitioner's duty to act in accordance with an advance direction given by the patient arises only if the practitioner 'has notice of that direction'.

234 *Powers of Attorney Act 1998* (Qld) s 96 does not seem to apply to knowledge of an invalid *directive* or to knowledge of whether an advance health directive exists. It does, however, apply to knowledge that a power for a health matter under an enduring document is invalid: see [9.246] above.

235 In contrast, see *Guardianship and Administration Act 2000* (Qld) s 77, which refers to a health provider who 'knew, or could reasonably be expected to have known'.

eyes to the relevant facts which would be obvious if he opened his eyes'.<sup>236</sup> A person may also be treated 'as having constructive knowledge of the facts ... if he has actual knowledge of circumstances which would indicate the facts to an honest and reasonable man'.<sup>237</sup>

9.251 The issue is whether it is appropriate that a health provider is protected under sections 100 and 102 provided that he or she does not have actual knowledge of the relevant matters, or whether the provisions should be amended so that, if a health provider has actual or constructive knowledge of the invalidity of the advance health directive (for section 100) or of the existence of an advance health directive (for section 102), the health provider is not protected by those sections. Too high a threshold 'offers doctors no incentive to investigate the scope and validity of advance directives'.<sup>238</sup> On the other hand, a threshold that is too low may unsatisfactorily impose liability on health providers who have acted honestly and reasonably.

**A different test for protection: acting in good faith with reasonable care and skill**

9.252 An alternative approach that has been raised is whether the protection should continue to depend on the absence of knowledge. It has been suggested that, rather than a test of knowledge, the protection should depend on whether the person 'acted in good faith with reasonable care and skill', allowing individual circumstances to be taken into account.<sup>239</sup>

In some cases, for example, where the invalidity is less obvious ... 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 [Advance Health Directive] is clearly invalid ... 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.

9.253 To the extent that this approach focuses on whether the person would have known of the invalidity if he or she had made the inquiries that a reasonable person would have made in the circumstances, this alternative approach seems to advocate a threshold of constructive knowledge.<sup>240</sup>

9.254 The incorporation of a good faith test would be consistent with the position in Victoria and Western Australia. In Victoria, a combined good faith and knowledge test applies: a medical practitioner is protected from liability if he or she

236 *Baden v Société Générale pour Favoriser le Développement du Commerce et de l'Industrie en France SA* [1993] 1 WLR 509, 576 (Peter Gibson J).

237 *Ibid.*

238 K Stern, 'Advance directives' (1994) 2 *Medical Law Review* 57, 74.

239 B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 40. See also 43–4 of that paper in relation to the protection given by s 102 of the *Powers of Attorney Act 1998* (Qld).

240 Eg RP Meagher, JD Heydon and MJ Leeming, *Equity: Doctrines and Remedies* (4th ed, 2002) [8-270]; 'Constructive knowledge' and 'Constructive notice' in LexisNexis, *Encyclopaedic Australian Legal Dictionary* (27 October 2008).

acts 'in good faith and in reliance on a refusal of treatment certificate' but is not aware that the certificate has been cancelled.<sup>241</sup>

9.255 In Western Australia, if a health professional takes treatment action 'relying in good faith on what is purportedly a treatment decision in an advance health directive made by the patient', the health professional is taken for all purposes to take the treatment action in accordance with a treatment decision that has effect as if it had been made by the patient and the patient were of full legal capacity.<sup>242</sup>

9.256 An approach based on good faith and reasonable care has been criticised, however, for failing to adequately indicate the extent to which a health professional would be required to investigate the validity of the directive.<sup>243</sup>

## Discussion Paper

9.257 In the Discussion Paper, the Commission sought submissions on whether:<sup>244</sup>

- the *Powers of Attorney Act 1998* (Qld) should define what an 'invalid' advance health directive means for the purpose of section 100 of the Act;
- the *Powers of Attorney Act 1998* (Qld) should define 'knowledge' for the purpose of sections 100 and 102 of the Act and, if so, how — for example, whether a person should have the benefit of the protection if he or she did not actually know that the directive was invalid even if he or she should have known that the directive was invalid;
- the test in sections 100 and 102 of the *Powers of Attorney Act 1998* (Qld) for protection from liability should be one of knowledge or whether a different test should be used, such as a 'good faith' test.

## Submissions

9.258 A legal academic with expertise in health law and guardianship law considered that the *Powers of Attorney Act 1998* (Qld) should clarify what is meant by the 'invalidity' of an advance health directive:<sup>245</sup>

241 *Medical Treatment Act 1988* (Vic) s 9.

242 *Guardianship and Administration Act 1990* (WA) s 110ZK(2)(a), (c)–(d). See also Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 42, 46.

243 K Stern, 'Advance directives' (1994) 2 *Medical Law Review* 57, 74.

244 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 263.

245 Submission 144.

It would seem sensible that the term extends to a valid directive that has been revoked. Again, protection should depend on whether appropriate steps have been taken by the health professional to establish validity.

9.259 This respondent was also of the view that the protection afforded by section 102 of the *Powers of Attorney Act 1998* (Qld) should not be based on an absence of actual knowledge:

It may be that a doctor does not agree with advance directives, as a matter of principle, and he or she takes active steps to avoid notification of the advance directive. A health provider should not be protected if he or she has constructive knowledge of the advance directive.

9.260 Another respondent suggested that the protection afforded by sections 100 and 102 of the *Powers of Attorney Act 1998* (Qld) should depend on the health provider acting in good faith.<sup>246</sup>

9.261 The Adult Guardian considered that health providers should be protected if they make reasonable inquiries about the existence of an advance health directive, undertake a limited examination of its validity, and act in good faith and with reasonable care and skill.<sup>247</sup>

Recognition ... needs to be given to the often short time that doctors have to enquire about and examine legal documents and their often limited understanding about formal requirements. These problems could be assisted if the form was simplified and included for example a warning that it is not binding on a medical practitioner if certain key elements are incomplete (for example no witness, no medical certificate). However the requirement on the medical practitioner should be to make reasonable enquiries about the existence of the form, to undertake a very narrow examination re validity to be specified in the legislation, and on that basis they should receive immunity from acts then undertaken by them provided that they acted in good faith and with reasonable skill and care.

9.262 One respondent commented that sections 100 and 102 of the *Powers of Attorney Act 1998* (Qld) should not be changed.<sup>248</sup>

## **The Commission's view**

### ***The meaning of an 'invalid' advance health directive under section 100***

9.263 Because section 100 of the *Powers of Attorney Act 1998* (Qld) refers to an 'invalid' advance health directive, it is not clear that the section would apply if a health provider acted in reliance on a direction in an advance health directive without knowing that the advance health directive had been revoked. Arguably, invalidity arises from non-compliance with the requirements for making an advance health directive. On that basis, an advance health directive that was validly made

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246 Submission 165.

247 Submission 164.

248 Submission 161.

would not become an 'invalid' advance health directive if it was revoked, even though it would no longer have effect.

9.264 In the Commission's view, the *Powers of Attorney Act 1998* (Qld) should be amended to ensure that the protection given by section 100 extends to the situation where the person acts in reliance on an advance health directive that has been revoked. This can be achieved by amending either section 96 or 100 of the Act to include a definition of 'invalidity, of an advance health directive' that clarifies that an invalid advance health directive includes one that has been revoked. The definition should generally mirror the definition of 'invalidity, of a power under a document' that appears in section 96, subject to necessary modifications. The new definition should be to the following general effect:

**invalidity**, of an advance health directive, means invalidity because—

- (a) the document was made in another State and does not comply with the other State's requirements; or
- (b) the document has been revoked.

**know**, of an advance health directive's invalidity, includes—

- (a) know of the happening of an event that invalidates the document; or
- (b) have reason to believe the document is invalid.

9.265 Generally, the events that would revoke an advance health directive, thereby rendering it invalid within the definition, are revocation by the principal,<sup>249</sup> revocation by making a later inconsistent advance health directive,<sup>250</sup> the death of the principal,<sup>251</sup> and revocation according to the terms of the document.<sup>252</sup>

### **Acting under an inoperative direction**

9.266 Earlier in this chapter, the Commission has recommended that the *Powers of Attorney Act 1998* (Qld) be amended to provide that a direction in an advance health directive does not operate if:<sup>253</sup>

- the direction is uncertain; or
- circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

<sup>249</sup> *Powers of Attorney Act 1998* (Qld) ss 48–49.

<sup>250</sup> *Powers of Attorney Act 1998* (Qld) s 50.

<sup>251</sup> *Powers of Attorney Act 1998* (Qld) s 51.

<sup>252</sup> *Powers of Attorney Act 1998* (Qld) s 54.

<sup>253</sup> See [9.79]–[9.85] above.

9.267 Under the recommended provision, it will be a question of fact whether or not the direction falls within one of the specified circumstances such that it does not operate. In practical terms, however, unless the Tribunal or the Supreme Court has made a declaration that a direction does not operate, it will be the adult's health provider who will need to form a view about whether the direction operates.

9.268 There are two ways in which the health provider could wrongly assess whether a direction is operative:

- the first is where the health provider wrongly forms the view that the direction falls within one of the specified circumstances when in fact the direction is operative;
- the second is where the health provider wrongly forms the view that the direction does *not* fall within one of the specified circumstances when in fact the direction does not operate.

9.269 In the first situation, if the health provider has reasonable grounds for the relevant belief, he or she will be protected by section 103 of the *Powers of Attorney Act 1998* (Qld) and will not incur liability for not acting in accordance with the direction, even though the direction is still operative. However, in the second situation, if the health provider treats the adult in the belief that the direction is operative, when in fact it is not, section 103 of the Act will have no application.<sup>254</sup> Nor will section 100 apply as its protection is limited to where a person acts in reliance on an invalid advance health directive or an invalid exercise of power under an enduring document. It does not protect a person who relies on an inoperative direction contained in a valid advance health directive.

9.270 In view of the Commission's recommendation that the *Powers of Attorney Act 1998* (Qld) be amended to provide that, in specified circumstances, a direction in an advance health directive does not operate, it is important that the Act is also amended to protect a person who acts in reliance on an inoperative direction. This can be achieved by amending section 100 of the Act so that it also applies if a person, in the circumstances prescribed by that section (including the modification recommended below),<sup>255</sup> acts in reliance on a direction that does not operate.

### ***The requirement for protection under sections 100 and 102: acting in good faith***

9.271 As explained earlier, the protection given by sections 100 and 102 of the *Powers of Attorney Act 1998* (Qld) depends on an absence of actual knowledge of the invalidity of an advance health directive (for section 100) and of the existence of an advance health directive (for section 102).

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*Powers of Attorney Act 1998* (Qld) s 103, when amended in accordance with the Commission's recommendations (see [9.312]–[9.335] and Recommendation 9-18 below) will apply if a health provider has reasonable grounds to believe that the direction is uncertain or inappropriate in light of changed circumstances. In this second situation, however, the health provider wrongly believes that the direction is certain and that it continues to be appropriate. Accordingly, s 103 of the Act will not protect the health provider from liability in this situation.

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See [9.274] below.

9.272 The Commission's recommendation at [9.263]–[9.265] above will have the effect that section 100 of the *Powers of Attorney Act 1998* (Qld) will not protect a health provider who acts under an invalid or revoked advance health directive if he or she has reason to believe that the advance health directive has been revoked or is invalid. Subject to that recommendation, the Commission is of the view that section 100 should not be amended to limit the protection given by that section to where there is an absence of both actual and constructive knowledge. Similarly, section 102 of the *Powers of Attorney Act 1998* (Qld) should not be amended to limit the protection given by that section to where there is an absence of both actual and constructive knowledge. Such a change would, in effect, require a health provider to make inquiries about the validity of an advance health directive (for section 100) and about the existence of an advance health directive (for section 102). The Commission has earlier in this chapter rejected the suggestion that a health provider should be under a duty to inquire as to whether an adult has an advance health directive on the basis that such a requirement would be too onerous.<sup>256</sup>

9.273 However, the Commission considers it important to ensure that a health provider is protected by section 100 or 102 only if he or she is acting in good faith. Earlier in this chapter, the Commission has recommended that the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that a person who is in charge of a health care facility has certain specified duties, including, if he or she knows that an adult in the facility has an advance health directive, a duty to take reasonable steps to ensure that the advance health directive is brought to the attention of the adult's health providers. If the person in charge of a hospital complied with that duty by placing the advance health directive with the adult's medical record in a prominent way,<sup>257</sup> the inclusion of a good faith requirement in section 102 would mean that a health provider who deliberately refrained from looking at the part of the record that included the advance health directive would not be protected by the section as it could not be said that he or she was acting in good faith.

9.274 Accordingly, section 100 of the *Powers of Attorney Act 1998* (Qld) should be amended so that it applies only if a person, *in good faith* and without knowledge of the relevant matter, acts in reliance on the advance health directive or purported exercise of power or on the inoperative direction.

9.275 Similarly, section 102 of the *Powers of Attorney Act 1998* (Qld) should be amended so that it applies to a health provider who '*acting in good faith*, does not know the adult has an advance health directive'.

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256 See [9.219] above.

257 See the discussion at [9.216]–[9.217] above of what would amount to compliance in a particular case.

## PROTECTION OF HEALTH PROVIDER: NOT ACTING IN ACCORDANCE WITH THE ADVANCE HEALTH DIRECTIVE

### Introduction

9.276 It appears that, at common law, an advance decision in relation to health care (here referred to as an advance directive<sup>258</sup>) will be binding and effective only if, among other things, the adult's decision 'was made with reference to and was intended to cover the particular (and perhaps changed or unforeseen) circumstances which have in fact subsequently occurred'.<sup>259</sup> A health provider will not be bound to follow a direction in an advance directive if it:<sup>260</sup>

- is uncertain or ambiguous, for example, because its language is vague or imprecise or because it refers to outdated medical treatments; or
- does not, or was not intended to, apply to the circumstances. For example, the adult's personal circumstances or advances in medical science may have changed such that the adult would not have intended the directive to apply in the changed circumstances, or it may have been made on incorrect information or assumptions.

### The law in Queensland

9.277 In Queensland, section 103 of the *Powers of Attorney Act 1998* (Qld) gives protection to a health provider who, in specified circumstances, does not act in accordance with a direction in an advance health directive. Section 103 provides:

**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.

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See the discussion at [9.378]–[9.379] below of the various terms used to refer to advance decisions about health care and of their effectiveness at common law.

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J Munby, 'Rhetoric and reality: the limitations of patient self-determination in contemporary English law' (1998) 14(2) *Journal of Contemporary Health Law and Policy* 315, 329. See also *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 116 (Lord Donaldson MR); C Stewart, 'Advance directives, the right to die and the common law: recent problems with blood transfusions' (1999) 23 *Melbourne University Law Review* 161, 175–7.

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L Willmott, B White and M Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211, 222–4, 234–5. A change in circumstances could include a change in the adult's religious beliefs or a change of mind about a direction such that there is evidence the adult intended to revoke it.

- (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.

### The law in other jurisdictions

9.278 The legislation in the ACT and the Northern Territory includes a similar, although narrower, provision that applies if a health provider considers that the adult changed or intended to revoke his or her decision.<sup>261</sup>

### Issues for consideration

9.279 While some elements of section 103 of the *Powers of Attorney Act 1998* (Qld) are consistent with the common law requirements for an effective advance directive, concerns have been raised about the potentially wider operation of section 103.

### Uncertainty and changed circumstances

9.280 Section 103 reflects the position at common law that a health provider is not bound to follow an advance direction that is uncertain or ambiguous or that is not intended to apply in the circumstances that have arisen.

9.281 However, it has been suggested that section 103 has a different focus from the common law and gives a health provider greater scope not to act in accordance with an adult's directions than would be the case at common law.<sup>262</sup>

At common law, the test that is applied is whether the change in circumstances is such that *the adult* would not have intended his or her refusal to apply to the circumstances that have arisen. The wording of the Queensland provision, however, with its reference to a *health professional's belief* (on reasonable grounds) that the direction is *inappropriate* seems to shift the focus of the enquiry away from the adult and towards the health professional.

How such a provision might operate can be illustrated by the example of a 25-year-old woman who makes an advance directive refusing life-sustaining medical treatment. Subsequent to the completion of the directive, the woman has a child. The Queensland provision is wide enough to allow a health professional not to follow the advance directive on the basis that, since the adult now has the responsibility for a young child, it is no longer 'appropriate' to comply with the directive. The authors contend that the excuse as drafted in Queensland is too wide as it enables an unjustifiable departure from an adult's directive. The common law position is to be preferred as it strikes a more sensible balance between principles of autonomy and the sanctity of life. (emphasis in original, notes omitted)

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*Medical Treatment (Health Directions) Act 2006* (ACT) s 12; *Natural Death Act* (NT) s 4(3).

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L Willmott, B White and M Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211, 230.

9.282 On another view, the discretion given to health providers by section 103 may be considered desirable. A health provider may not be sure, for example, that the adult would have changed his or her mind, but may properly consider that the circumstances have changed so significantly that reliance on the directive as specific and binding consent, or refusal, is untenable. It has been suggested, for example, that a truly autonomous decision is one that is 'freely made, by a competent person, based on his or her most recent set of values' and that is 'applicable to the circumstances in question, with a full understanding of the relevant facts'.<sup>263</sup> Arguably, acting upon an advance directive that does not meet these conditions may risk serious harm to the adult.

9.283 The competing considerations were referred to in *HE v A Hospital NHS Trust*.<sup>264</sup>

Whether there truly is some real reason to doubt, whether the doubt is a real doubt or only some speculative or fanciful doubt, will inevitably depend on the circumstances. Holding the balance involves awesome responsibility. Too ready a submission to speculative or merely fanciful doubts will rob advance directives of their utility and may condemn those who in truth do not want to be treated to what they would see as indignity or worse. ... Too sceptical a reaction to well-founded suggestions that circumstances have changed may turn an advance directive into a death warrant for a patient who in truth wants to be treated.

... the longer the time which has elapsed since an advance directive was made, and the greater the apparent changes in the patient's circumstances since then, the more doubt there is likely to be as to its continuing validity and applicability.

9.284 An issue is whether the formulation in section 103 is appropriate. On the one hand, the protection should not be so wide as to unjustifiably infringe the adult's right to give or refuse consent in advance. On the other hand, consideration must be given to the need for consent, even if given in advance, to be specific to the health care in question.

9.285 Section 103 may also appropriately allow a discretion in departing from an advance health directive where the adult's current views differ from those expressed in the directive, particularly given that a principal may revoke an advance health directive only if he or she has sufficient capacity to do so.<sup>265</sup>

9.286 In the Discussion Paper, it was suggested that additional guidance might be drawn from section 110S(4) of the *Guardianship and Administration Act 1990* (WA).<sup>266</sup> That section requires certain matters to be taken into account when determining under section 110S(3) whether circumstances exist or have arisen that the maker of the directive would not have reasonably anticipated at the time of

263 P Biegler et al, 'Determining the validity of advance directives' (2000) 172 *Medical Journal of Australia* 545, 545 citing G Dworkin, *The Theory and Practice of Autonomy* (1988).

264 [2003] EWHC 1017, [44]–[45] (Munby J).

265 Eg M Wallace, *Health Care and the Law* (3rd ed, 2001) [5.116].

266 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, [11.111].

making the directive and would have caused a reasonable person in the maker's position to change his or her mind about the treatment decision.<sup>267</sup> Section 110S(4) refers to the following matters:

- (a) the maker's age at the time the directive was made and at the time the treatment decision would otherwise operate;
- (b) the period that has elapsed between those times;
- (c) whether the maker reviewed the treatment decision at any time during that period and, if so, the period that has elapsed between the time of the last such review and the time at which the treatment decision would otherwise operate;
- (d) the nature of the condition for which the maker needs treatment, the nature of that treatment and the consequences of providing and not providing that treatment.

### **Requirement to consult attorney**

9.287 Section 103(3) of the *Powers of Attorney Act 1998* (Qld) provides that a health provider will have reasonable grounds to believe that the direction is uncertain only if he or she has consulted with the attorney appointed under the advance health directive (if there is one).

9.288 This requirement appears to be consistent with a principal's power under section 35(1)(c) of the Act to appoint an attorney in an advance health directive to exercise power in the event that the direction proves inadequate. However, the requirement to consult may be diluted in practice if there is no corresponding obligation to accept the attorney's interpretation.<sup>268</sup>

9.289 It has also been noted that the provision requires consultation with an attorney appointed under an advance health directive, but not one appointed under an enduring power of attorney.<sup>269</sup>

### **Inconsistency with good medical practice**

9.290 One element of section 103 of the *Powers of Attorney Act 1998* (Qld) that appears to be broader than the common law is the protection from liability given to a health provider who does not act in accordance with a direction refusing health

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A treatment decision in an advance health directive does not operate if such circumstances exist or have arisen: *Guardianship and Administration Act 1990* (WA) s 110S(3).

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L Willmott, B White and M Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211, 232. The authors also argue that an attorney may interpret the directive in accordance with his or her own views, rather than giving an unbiased account of what the adult intended. However, this risk is inherent in all substitute decision-making appointments and is not specific to the situation addressed by s 103 of the *Powers of Attorney Act 1998* (Qld).

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L Willmott, B White and M Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211, 232.

care where he or she has reasonable grounds to believe the direction is inconsistent with good medical practice.<sup>270</sup>

9.291 On one view, this is inconsistent with the purpose of making an advance health directive, namely, to permit an adult to refuse treatment that he or she does not want to receive.<sup>271</sup> The decision to complete an advance health directive and refuse certain treatment is likely to be informed by a range of considerations including medical advice, personal preferences, lifestyle choices and perhaps spiritual or religious beliefs. These are matters on which people are likely to have different views. Permitting a medical practitioner, on the grounds of good medical practice, to provide treatment that has been refused expressly is inconsistent with respecting that person's autonomous choice. Such an approach is also out of step with the position in other Australian jurisdictions as no other State or Territory provides protection for a health provider based on good medical practice.<sup>272</sup>

9.292 On the other hand, it has been suggested that it is important for doctors to retain the right to exercise their professional discretion to give treatment that they consider to be medically necessary.<sup>273</sup>

9.293 When the Powers of Attorney Bill 1997 (Qld) was introduced, it did not refer to the circumstance, now found in section 103(1) of the Act, where a health provider has reasonable grounds to believe that a direction in an advance health directive is inconsistent with good medical practice. It appears that the Government accepted the proposal to amend the Bill to add this circumstance<sup>274</sup> because of a concern that a health provider should not be required to *provide* health care that is inconsistent with good medical practice, rather than to allow a health provider to override an adult's *refusal* of health care on this ground.<sup>275</sup>

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270 Ibid 235.

271 Ibid 235–6.

272 Ibid 227.

273 Australian Medical Association, Position Statement, *The Role of the Medical Practitioner in Advance Care Planning* (2006) <<http://www.ama.com.au/node/2428>> at 25 August 2010. Although note the criticism of this policy in relation to this point by M Parker et al 'Two steps forward, one step back: advance care planning, Australian regulatory frameworks and the Australian Medical Association' (2007) 39(9) *Internal Medicine Journal* 637.

274 The amendment was proposed by Liz Cunningham: Queensland, *Parliamentary Debates*, Legislative Assembly, 12 May 1998, 1025. Her comments do not appear, however, to be restricted specifically to the provision of treatment that is not clinically indicated:

So the addition of these words in this clause just gives the added clarification that, if an advance health directive is contrary to what would be good medical practice, then the doctor is well within his rights—indeed, he has the responsibility—not to take notice of that advance health directive but to comply with good medical practice.

See also the Draft Advance Care Directives Framework 2010, where it is noted that an 'advance care directive' should not be capable of demanding treatment that is not warranted or medically indicated: Clinical, Technical and Ethical Principal Committee, Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 37.

275 Queensland, *Parliamentary Debates*, Legislative Assembly, 12 May 1998, 1025 (Denver Beanland, Attorney-General and Minister for Justice). See n 271 above.

The doctor can never be required to carry out medical treatment which would be contrary to good medical practice. This principle has always been implicit in the Bill, as is the case with the observance of the Criminal Code. This amendment merely restates this in legislative form. Nevertheless, in light of certain representations, I am prepared to propose that the phrase be included as an amendment to this clause.

## Discussion Paper

9.294 In the Discussion Paper, the Commission sought submissions on whether:<sup>276</sup>

- there are any difficulties with section 103(1) of the *Powers of Attorney Act 1998* (Qld) in terms of the circumstances in which a health provider is protected from liability for departing from a direction given in an advance health directive;
- section 103 of the *Powers of Attorney Act 1998* (Qld) should include a list of factors, such as those included in section 110S(4) of the *Guardianship and Administration Act 1990* (WA), to be taken into account when considering whether circumstances have changed such that a direction in an advance health directive is no longer appropriate; and
- section 103(3) of the *Powers of Attorney Act 1998* (Qld) is appropriate.

## Submissions

### General comments

9.295 A number of respondents commented on the three circumstances mentioned in section 103(1) of the *Powers of Attorney Act 1998* (Qld).

9.296 Family Voice Australia was of the view that all three of the circumstances mentioned in section 103 are appropriate:<sup>277</sup>

These are all appropriate conditions for protection from liability. They help ensure that advance health directives, which can be a useful guide to a person's preferences for health care treatment, are not inappropriately applied in ways that could be contrary to the person's actual intentions or that violate good medical practice.

9.297 Right to Life Australia was also of the view that section 103 should be retained in its present form:<sup>278</sup>

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<sup>276</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 269.

<sup>277</sup> Submission 157.

<sup>278</sup> Submission 149.

We would strongly support the retention of section 103 of the *Powers of Attorney Act 1998* (Qld). Obviously discretion must be given to doctors if the wording of the directive is uncertain. The only alternative would seem to be that they be required to do nothing in those circumstances.

The medical profession must be allowed to act in accord with good medical practice. For example, an AHD [advance health directive] may state that a ventilator is never to be used but a situation may arise where by using a ventilator for an hour or two the person's life may be saved and restored to normal.

If the health provider has reasonable grounds to believe that circumstances in medical science have changed to the extent that the terms of the direction are inappropriate, then they should be able to depart from the directive.

9.298 One respondent commented that the circumstances in section 103 were subjective.<sup>279</sup>

### **Uncertainty**

9.299 One respondent was of the view that section 103 should not include the circumstance that a health provider has reasonable grounds to believe that a direction is uncertain.<sup>280</sup>

9.300 A legal academic with expertise in health law and guardianship law commented on the requirement in section 103(3) of the *Powers of Attorney Act 1998* (Qld) that, if an attorney is appointed under the advance health directive, the health provider has reasonable grounds to believe that a direction is uncertain only if, among other things, the health provider has consulted the attorney about the direction. In this respondent's view, the requirement for consultation should not be limited to an attorney appointed under the advance health directive.<sup>281</sup>

9.301 The Adult Guardian suggested that the requirement in section 103(3) to consult an attorney appointed under the advance health directive should be extended to a requirement to consult any attorney for health matters or a statutory health attorney.<sup>282</sup>

### **Inconsistency with good medical practice**

9.302 A legal academic with expertise in health law and guardianship law emphasised the fact that the excuse in section 103 that the direction is inconsistent with good medical practice has no equivalent at common law. In her view, 'the excuse that relates to good medical practice erodes the autonomy of a person who

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279 Submission 165.

280 Submission 161.

281 Submission 144.

282 Submission 164.

makes an advance directive in the context of a directive refusing treatment' and should be abolished.<sup>283</sup>

9.303 The Adult Guardian also considered that it was not justifiable to allow a health provider to depart from the terms of an advance health directive on the ground that the direction is inconsistent with good medical practice.<sup>284</sup>

9.304 The Christian Science Committee on Publication for Queensland was also of the view that the legislation should not allow a health provider to override a patient's wishes on the ground of good medical practice.<sup>285</sup>

we specifically support the statements in ... the Discussion Paper that the decision to complete an advance health directive and refuse certain treatment is likely to be informed by a range of considerations including medical advice, personal preferences, lifestyle choices and perhaps spiritual or religious beliefs. These are matters on which people may have different views. However, the views of the individual affected are paramount. Permitting a medical practitioner, on the grounds of good medical practice, to override a person's autonomous choice as to the preferred method of treatment is inconsistent with that principle and should not be promoted through this legislation.

9.305 The Watchtower Bible and Tract Society of Australia was similarly concerned about protection being given where the health provider believes that the direction is inconsistent with good medical practice:<sup>286</sup>

We have grave concerns about the potential application of s 103 of the PAA. In particular, the defence that the health provider believes the directions are 'inconsistent with good medical practice' does ... 'erode one of the important functions of these documents: to make choices that others (including an adult's health provider) may not agree with.' While we do not believe that a health provider should have to treat a patient in a way that is against the health provider's conscience, we also do not believe that the health provider should be able to make qualitative judgments for an adult who has made a competent decision about health care.

9.306 It considered that the good medical practice protection given by section 103 undermines an adult's right to self-determination:<sup>287</sup>

The definition of 'good medical practice' contained in the *Powers of Attorney Act 1998* (Qld) has regard not only to 'the recognised medical standards, practices and procedures' but also to 'the recognised ethical standards of the medical profession in Australia'.

By referring to the ethical standards of the medical profession, the definition in the legislation incorporates the standard that good medical practice should be 'patient-centred', thus 'ensuring that [the doctor's] personal views do not

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283 Submission 144.

284 Submission 164.

285 Submission 151.

286 Submission C133.

287 Submission 176.

adversely affect the care of [the] patient'. Such a holistic approach to 'good medical practice' includes taking into account a patient's values and beliefs. It is likely, however, that this definition may be narrowly construed, so that a health provider focuses merely on the medical position. An advance directive would be inoperative, if a health provider were to feel entitled to disregard it on this interpretation of 'good medical practice'.

Despite the many advances in medical science, the practice of medicine is still fraught with uncertainty and subjectivity, which has been recognised by the High Court of Australia in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 251. While some health professionals may have one view as to what satisfies this requirement in a particular case, other health professionals may have very different opinions and be of the view that the condition can be treated satisfactorily, or even preferably, in a way that is acceptable to the patient and not in contravention of a direction given in their advance health directive.

As the Discussion Paper acknowledges, this amendment was included to address the concern about doctors being directed to provide treatment that 'good medical practice' dictates should not be offered. However, its prospective application is of great concern. It has the potential to erode one of the important functions of advance health directives, that is, the right to make choices with which others (including a treating health professional) may not agree. Clearly, there are difficulties with s 103 of the *Powers of Attorney Act 1998 (Qld)*. It potentially undermines established legal rights relative to self-determination and personal autonomy. (notes omitted)

9.307 The Watchtower Bible and Tract Society of Australia expressed the view that section 103 of the *Powers of Attorney Act 1998 (Qld)* was unnecessary because 'a health professional is ethically entitled to decline to participate in treatments which are, in his/her subjective opinion, contrary to "good medical practice" or to which s/he conscientiously objects'. However, it submitted that, if section 103 were retained, it should be amended so that it does not protect a health provider from liability for not complying with a direction in an advance health directive on the ground that the direction was inconsistent with good medical practice:

a health professional should not be able to make contrary qualitative judgments for an adult who has already made a competent decision in advance about their health care. If this were to occur, it would derogate from or even eliminate established common law rights. Moreover, such an approach would almost certainly have led to a different outcome in the recent NSW Supreme Court case of *Hunter and New England Area Health Service v A* [2009] NSWSC 761. (note omitted)

9.308 Another respondent was also of the view that section 103 should not include the circumstance that a health provider has reasonable grounds to believe that a direction is inconsistent with good medical practice.<sup>288</sup>

### ***Changed circumstances, including advances in medical science***

9.309 A legal academic with expertise in health law and guardianship law commented that the excuse that relates to a change of circumstances should put the focus on the individual rather than the health professional:<sup>289</sup>

That is, the directive should only be disregarded if [the adult] would not have intended it to apply in the changed circumstances, rather than the health professional. This reflects the common law position.

9.310 Several respondents, including Right to Life Australia and Family Voice Australia, considered that, in deciding whether circumstances have changed to the extent that a direction in an advance health directive is no longer appropriate, the matters listed in section 110S(4) of the *Guardianship and Administration Act 1990* (WA) would complement section 103 of the *Powers of Attorney Act 1998* (Qld).<sup>290</sup> The Adult Guardian was also of the view that the inclusion of those matters in the legislation would be very helpful, especially if the Commission did not accept her submission that an advance health directive should be effective for two years only.<sup>291</sup>

9.311 However, other respondents did not support that approach.<sup>292</sup> A legal academic with expertise in health law and guardianship law commented:<sup>293</sup>

I would be reluctant to see a list as wide as is included in WA inserted into the legislation. Given the reluctance of health professionals to comply with advance directives, inserting this list of provisions may unduly encourage a health professional to come to the conclusion that circumstances have changed and that would have caused the adult to change his or her mind about treatment.

### **The Commission's view**

9.312 Earlier in this chapter, the Commission has recommended that section 36 of the *Powers of Attorney Act 1998* (Qld) be amended to provide that a direction in an advance health directive does not operate if:<sup>294</sup>

- the direction is uncertain; or
- circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

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289 Submission 144.

290 Submissions 149, 157, 165.

291 Submission 164.

292 Submissions 144, 161.

293 Submission 144.

294 See [9.83] above.

9.313 The implementation of that recommendation will change the circumstances in which section 103 of the Act is relevant. At present, a direction in an advance health directive is effective even though, for example, circumstances have changed to the extent that the terms of the direction are inappropriate. In those circumstances, section 103 protects a health provider from liability for not acting in accordance with the direction. However, if section 36 is amended as recommended, such a direction will not be effective in the first place, which means that a health provider will not need protection from liability for not acting in accordance with the direction.

9.314 Instead, section 103 will be relevant where the direction in question is operative under section 36, as amended, but the health provider wrongly believes (but has reasonable grounds for the belief) that the direction does not operate and for that reason does not act in accordance with the direction.

9.315 The Commission's view as set out below is premised on section 36 of the *Powers of Attorney Act 1998* (Qld) being amended in accordance with the Commission's earlier recommendation regarding the circumstances in which a direction in an advance health directive will operate.

### **Uncertainty**

9.316 Section 103 of the *Powers of Attorney Act 1998* (Qld) currently protects a health provider who has reasonable grounds to believe that a direction in an advance health directive is uncertain and who does not act in accordance with the direction. At common law, a health provider is not required to comply with an uncertain advance directive.

9.317 The effect of the Commission's earlier recommendation is that a direction that is uncertain will not be operative. However, although it may ultimately be determined that a direction is certain and therefore operative, a health provider could nevertheless have reasonable grounds to believe that the direction is uncertain. The Commission is therefore of the view that it is appropriate for section 103 of the *Powers of Attorney Act 1998* (Qld) to continue to protect a health provider from liability for not acting in accordance with the direction on this ground.

9.318 The Commission is also of the view that section 103(3), which applies if an attorney is appointed under the advance health directive, should be retained. That provision ensures that a health provider cannot have reasonable grounds to believe that a direction is uncertain without first consulting the attorney about the direction. However, section 103(3) should be amended so that the requirement to consult applies in respect of:

- an attorney appointed under the advance health directive; or
- if an attorney is not appointed under the advance health directive, but the advance health directive names an attorney for health matters appointed under the adult's enduring power of attorney — the named attorney.<sup>295</sup>

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See Advance Health Directive (Form 4) Section 6: Enduring power of attorney for personal/health matters.

9.319 It can reasonably be assumed that an attorney who is named in an advance health directive will be as familiar with the adult's views and wishes as one who is appointed by the advance health directive. Further, this recommendation, being limited to an attorney who is named in an advance health directive, does not require an adult's health provider to ascertain whether the adult may have an attorney for health matters who has been appointed under an enduring power of attorney but who is not named in the advance health directive.

9.320 The Commission does not, however, consider that the requirement should extend to a statutory health attorney of an adult. An attorney who is appointed under an advance health directive or who is named in an advance health directive is more likely than a statutory health attorney to be aware of the adult's intentions in relation to the direction that is considered to be uncertain.

### ***Inconsistency with good medical practice***

#### *Directions refusing health care*

9.321 In the Commission's view, the value of being able to make an advance health directive is that an adult may give a direction refusing particular health care. It seriously undermines an adult's right to self-determination if a health provider is protected from liability for giving the health care, despite the adult's direction, on the ground that the health provider has reasonable grounds to believe that the direction is inconsistent with good medical practice. A health provider is not similarly protected under the common law and no other Australian jurisdiction has a provision that protects a health provider in this situation.

9.322 The Commission is therefore of the view that section 103(1) of the *Powers of Attorney Act 1998* (Qld) should be amended so that the section does not apply to a health provider who has reasonable grounds to believe that a direction in an advance health directive refusing health care is inconsistent with good medical practice.

#### *Directions requiring health care*

9.323 The fact that the *Powers of Attorney Act 1998* (Qld) enables a principal to give a direction consenting to health care (and not just a direction refusing health care) is a positive feature of the Queensland legislation. It means that it is possible for an adult to authorise health care directly by way of his or her advance health directive. This avoids the need for a health provider to seek consent for the health care from the adult's substitute decision-maker. It also means that the decision to receive the health care is the adult's decision, rather than that of the adult's substitute decision-maker.

9.324 However, the situation may arise where an adult's advance health directive gives a direction requiring particular health care and the health provider considers that the required health care would be inconsistent with good medical practice.

9.325 Under section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld), a direction in an advance health directive *is as effective as if the principal gave the*

*direction* when decisions about the matter needed to be made and the principal then had capacity for the matter. The section does not give a direction requiring health care any greater effect than such a direction would have at common law if given by a competent adult. As explained earlier, at common law, a competent adult is not generally entitled to insist that a treatment that is not offered be provided.<sup>296</sup>

9.326 While section 36(1)(b) of the Act does not appear to change this principle, the position is complicated by the drafting of sections 65 and 66 of the *Guardianship and Administration Act 2000* (Qld). Those sections establish a priority for decision-making in relation to special health matters and health matters, and sections 65(2) and 66(2) provide that, if an adult with impaired capacity for a health matter has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction. These sections give rise to the argument that, despite the terms of section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld), if a direction in an advance health directive requires health care to be provided, the health care may be carried out only in accordance with that direction. The contrary argument is that sections 65(2) and 66(2) of the *Guardianship and Administration Act 2000* (Qld) assume the existence of a direction that is effective under section 36 of the *Powers of Attorney Act 1998* (Qld) and would not therefore require the health care to be carried out if the direction would not be effective if given by an adult with capacity for the matter.

9.327 In the Commission's view, it is undesirable for there to be any uncertainty about the effect of sections 65(2) and 66(2) in this respect. While advance health directives play an important role in ensuring that adults may effectively give directions about their future health care, as a matter of principle a direction in an advance health directive cannot be more effective than if the decision were made by the adult at the time the decision is needed. The guardianship legislation should therefore be amended to remove this uncertainty.

9.328 The Commission considered whether the tension between section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld) and sections 65(2) and 66(2) of the *Guardianship and Administration Act 2000* (Qld) should be addressed by amending section 103 of the *Powers of Attorney Act 1998* (Qld) to provide that, if a health provider has reasonable grounds to believe that a direction in an advance health directive *requiring* health care is inconsistent with good medical practice, the health provider does not incur any liability for not acting in accordance with the direction.

9.329 However, the Commission considers that an amendment of section 103 to refer to a direction *requiring* health care could cause confusion by perpetuating the misconception that, ordinarily, an adult can compel the provision of health care.<sup>297</sup> Further, because the *Powers of Attorney Act 1998* (Qld) defines 'health care' to include the withholding or withdrawal of a life-sustaining measure,<sup>298</sup> if section 103

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<sup>296</sup> See [9.28]–[9.31] above for a discussion of the limitations on the effectiveness of an adult's decision *requiring* the provision of health care.

<sup>297</sup> See the discussion of *R (Burke) v General Medical Council* [2006] QB 273 at [9.28]–[9.31] above.

<sup>298</sup> *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2).

were amended to refer to a direction requiring ‘health care’, it would also be necessary to provide that, for the purpose of the section, a direction requiring health care does not include a direction to withhold or withdraw a life-sustaining measure. Otherwise a direction *requiring* health care would include a direction *refusing* a life-sustaining measure.

9.330 Given the Commission’s decision that section 103 of the *Powers of Attorney Act 1998* (Qld) should not protect a health provider who has reasonable grounds to believe that a direction refusing health care is inconsistent with good medical practice,<sup>299</sup> the better approach is for section 103 to omit altogether the reference to a direction that is inconsistent with good medical practice.

9.331 The problem that may be encountered by a health provider in treating a patient with an advance health directive that includes a direction requiring the provision of health care that is inconsistent with good medical practice should be addressed by ensuring that sections 65 and 66 of the *Guardianship and Administration Act 2000* (Qld) do not limit the operation of section 36 of the *Powers of Attorney Act 1998* (Qld). Accordingly, section 65 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 65(2) is subject to section 36 of the *Powers of Attorney Act 1998* (Qld). Similarly, section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 66(2) is subject to section 36 of the *Powers of Attorney Act 1998* (Qld).

9.332 Further, to emphasise the fact that a competent adult cannot ordinarily compel the provision of health care that has not been offered, section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld) should be amended so that it provides:

- (1) A direction in an advance health directive—
  - ...
  - (b) is as effective as, but no more effective than, if—
    - (i) the principal gave the direction when decisions about the matter needed to be made; and
    - (ii) the principal then had capacity for the matter.

9.333 This approach has the advantage that it allows the common law regarding the effect of a competent adult’s demand for treatment to determine whether a direction requiring health care will be effective. Further, this approach can be adapted to address the similar situation that may arise where an adult’s substitute decision-maker requires health care for the adult that the health provider considers is inconsistent with good medical practice.<sup>300</sup>

299 See [9.321]–[9.322] above.

300 See Recommendations 10-6, 15-5, 16-9 of this Report.

### ***Changed circumstances, including advances in medical science***

9.334 Section 103 of the *Powers of Attorney Act 1998* (Qld) currently applies to a health provider who 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. While the Commission is generally of the view that it is appropriate that a health provider should be protected from liability for not acting in accordance with an advance health directive in these circumstances, it considers that section 103(1) of the *Powers of Attorney Act 1998* (Qld) should be amended to make it clear that the inappropriateness of the direction is to be viewed from the adult's perspective rather than from the health provider's. This can be implemented by amending section 103(1), relevantly, to read:

This section applies if a health provider has reasonable grounds to believe that ... circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

9.335 The effect of the Commission's earlier recommendation in relation to section 36 of the *Powers of Attorney Act 1998* (Qld) is that, if circumstances have changed to the extent that the adult would have considered the terms of the direction to be inappropriate, the direction will not be operative. However, although it may ultimately be determined that circumstances have not changed to that extent and that the direction is therefore operative, a health provider could nevertheless have reasonable grounds to believe that the direction was not operative. The Commission is therefore of the view that it is appropriate for section 103 of the *Powers of Attorney Act 1998* (Qld) to continue to protect a health provider from liability for not acting in accordance with the direction.

9.336 The Commission does not consider it necessary to amend section 103 of the *Powers of Attorney Act 1998* (Qld) to include a list of factors to be taken into account when considering whether circumstances have changed to the extent that the direction is no longer appropriate.

### ***The requirement for consent or authorisation of health care that is not in accordance with the direction***

9.337 If a direction in an advance health directive is in fact uncertain or inappropriate in light of changed circumstances, the effect of the Commission's recommendation to amend section 36 of the *Powers of Attorney Act 1998* (Qld) to provide that the direction does not operate means that power for a health matter that is the subject of the direction will be able to be exercised by the adult's guardian, attorney or statutory health attorney.<sup>301</sup> Similarly, if the direction relates to a special health matter, the Tribunal will be able to exercise power for that matter.<sup>302</sup> In addition, if, but for the direction in the advance health directive, the *Guardianship and Administration Act 2000* (Qld) would authorise health care to be

<sup>301</sup> *Guardianship and Administration Act 2000* (Qld) s 66(3)–(5).

<sup>302</sup> *Guardianship and Administration Act 2000* (Qld) s 65(4).

carried out without consent, the fact that the direction does not operate means that it will not prevent the health care from being carried out without consent.<sup>303</sup>

9.338 As explained earlier, as a result of the Commission's recommendation to amend section 36 of the *Powers of Attorney Act 1998* (Qld) in this way, section 103 will be relevant where the direction in question is operative under section 36, but the health provider wrongly believes, but on reasonable grounds, that the direction does not operate and for that reason does not act in accordance with the direction.<sup>304</sup> If a health provider has reasonable grounds to believe that one of the conditions in section 103(1) of the *Powers of Attorney Act 1998* (Qld) is satisfied, section 103(2) provides that the health provider 'does not incur liability, whether to the adult or anyone else, if the health provider does not act in accordance with the direction'. However, it is not clear whether the health provider's protection for not acting in accordance with the direction, where that involves carrying out health care contrary to the direction, depends on the health care otherwise being authorised or the subject of consent.

9.339 It would be against the policy of the guardianship legislation for a health provider to be protected from liability for carrying out health care without authorisation or consent.<sup>305</sup> However, in the circumstances in which section 103 will now apply, there will be an operative direction (even though the health provider has reasonable grounds to believe that there is not an operative direction). This raises the issue of how to clarify that section 103, in protecting a health provider from liability for not acting in accordance with the direction, does not protect a health provider for carrying out health care that is not authorised or is not the subject of consent.

9.340 There are two ways in which a health provider can act in a way that is not in accordance with the direction:

- carrying out health care contrary to a direction refusing the health care; and
- not carrying out health care contrary to a direction requesting or even demanding the health care.

9.341 In the second situation, where health care *is not* carried out, no consent or authorisation is required.<sup>306</sup>

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303 See eg *Guardianship and Administration Act 2000* (Qld) ss 63(2), 63A(2), 64(2).

304 See [9.314] above. If the health provider's belief about the operation of the direction were correct, the direction would not, under the Commission's recommendation about the operation of a direction under s 36 of the *Powers of Attorney Act 1998* (Qld), be effective and the health provider would not need to be protected from liability for not acting in accordance with it.

305 See *Guardianship and Administration Act 2000* (Qld) s 79.

306 Note, however, that, if the health care consists of a life-sustaining measure, consent is ordinarily required for the lawful withholding (or withdrawal) of the measure: see *Guardianship and Administration Act 2000* (Qld) s 79.

9.342 However, in the first situation, where health care *is* carried out, it should be clear that section 103 of the *Powers of Attorney Act 1998* (Qld) does not itself authorise the health care and does not protect a health provider who carries out health care without any authorisation or consent. A health provider in this situation should not have any greater protection than he or she would have if the direction was in fact inoperative under section 36 of the Act, as amended in accordance with the Commission's recommendation about that section.

9.343 Accordingly, section 103 of the *Powers of Attorney Act 1998* (Qld) should be amended by inserting a new subsection to the effect that, if the health provider carries out health care that is not in accordance with the direction, the health provider is protected only to the extent that, if the direction had been inoperative under section 36 of the Act, the health care would have been authorised or the subject of consent. The authorisation to carry out the health care could be found in sections 63, 63A or 64 of the *Guardianship and Administration Act 2000* (Qld) if those sections, but for the direction, would have authorised the health care. Similarly, consent for the health care could be given by the adult's substitute decision-maker if, but for the direction, the substitute decision-maker would have had the power to consent to the health care.

## **POWERS TO REMOVE AND REPLACE AN ATTORNEY OR CHANGE OR REVOKE AN ADVANCE HEALTH DIRECTIVE**

### **The law in Queensland**

9.344 Under the *Powers of Attorney Act 1998* (Qld), the Tribunal is given the same jurisdiction and powers for enduring documents as the Supreme Court.<sup>307</sup> For that purpose, the Act applies, with necessary changes, as if references to the Supreme Court were references to the Tribunal.<sup>308</sup>

9.345 Relevantly, the Act gives the Supreme Court and the Tribunal the power to remove and replace an attorney appointed under an advance health directive, to give a power that has been removed from an attorney to another attorney or to a new attorney, to change the terms of an advance health directive, and to revoke all or part of an advance health directive.

9.346 Sections 116 and 117 of the *Powers of Attorney Act 1998* (Qld) provide:<sup>309</sup>

#### **116 Order removing attorney or changing or revoking document**

The court may, by order—

- (a) remove an attorney and appoint a new attorney<sup>81</sup> to replace the removed attorney; or

<sup>307</sup> *Powers of Attorney Act 1998* (Qld) s 109A(1).

<sup>308</sup> *Powers of Attorney Act 1998* (Qld) s 109A(2).

<sup>309</sup> See the discussion of these provisions commencing at [16.308] below.

- (b) remove a power from an attorney and give the removed power to another attorney or to a new attorney; or
- (c) change the terms of a power of attorney, enduring power of attorney or advance health directive; or
- (d) revoke all or part of a document mentioned in paragraph (c).

81 The court is not limited to appointing an *eligible attorney* (defined in section 29).

### 117 Changed circumstances as basis for change or revocation

Without limiting the grounds on which the court may make an order changing the terms of a power of attorney, enduring power of attorney or advance health directive, or revoking all or part of 1 of these documents, the court may make the order if the court considers the principal's circumstances or other circumstances (including, for a health power, advances in medical science) have changed to the extent that 1 or more terms of the document are inappropriate.

9.347 The Commission is not aware that either the Supreme Court or the Tribunal has exercised the power under section 116(c) or (d) to change the terms of an advance health directive or to revoke all or part of an advance health directive.

9.348 It is a significant step to make a health care decision for an adult that is inconsistent with views expressed by the adult while he or she was competent. This issue arose in *State of Queensland v Astill*,<sup>310</sup> where the State applied to the Supreme Court for its authorisation to administer a blood transfusion to Mrs Astill, who had sustained life-threatening injuries in a motor vehicle accident while she was a passenger in a vehicle being driven by her daughter. Mrs Astill was a member of the Jehovah's Witness faith, and had purported to make an advance health directive refusing a blood transfusion. However, the document did not comply with the requirements of the *Powers of Attorney Act 1998* (Qld) and did not, therefore, have effect. Muir J (as his Honour then was) considered that '[o]n an application such as this the overwhelming consideration is the welfare of the person whose life is threatened'.<sup>311</sup> His Honour accepted that, in February 2000, almost six years before the accident, Mrs Astill's wish was that she should not receive a blood transfusion. However, his Honour also considered whether that should be taken to be her current view. Muir J commented:<sup>312</sup>

Circumstances change ... and Mrs Astill is not in a position to communicate her present intention to the Court or anyone else.

One matter which seems to me to be highly pertinent is the circumstance in which the accident came about. Were Mrs Astill able to be consulted, no doubt she would wish to weigh the impact on her daughter should she die as a result of the accident and should her death result from the lack of a blood transfusion.

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310 Unreported, Supreme Court of Queensland, Muir J, 18 January 2006.

311 Ibid 4.

312 Ibid.

9.349 Having regard to the circumstances of the accident and the disparate views of Mrs Astill's family, Muir J authorised the giving of a blood transfusion that was, in the opinion of a medical practitioner treating Mrs Astill, necessary to save her life or to enhance her prospects of recovery.<sup>313</sup>

9.350 This case may well have been decided differently if it had concerned a valid advance health directive made under the *Powers of Attorney Act 1998* (Qld). In that situation, a direction refusing a blood transfusion would ordinarily be effective. Further, although the Supreme Court and the Tribunal have the power under section 116(c) and (d) of the Act to change the terms of an advance health directive or to revoke part of the document, in exercising either power, they are required to comply with the General Principles and, for a health matter, the Health Care Principle.<sup>314</sup>

9.351 Where an adult has made a valid advance health directive (which was not the case in *State of Queensland v Astill*), there is an important issue as to whether and, if so, in what circumstances, it is appropriate for the *Powers of Attorney Act 1998* (Qld) to enable the Supreme Court and the Tribunal to change or revoke the advance health directive.

## The Commission's view

### ***The power to appoint a new attorney under an advance health directive***

9.352 If an attorney who is appointed under an advance health directive is removed and there is a need for a formal appointment to be made,<sup>315</sup> the Tribunal may appoint a guardian under section 12 of the *Guardianship and Administration Act 2000* (Qld) to exercise power for the relevant health matters. This was not possible when the *Powers of Attorney Act 1998* (Qld) was originally enacted, as the Guardianship and Administration Tribunal was not established until some two years later when the *Guardianship and Administration Act 2000* (Qld) was enacted.<sup>316</sup>

9.353 The fact that the *Guardianship and Administration Act 2000* (Qld) enables a guardian to be appointed for health matters raises the issue of whether it is necessary for the Tribunal and the Supreme Court to retain the power under section 116(a) of the *Powers of Attorney Act 1998* (Qld) to appoint a new attorney to replace an attorney who has been removed from an advance health directive.

<sup>313</sup> Ibid 5. As explained at [11.26] below, at common law, where there is doubt about an adult's wishes, 'that doubt falls to be resolved in favour of the preservation of life': *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 (Lord Donaldson MR). However, in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, McDougall J cautioned (at 96) that any such doubt must be rationally founded, and that an individual's right to self-determination should not be undermined by 'over-nice or merely speculative analysis'.

<sup>314</sup> *Powers of Attorney Act 1998* (Qld) s 76.

<sup>315</sup> Note, if there is no continuing attorney under the advance health directive, the principal will have a statutory health attorney under s 63 of the *Powers of Attorney Act 1998* (Qld).

<sup>316</sup> From 1 December 2009, the Guardianship and Administration Tribunal was replaced by the Queensland Civil and Administrative Tribunal.

9.354 The *Guardianship and Administration Act 2000* (Qld) provides a comprehensive scheme for the appointment of guardians and administrators. It deals with the Tribunal's power to make an appointment (section 12), the eligibility requirements for appointment (section 14), the appropriateness of the appointee (section 15), and the periodic review of the appointment (section 28). While the Tribunal and the Supreme Court would no doubt consider the suitability of a proposed new attorney before deciding whether to appoint a new attorney under section 116(a) of the *Powers of Attorney Act 1998* (Qld), the Commission considers it preferable, where the need for the appointment of a substitute decision-maker arises from the removal of an attorney under an advance health directive, for the appointment to be made under the *Guardianship and Administration Act 2000* (Qld), which specifically regulates the appointment of substitute decision-makers and the review of those appointments. In so far as section 116(a) enables the Tribunal or the Supreme Court to appoint a new attorney to replace an attorney who has been removed under an advance health directive, it is not necessary to retain that power and section 116(a) should be amended accordingly.<sup>317</sup>

9.355 For consistency with this decision, section 116(b) of the *Powers of Attorney Act 1998* (Qld), in so far as it applies to an attorney appointed under an advance health directive, should be amended so that it does not empower the Tribunal or the Supreme Court to give a power that has been removed from an attorney to another attorney or to a new attorney. If the Tribunal or the Supreme Court is of the view that a power should be removed from an attorney and that it should be exercisable by another person, the appropriate course is for the Tribunal or the Supreme Court to remove the power from the attorney under section 116(b) of the *Powers of Attorney Act 1998* (Qld) and for the Tribunal to appoint the other person as a guardian with the relevant power under section 12 of the *Guardianship and Administration Act 2000* (Qld).<sup>318</sup>

***The powers to change the terms of an advance health directive and revoke all or part of an advance health directive***

*Majority view*

9.356 As explained above, in exercising power under the *Powers of Attorney Act 1998* (Qld), the Tribunal and the Supreme Court must comply with the General Principles and, for a health matter, the Health Care Principle.<sup>319</sup> Accordingly, while section 116(c) and (d) of the *Powers of Attorney Act 1998* (Qld) does not confine the circumstances in which the Tribunal or the Supreme Court may change the terms of an advance health directive or revoke all or part of the document, it is difficult to envisage circumstances in which a direction in the document could be

<sup>317</sup>

See also Recommendation 16-20(a) of this Report where the Commission has recommended that, in so far as s 116(a) of the *Powers of Attorney Act 1998* (Qld) applies to an attorney under an enduring power of attorney, the section should be amended so that it does not empower the court to appoint a new attorney to replace an attorney who has been removed. The exercise of power under that section in relation to an attorney appointed under a general power of attorney is outside the scope of this review.

<sup>318</sup>

If s 245 of the *Guardianship and Administration Act 2000* (Qld) applies, the Supreme Court may exercise all the powers of the Tribunal under ch 3 of the Act: s 245(2). This would include the power to appoint a guardian under s 12 of the Act.

<sup>319</sup>

*Powers of Attorney Act 1998* (Qld) s 76.

changed or revoked so that the document expressed a different view from that intended by the principal. Such a change would constitute a serious erosion of the principal's autonomy and would be inconsistent with the principle of substituted judgment that is reflected in the General Principles.

9.357 However, an express power to change the terms of an advance health directive does, in effect, enable the Tribunal and the Supreme Court to rectify an advance health directive in appropriate circumstances. A majority of the Commission considers that this could be necessary where there is an error in the document, for example, the omission of material words. In that situation, the advance health directive could be amended to include the missing words so that the document reflects the adult's views and wishes.

9.358 If an advance health directive were invalid, the usual course would be for the Tribunal or the Supreme Court to make a declaration to that effect. However, if a direction in an advance health directive is inoperative, the power to revoke part of an advance health directive enables the Tribunal or the Supreme Court to revoke that part of the document. If the revoked part of the document is physically struck through, that can avoid the situation where health providers rely on the document without being aware that part of it had been declared to be invalid.

9.359 Although the powers in section 116(c) and (d) of the *Powers of Attorney Act 1998* (Qld) are expressed in broad terms, a majority of the Commission considers that these provisions should be retained. It is not possible to predict all of the circumstances in which these powers could be needed and their omission could leave the Tribunal or the Supreme Court without the necessary power to deal with a particular situation. To the extent that there may be concern about the powers being exercised in a way that might be inconsistent with an adult's views and wishes, a majority of the Commission is satisfied that the requirement to comply with the General Principles and, where relevant, the Health Care Principle is an appropriate safeguard.

#### *Minority view*

9.360 One member of the Commission, Associate Professor White, considers that the power of the Tribunal and the Supreme Court to change or revoke an advance health directive should be removed, primarily for two reasons: the power is not needed; and it creates an unacceptable risk of undermining the adult's autonomy.

9.361 In relation to need, one argument for why such a power might be needed is that it could allow the Tribunal or the Supreme Court to change or revoke an advance health directive to reflect an adult's views and wishes better. However, Associate Professor White considers that when an advance health directive is insufficient to make a decision about a health matter and requires amendment to do so, it should not be relied upon as the basis for decision-making.

9.362 When completing an advance health directive, an adult presumably wishes to give instructions that are sufficient to make decisions about health matters in the future. There are already a series of safeguards or procedures that

help ensure an adult, when completing an advance health directive, is making informed, considered decisions about his or her future health care. Examples include the explanatory information provided in the prescribed form and the requirement for a doctor to be involved in the completion of an advance health directive. In this Report, the Commission has also made a number of recommendations to ensure that this decision-making is informed and considered. An example is making use of the prescribed form mandatory so that adults completing advance health directives will always have available the relevant information contained in that form.

9.363 If, despite these safeguards and procedures, an adult's advance health directive is insufficient to make a decision about a health matter, then the adult should be treated as not having made the relevant decision. Instead, the appropriate course is to rely on the substitute decision-making regime that has been established by the guardianship legislation to deal with that situation. That decision-making is subject to the General Principles and the Health Care Principle and the views expressed by the adult in the advance health directive would be considered significant in those deliberations. Associate Professor White considers that autonomy should be promoted and as much weight as possible be given to the directive as reflecting the adult's views and wishes (even when the terms of the directive themselves are not capable of making the relevant decision). However, he considers that this promotion of autonomy is more appropriately facilitated through the substitute decision-making regime established for this purpose. Accordingly, the power to change or revoke an advance health directive is not needed on that basis.

9.364 The need for a power to change or revoke an advance health directive could also be argued on the basis that an adult's wishes as expressed in such a directive should not be followed in particular circumstances. Associate Professor White does not consider that the power should be used in this way as it is inconsistent with the notion of an advance health directive as an expression of an adult's autonomy.

9.365 Indeed, the second reason for removing this power is that it is capable of being used in a way that undermines an adult's autonomy and creates an unacceptable risk of this occurring. In a related context where requests are made to provide treatment contrary to an adult's wishes — pregnant women refusing treatment — it has been noted that:<sup>320</sup>

When human life is at stake the pressure to provide an affirmative answer authorising unwanted medical intervention is very powerful. Nevertheless, the autonomy of each individual requires continuing protection even, perhaps particularly, when the motive for interfering with it is readily understandable, and indeed to many would appear commendable ...

9.366 This 'pressure' also appears to have been influential in decisions involving advance directives. It has been argued that when confronted with an advance directive, which if acted upon will lead to a person's death, some judges have

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*St George's Healthcare NHS Trust v S* [1999] Fam 26, 46–7 (Judge LJ delivering the judgment of the English Court of Appeal).

tended to avoid finding that the directive is binding on health professionals. A recent review by one commentator of all the publicly available decisions involving advance directives at common law in England and Australia concluded that:<sup>321</sup>

despite the clarity of the law on the supremacy of autonomy and self-determination and the rhetoric to that effect in the judgments, some judges simply regard the sanctity of life as the more compelling principle, and allow that principle to dictate the outcome.

9.367 A power that expressly permits the Tribunal and the Supreme Court to change or revoke an advance health directive creates an unacceptable risk that autonomy will be undermined by the desire to preserve life. While such a desire may be understandable, the exercise of such a power in this way has significant implications for bodily integrity and the right of a person to refuse treatment.

9.368 Associate Professor White notes that any exercise of this power would be constrained by the General Principles and the Health Care Principle. However, these principles are necessarily general, contain potentially conflicting instructions and are capable of being applied in different ways to achieve a wide variety of outcomes in the same situation.<sup>322</sup> As such, these principles are an insufficient safeguard against the power being exercised in a manner inconsistent with the adult's autonomy.

9.369 Accordingly, Associate Professor White is of the view that section 116(c) and (d) of the *Powers of Attorney Act 1998* (Qld) should not enable the Supreme Court, or the Tribunal through the operation of section 109A, to change the terms of an advance health directive or to revoke all or part of an advance health directive.

### **Changed circumstances as a basis for change or revocation**

#### *Majority view*

9.370 Although a majority of the Commission has not recommended any amendment of section 116(c) or (d) of the *Powers of Attorney Act 1998* (Qld), these members are nevertheless of the view that section 117 of the Act should be amended to emphasise the importance of viewing any change in circumstances from the adult's perspective. Section 117 should be amended so that it provides:

Without limiting the grounds on which the court may make an order changing the terms of a power of attorney, enduring power of attorney or advance health directive, or revoking all or part of 1 of these documents, the court may make the order if the court considers the principal's circumstances or other circumstances (including, for a health power, advances in medical science) have changed to the extent that the adult, if he or she had known of the change

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L Willmott, 'Advance Directives Refusing Treatment as an Expression of Autonomy: Do the Courts Practise What They Preach' (2009) 38 *Common Law World Review* 295, 335. For further critical analysis of the way in which judges have reasoned in advance directive cases, see also S Michalowski, 'Advance refusals of life-sustaining medical treatment: the relativity of an absolute right' (2005) 68(6) *Modern Law Review* 958; A Maclean, 'Advance directives and the rocky waters of anticipatory decision-making' (2007) 15 *Medical Law Review* 1.

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M Howard, 'Principles for Substituted Decision-Making about Withdrawing or Withholding Life-Sustaining Measures in Queensland: A Case for Legislative Reform' (2006) 6(2) *QUT Law and Justice Journal* 166.

in circumstances, would have considered that 1 or more terms of the document are inappropriate.

9.371 This change is consistent with the change recommended earlier to section 103(1) of the *Powers of Attorney Act 1998* (Qld), which uses a similar expression.<sup>323</sup> Because of the opening words of section 117, this recommendation will not narrow the grounds on which an advance health directive, power of attorney or enduring power of attorney may be changed or revoked. However, it nevertheless provides guidance to the Tribunal and the Supreme Court in exercising their discretion under section 116(c) and (d).

#### *Minority view*

9.372 As noted above, one member of the Commission, Associate Professor White, is of the view that the power of the Supreme Court, or the Tribunal through the operation of section 109A, to change or revoke an advance health directive under section 116(c) and (d) of the *Powers of Attorney Act 1998* (Qld) should be removed. In light of that view, he also considers that section 117 of the *Powers of Attorney Act 1998* (Qld) should be amended to omit the current reference to ‘an advance health directive’.

## **THE EFFECT OF THE GUARDIANSHIP LEGISLATION ON THE OPERATION OF A CONSENT OR REFUSAL THAT WOULD OTHERWISE BE EFFECTIVE AT COMMON LAW**

### **Introduction**

9.373 As noted earlier, at common law, medical treatment ordinarily requires patient consent.<sup>324</sup>

9.374 What constitutes a valid consent is determined by the common law. The following elements are required to be satisfied for an adult’s consent to be valid.<sup>325</sup>

- The adult must be competent to give the consent — that is, he or she must be capable of understanding in broad terms the nature of the procedure to be performed.<sup>326</sup>
- The consent must be voluntary — that is, the decision is really that of the adult and the adult’s will has not been overborne.<sup>327</sup>

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<sup>323</sup> See [9.334] above.

<sup>324</sup> See [9.6] above.

<sup>325</sup> Generally, see J McIlwraith and W Madden, *Health Care & the Law* (5th ed, 2010) [4.65]–[4.105].

<sup>326</sup> See *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). The Court was referring in this context to the ‘consent necessary to negate the offence of battery’.

<sup>327</sup> *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113–14 (Lord Donaldson MR).

- The consent must be specific to the procedure that is to be performed.<sup>328</sup>

9.375 The common law also recognises that an adult with capacity may refuse any medical treatment that is offered, even if the adult's refusal of the treatment may lead to his or her death.<sup>329</sup> A refusal of treatment can relate to specific treatment that is offered or 'can take the form of a declaration of intention never to consent in the future or never to consent in some future circumstances'.<sup>330</sup>

9.376 For an adult's refusal to be effective:<sup>331</sup>

- the adult must have had capacity to make the decision;
- the decision must have been made voluntarily and must not have been vitiated by factors such as the provision of misinformation;<sup>332</sup> and
- the refusal must have been intended to apply in the circumstances that have arisen.

9.377 To be effective to authorise health care, consent must always precede the actual provision of the health care, at least to some degree. Generally, decisions about health care are made after treatment has been offered to a patient (but before treatment is provided). Sometimes, however, a person may make a decision to consent to particular health care or, more likely, to refuse particular health care, in advance of the need for that health care arising and, therefore, in advance of the person's consent being sought.

9.378 There are a number of terms, such as 'common law directive', 'advance directive' and 'advance care directive', that are used for convenience to refer to a decision about health care that is made more remotely in time from when the need for the decision arises than is usually the case. This range of terms is also used to distinguish an advance decision whose effectiveness is determined by the common law from an advance decision whose effectiveness has a statutory basis — such as an advance health directive made under the *Powers of Attorney Act 1998* (Qld).

9.379 Regardless of the particular term that is used, the effectiveness of an advance decision at common law depends on whether it meets the ordinary requirements of the common law about what constitutes an effective consent or refusal, although particular care may need to be taken to ensure that an advance

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328 *Candutti v ACT Health and Community Care* [2003] ACTSC 95, [33], [35].

329 *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [23]–[26] (Martin CJ); *Re B* [2002] 2 All ER 449, 455–6 (Butler-Sloss P); *Re MB* [1997] 2 FLR 426, 432 (Butler-Sloss LJ); *Airedale NHS Trust v Bland* [1993] AC 789, 857 (Lord Keith).

330 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 (Lord Donaldson MR).

331 *Ibid* 115–16.

332 Although a refusal of treatment may be vitiated by the provision of misinformation, Lord Donaldson MR did not intend by this statement to impose a requirement that a refusal must be fully informed to be effective: see *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 114, quoted at [9.135] above.

refusal is still intended to operate:<sup>333</sup>

where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it ... especial care may be necessary to ensure that the prior refusal of care is still properly to be regarded as applicable in the circumstances which have subsequently occurred ...

9.380 As discussed earlier in this chapter,<sup>334</sup> in *Hunter and New England Area Health Service v A*,<sup>335</sup> McDougall J held that the validity of an adult's 'advance care directive' did not require 'that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment'.<sup>336</sup>

9.381 However, it was suggested by Lord Donaldson MR in *Re T (Adult: Refusal of Treatment)*<sup>337</sup> that 'misinforming a patient, whether or not innocently, and the withholding of information which is expressly or impliedly sought by the patient may well vitiate either a consent or a refusal'.<sup>338</sup>

9.382 There are no specific formal requirements that determine whether an advance directive will be found to be effective at common law. Such matters will, however, go to the weight of evidence in determining whether an effective advance directive has been made.<sup>339</sup> For example, in the Canadian case of *Malette v Shulman*,<sup>340</sup> the patient's refusal of blood transfusions was evidenced by her signed 'no blood transfusion' card.

9.383 There have been few reported cases<sup>341</sup> (and only one in Australia<sup>342</sup>) where an adult's advance directive has been found to be effective at common law. However, it is not known how often in practice advance decisions are acted on by health providers on the grounds that they have satisfied the requirements at common law for an effective advance directive. It has been said that:<sup>343</sup>

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333 *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff).

334 See [9.124]–[9.125] above.

335 (2009) 74 NSWLR 88.

336 *Ibid* 98.

337 [1993] Fam 95.

338 *Ibid* 115.

339 Eg C Stewart, 'Advance directives: Disputes and dilemmas' in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 38, 40–1.

340 (1990) 72 OR (2d) 417.

341 *Malette v Shulman* (1990) 72 OR (2d) 417. Cf *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 (application for special leave to appeal to the High Court was refused).

342 *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88.

343 C Stewart, 'Advance directives: Disputes and dilemmas' in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 38, 38.

'Advance directives' are decisions made by patients about what medical treatments they would like in the future if, at some point, they cannot make decisions for themselves. When thought of in these broad terms, advance directives can be seen as an existing part of everyday medical practice, particularly surgical procedures, where patients consent to treatments many days, even weeks, before they are sedated for their operation.

9.384 'Advance directives', using that term to refer to anticipatory decisions about health care (particularly decisions refusing health care) made well before the need for the health care arises, tend to be the decisions that are the subject of judicial and academic consideration as there is often an issue about their effectiveness. However, in considering the extent to which the guardianship legislation affects what would otherwise be recognised at common law as an effective consent or refusal, it is important to consider the impact of the legislation not only on advance directives of that kind, but also the impact of the legislation more generally on health care decisions that are made more proximate in time to when the health care is needed. This requires a consideration of the broader range of circumstances in which decisions consenting to, or refusing, health care may be made — for example, a decision about particular health care that is made by an adult who is scheduled for surgery or a decision made by an adult with a terminal illness about particular treatments that might be relevant as his or her illness progresses (at which time the adult might not have capacity to make the decision).

### The law in Queensland

9.385 When the Commission considered this issue in its original 1996 Report, it recommended that 'the legislation provide that common law recognition of instructions about health care that are not given in an advance health care directive made under the legislation is not affected by the legislation'.<sup>344</sup> The Commission considered that:<sup>345</sup>

the preservation of common law rights, rather than increasing uncertainty, would maximise the opportunity for people to exercise control over their future medical treatment.

9.386 It also expressed the view that, 'since a court would be unlikely to give effect to an informal directive unless there was clear evidence that the directive did in fact represent the true wishes of the patient, there should be adequate protection for patients'.<sup>346</sup> This has been borne out in the case law.<sup>347</sup>

9.387 In the context of the Commission's original proposals for advance directives, it was particularly important that the effect of common law directives be

<sup>344</sup> Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 358.

<sup>345</sup> Ibid.

<sup>346</sup> Ibid.

<sup>347</sup> See [9.383] above. For a discussion of judicial attitudes to advance directives, see L Willmott, 'Advance Directives Refusing Treatment as an Expression of Autonomy: Do the Courts Practise What They Preach' (2009) 38 *Common Law World Review* 295.

preserved. The Commission recommended in its 1996 Report that ‘an advance directive which attempted to provide for “end of life” decision-making ... would not be within the scope of the scheme proposed by the Commission’.<sup>348</sup> Accordingly, it was envisaged that an advance directive that was recognised at common law would be the only way to give a direction about end-of-life health care.

9.388 The Commission’s original recommendation was implemented by section 39 of the *Powers of Attorney Act 1998* (Qld), which provides:

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.

9.389 Clearly, it was the legislature’s intention at the time the *Powers of Attorney Act 1998* (Qld) was passed that the Act was not to affect the common law’s recognition of what would otherwise be an effective consent to, or refusal of, health care.

9.390 However, doubt has been raised by commentators about whether, once the *Guardianship and Administration Act 2000* (Qld) was passed, the drafting of section 39 of the *Powers of Attorney Act 1998* (Qld) was adequate to ensure that what would previously have been an effective ‘common law directive’ would continue to be effective.<sup>349</sup>

9.391 The scheme for health care decisions for an adult with impaired capacity is derived from both the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld). The issue in terms of the continued operation of the common law is said to arise from the enactment of section 66 of the *Guardianship and Administration Act 2000* (Qld), which governs the way in which health matters for an adult with impaired capacity are to be dealt with.<sup>350</sup> Section 66, which is expressed as an exhaustive provision, does not refer anywhere in the order of priority for decision-making to instructions about health care that are recognised at common law. Further, section 8 of the *Guardianship and Administration Act 2000* (Qld) and section 6A(4) of the *Powers of Attorney Act 1998* (Qld) provide that, in the case of inconsistency between those two Acts, the *Guardianship and Administration Act 2000* (Qld) will prevail.<sup>351</sup>

9.392 The contrary view is that sections 65 and 66 of the *Guardianship and Administration Act 2000* (Qld), which set out the priority for health care decisions

<sup>348</sup> Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 347.

<sup>349</sup> B White and L Willmott, ‘Will you do As I ask? Compliance with instructions about health care in Queensland’ (2004) 4(1) *Queensland University of Technology Law and Justice Journal* 77. See also B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 25, 28.

<sup>350</sup> B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 25. A similar issue would, on this view, arise in relation to special health matters as a result of the enactment of s 65 of the *Guardianship and Administration Act 2000* (Qld). Section 66 is set out in full at [11.48] below.

<sup>351</sup> B White and L Willmott, ‘Will you do As I ask? Compliance with instructions about health care in Queensland’ (2004) 4(1) *Queensland University of Technology Law and Justice Journal* 77, 83.

that require consent,<sup>352</sup> do not apply in circumstances where there is an effective consent or refusal in relation to the health care in question. This view depends on the following construction of the *Guardianship and Administration Act 2000* (Qld).

9.393 The *Guardianship and Administration Act 2000* (Qld) assumes (correctly) the existence of a general rule of law that, subject to certain narrow exceptions, health care may not be carried out on an adult without the consent of the adult. To put it another way, the Act assumes the existence of a general rule of law that, at the time a health provider is proposing to carry out health care on an adult, the health provider must have an operative consent to the health care.

9.394 The Act does not define the circumstances in which an adult should be regarded as having consented to, or refused, the provision of health care. The following questions are all left to be determined by the common law:

- whether an adult has given consent, or refused health care, expressly and, if not, whether the adult's consent, or refusal, may be inferred from his or her conduct;
- whether the consent or refusal has been expressed in such a way as to cover the particular health care concerned; and
- how proximate to the actual provision of the health care the consent or refusal must be given in order to be effective.

9.395 Chapter 5 of the *Guardianship and Administration Act 2000* (Qld) is intended to address issues that arise where an adult has 'impaired capacity' for a health matter or a special health matter. Section 65 applies if an adult has 'impaired capacity for a special health matter', while section 66 applies if an adult has 'impaired capacity for a health matter'. The application of those sections turns on what it means to have 'impaired capacity' for such a matter.

9.396 The effect of the definitions of 'capacity' and 'impaired capacity' that appear in the *Guardianship and Administration Act 2000* (Qld) is that an adult has impaired capacity for a health matter or a special health matter if the adult is not capable of:<sup>353</sup>

- understanding the nature and effect of decisions about the matter;
- freely and voluntarily making decisions about the matter; and
- communicating the decisions in some way.

9.397 While these definitions clearly express a functional test of capacity,<sup>354</sup> they do not include a temporal element. In the present context, the critical issue is

<sup>352</sup> Sections 65 and 66 appear in div 2 of pt 2 of ch 5 of the *Guardianship and Administration Act 2000* (Qld): Health care and special health care—consent.

<sup>353</sup> See *Guardianship and Administration Act 2000* (Qld) sch 4 (definitions of 'capacity', 'impaired capacity').

<sup>354</sup> Decision-making capacity is considered in Chapter 7 of this Report.

whether sections 65 and 66, in referring to an adult with 'impaired capacity', are referring to the time when the decision about the health care is made or the time when the health care is proposed to be carried out. The distinction is important because, as explained above, it is possible for consent to health care, or a refusal of health care, to be effective at common law even though it was given some considerable period of time before the need arose for the health care to be carried out.<sup>355</sup> Moreover, there is no suggestion that, at common law, a competent adult's consent to, or refusal of, health care ceases to have effect if the adult subsequently loses capacity. If that were the case, it would not be possible for an adult to give an effective consent to surgery that requires a general anaesthetic.

9.398 Unlike section 39 of the *Powers of Attorney Act 1998* (Qld), the *Guardianship and Administration Act 2000* (Qld) does not provide expressly that it '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, section 61 of the *Guardianship and Administration Act 2000* (Qld) provides that one of the purposes of Chapter 5 of the Act, which includes sections 65 and 66, is to ensure that 'an adult is not deprived of necessary health care only because the adult has impaired capacity for a health matter or special health matter'.<sup>356</sup> It is therefore arguable that the purpose of Chapter 5 is to fill a gap in the law that arises when an adult lacks capacity and, as a result, is not able to make his or her own health care decisions. The Act does not evince an intention to regulate decisions about health care, or to provide a mechanism for making substitute decisions about health care, for an adult if the adult, while he or she had capacity, made an effective decision about the health care. In that situation, where there is an operative decision, there is simply no need for a substitute decision.

9.399 It is consistent with the purpose of Chapter 5 that, if, while an adult had capacity, he or she consented to, or refused, particular health care (other than in the form of an advance health directive, the operation of which *is* intended to be governed by sections 65 and 66), the adult does not have 'impaired capacity' for the health matter or special health matter within the meaning of sections 65 or 66.

9.400 The result of this construction is that, even though an adult might well be unconscious at the time of the provision of the health care, this does not mean that the adult has 'impaired capacity for the health matter' if the adult has previously consented to, or refused, the health care when he or she had capacity. Consequently, the *Guardianship and Administration Act 2000* (Qld) does not require the health care to be dealt with in accordance with section 65 or 66 of that Act.

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355 See [9.378]–[9.379] above.

356 *Guardianship and Administration Act 2000* (Qld) s 61(a).

## The law in other jurisdictions

9.401 In the ACT, the *Medical Treatment (Health Directions) Act 2006* (ACT) does not affect any common law right of a person to refuse medical treatment.<sup>357</sup>

9.402 Similarly, in Western Australia, the *Guardianship and Administration Act 1990* (WA) provides that Part 9B, which deals with advance health directives, 'does not affect the common law relating to a person's entitlement to make treatment decisions in respect of the person's future treatment'.<sup>358</sup>

9.403 In the Northern Territory<sup>359</sup> and Victoria,<sup>360</sup> the legislation provides, respectively, that it does not affect 'the right of a person to refuse medical or surgical treatment', or 'any right of a person under any other law to refuse medical treatment'. This would appear to be a reference to the right to make an advance refusal of treatment at common law.

## Discussion Paper

9.404 In the Discussion Paper, the Commission sought submissions on whether:<sup>361</sup>

- common law directives should apply alongside the legislative scheme for advance health directives; and
- if so, section 39 of the *Powers of Attorney Act 1998* (Qld) should be clarified to ensure that common law directives have effect despite the provisions of the *Guardianship and Administration Act 2000* (Qld).

9.405 The Commission also sought submissions on the more specific issues of whether the guardianship legislation should:<sup>362</sup>

- recognise a direction about the withholding or withdrawal of a life-sustaining measure only if it is made in an advance health directive; or
- provide that it does not affect a common law directive to withhold or withdraw a life-sustaining measure.

<sup>357</sup> *Medical Treatment (Health Directions) Act 2006* (ACT) s 6; *Legislation Act 2001* (ACT) Dictionary (definitions of 'territory law', 'law, of the Territory' para (d)).

<sup>358</sup> *Guardianship and Administration Act 1990* (WA) s 110ZB.

<sup>359</sup> *Natural Death Act* (NT) s 5(1).

<sup>360</sup> *Medical Treatment Act 1988* (Vic) s 4(1). However, it has been suggested that, in Victoria, 'the common law might be negated because of the substitute decision-making regime established by the *Guardianship and Administration Act 1986* (Vic)': L Willmott, 'Advance directives and the promotion of autonomy: A comparative Australian statutory analysis' (2010) 17 *Journal of Law and Medicine* 556, 566.

<sup>361</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 272.

<sup>362</sup> *Ibid* 306.

## Submissions

### *Recognition of common law directives generally*

9.406 Several respondents were of the view that the guardianship legislation should allow advance directives that are effective at common law to operate alongside the statutory scheme for advance health directives.<sup>363</sup>

9.407 A legal academic with expertise in health law and guardianship law commented:<sup>364</sup>

This is particularly important if the restrictions that apply in the legislation (ie the excuses in s 103 and the limitations as to applicability in s 36) remain. This was also recommended by the QLRC in its initial review of guardianship legislation, and was intended by Parliament when enacting the legislation. A two-tiered system exists in all jurisdictions (with the possible exception of Victoria).

9.408 The former Acting Public Advocate was also of the view that the legislation should be clarified to ensure that common law directives can operate alongside statutory advance health directives as this would give maximum effect to the personal wishes of the adult. The former Acting Public Advocate acknowledged the potential for uncertainty, but considered that this could be reduced through education.<sup>365</sup>

While it has been suggested that the recognition of common law directives as well as AHDs would create confusion and uncertainty for health professionals, if the legislation were amended to clearly express and clarify that common law directives must be recognised, and if all health professionals were provided with appropriate education and training in relation to the effect of a common law directive, such uncertainty would be significantly reduced.

9.409 The Watchtower Bible and Tract Society of Australia strongly supported the legal recognition of common law directives.<sup>366</sup>

Our main reason for advocating the continued use of a common law directive is that it maximises the opportunity for individuals to exercise their right to self-determination. Supporting this right is clearly a major aim of the legislation.

It may be argued that individuals who truly want to give advance direction regarding their health care should be sufficiently motivated to complete an advance health directive that complies with the statutory regime. We agree that, wherever possible, individuals should make complying advance health directives. However, to restrict the effectiveness of common law health directives because a statutory advance health directive is possible is to fail to acknowledge that sometimes individuals cannot, or will not, make complying advance health directives.

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363 Submissions C133, 20B, 144, 160, 165.

364 Submission 144.

365 Submission 160.

366 Submission C133.

9.410 The Society was of the view that the recognition of common law directives is especially important for people who unsuccessfully attempt to make a statutory advance health directive or who are overwhelmed by the requirements of making a statutory advance health directive:

What of individuals who may have endeavoured to make a complying advance health directive but who for some reason have failed to do so? Where the statutory regime has a number of requirements, even though those requirements may be reasonable, there is an increased possibility of errors being made. Perhaps the witness has failed to sign or date the directive. Perhaps the doctor is a relation of the individual. The advance health directive would then not meet the legislative requirements but would arguably function as a common law directive. If an error in completing the statutory form is made, should the person's competent directions then be ignored?

What of persons who feel overwhelmed by the extensive nature of the formal requirements for an advance health directive? Individuals who suffer from extreme ill health or the problems that come with advanced age, people who have educational limitations or language difficulties, persons who live in remote areas, individuals who unexpectedly require medical treatment within a limited timeframe, and others may find it very difficult to make the necessary arrangements to complete an advance health directive. Should such individuals be prevented from giving directions as to their health care in a more informal way than the law presently envisages?

9.411 The Society acknowledged the arguments made against the recognition of common law directives — namely, that it creates a two-tier system and that common law directives often lack specificity. However, the Society did not consider that those arguments would justify not recognising common law directives:

We do not see that there is a particular difficulty in having a two-tier system, especially where s 66 of the GAA already sets out a tiered system for consenting to health care. In regard to the second point that different law would then apply to statutory as opposed to common law directives, if the legislature saw fit, similar limitations regarding decisions about withholding or withdrawing life-sustaining measures could be imposed upon common law directives. The application of the law could be made more consistent in regard to substantive issues, while the extensive formal requirements would not need to be met for common law directives.

The ... argument regarding lack of specificity may indeed mean that a common law directive does not cover the matter at hand. However, we do not agree that this is a reason not to recognise common law directives. Even a statutory advance health directive may not cover all matters. If an advance health directive, whether statutory or common law, does not cover the matter, then the next step in s 66 would be taken and a substitute decision-maker would be used to make the necessary decision. But where there is specific advance direction given, we submit that the direction should be followed.

9.412 Although the Adult Guardian was generally of the view that common law directives should operate alongside statutory advance health directives, she was of the view that, if the direction related to the withholding or withdrawal of a life-

sustaining measure, the direction should operate only if it was made in a statutory advance health directive.<sup>367</sup>

9.413 Three respondents were of the view that section 39 of the *Powers of Attorney Act 1998* (Qld) should be clarified to ensure that common law directives have effect despite the provisions of the *Guardianship and Administration Act 2000* (Qld).<sup>368</sup>

***Recognition of common law directives in relation to the withholding or withdrawal of life-sustaining measures***

9.414 The Adult Guardian was of the view that the guardianship legislation should recognise a direction about the withholding or withdrawal of a life-sustaining measure only if it is made in an advance health directive.<sup>369</sup>

9.415 A respondent whose daughter sustained a brain injury in an accident was of the same view.<sup>370</sup>

9.416 However, a legal academic with expertise in health law and guardianship law was of the view that the common law should operate alongside the statutory regime.<sup>371</sup>

**The Commission's view**

9.417 As explained above, there is some ambiguity about whether sections 65 and 66 of the *Guardianship and Administration Act 2000* (Qld) have the effect that what would otherwise be recognised at common law as being an effective consent to, or refusal of, health care will not be effective.<sup>372</sup> In the Commission's view, it is important that the guardianship legislation does not affect what would otherwise be recognised at common law as an effective consent to, or refusal of, health care, and that there is no ambiguity about this issue. If the legislation did not allow the common law in relation to consent and refusal to operate, it would always be the case that, if an adult's health care involved a general anaesthetic, the adult would necessarily have impaired capacity for the matter as soon as the anaesthetic took effect.

9.418 The continued operation of the common law in this area also supports the important role that advance care planning plays in the care of adults who have a terminal illness by ensuring that decisions made at a time when they are competent will continue to be effective even if they reach the stage that they no longer have the capacity to make decisions about their health care. In many cases, these

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367 Submission 164.

368 Submissions 20B, 144, 165.

369 Submission 164.

370 Submission 161.

371 Submission 144. See [9.407] above.

372 See [9.390]–[9.400] above.

instructions about health care are not given in the form of an advance health directive.<sup>373</sup> The Commission considers it important that the law should reflect the actual practice in this area of decision-making by ensuring the effectiveness of these instructions provided that they satisfy the requirements of the common law.<sup>374</sup>

9.419 This decision means that what are commonly described as ‘advance directives’ or ‘common law directives’ will also be capable of operating if they are made in a way that meets the common law requirements for a valid consent to, or refusal of, health care. While there may be some concerns about allowing directives to operate that do not have to satisfy the requirements for an advance health directive made under the *Powers of Attorney Act 1998* (Qld), the courts nevertheless require sufficient evidence in order to be satisfied that an adult’s advance directive is valid.

9.420 The Commission does not consider it necessary to amend section 65 or 66 of the *Guardianship and Administration Act 2000* (Qld) to clarify this issue. However, Chapter 5 of the *Guardianship and Administration Act 2000* (Qld) should be amended to include a new provision that provides that nothing in that Act affects the operation at common law of an adult’s consent to, or refusal of, health care given at a time when the adult had capacity to make decisions about the matter. The new provision should also include a note referring to the similar provision in section 39 of the *Powers of Attorney Act 1998* (Qld).

9.421 For consistency with this recommendation, section 39 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that nothing in that Act affects the operation at common law of an adult’s consent to, or refusal of, health care given at a time when the adult had capacity to make decisions about the matter. Section 39 should also be amended to include a note referring to the similar provision that has been recommended for inclusion in the *Guardianship and Administration Act 2000* (Qld).

9.422 It is also important to consider the relationship between an effective consent to, or refusal of, health care by an adult and the criminal responsibility imposed by section 79 of the *Guardianship and Administration Act 2000* (Qld). Section 79 makes it an offence to carry out health care of an adult with impaired capacity for a health matter unless the health care is authorised in one of the three ways specified in section 79(1). It provides:

**79 Offence to carry out health care unless authorised**

- (1) It is an offence for a person to carry out health care of an adult with impaired capacity for the health matter concerned unless—

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373 See eg Queensland Health’s new Acute Resuscitation Plan, released in April 2010, which makes provision for a patient’s views and wishes about his or her end-of-life health care to be recorded.

374 The importance of preserving the common law recognition of ‘advance care directives’ is noted in the Draft Advance Care Directives Framework 2010: see Clinical, Technical and Ethical Principal Committee, Australian Health Ministers’ Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft 2010* (2010) 30.

- (a) this or another Act provides the health care may be carried out without consent; or

*Editor's note—*

See sections 63 (Urgent health care), 63A (Life-sustaining measure in an acute emergency) and 64 (Minor, uncontroversial health care).

- (b) consent to the health care is given under this or another Act; or
- (c) the health care is authorised by an order of the court made in its *parens patriae* jurisdiction.

*Editor's note—*

**Court** means the Supreme Court—see schedule 4 (Dictionary). The *parens patriae* jurisdiction is based on the need to protect those who lack the capacity to protect themselves. It allows the Supreme Court to appoint decision makers for people who, because of mental illness, intellectual disability, illness, accident or old age, are unable to adequately safeguard their own interests.

Maximum penalty—

- (a) if special health care is carried out—300 penalty units; or
  - (b) if other health care is carried out—200 penalty units.
- (2) This section has effect despite the Criminal Code, section 282.

9.423 As well as amending the guardianship legislation to ensure that it does not limit the operation of what would otherwise be an effective consent to, or refusal of, health care, it is also important to ensure that there is no doubt about the lawfulness of health care of an adult that is carried out in accordance with such a consent or refusal. To avoid any doubt, section 79 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that, in addition to the circumstances currently mentioned in section 79(1), it is not an offence to carry out health care of an adult with impaired capacity for the health matter concerned if:

the adult consented to the health care at a time when he or she had capacity to make decisions about the matter.

9.424 In addition, section 79(1) should be redrafted as follows to better reflect the usual requirements for consent:

- (1) It is an offence for a person to carry out health care of an adult with impaired capacity for the health matter concerned unless—
  - (a) the adult consented to the health care at a time when he or she had capacity to make decisions about the matter; or
  - (b) consent to the health care is given under this or another Act; or
  - (c) the health care is authorised by an order of the court made in its *parens patriae* jurisdiction; or

*Editor's note—*

**Court** means the Supreme Court—see schedule 4 (Dictionary). The *parens patriae* jurisdiction is based on the need to protect those who lack the capacity to protect themselves. It allows the Supreme Court to appoint decision makers for people who, because of mental illness, intellectual disability, illness, accident or old age, are unable to adequately safeguard their own interests.

- (d) this or another Act provides the health care may be carried out without consent.

*Editor's note—*

See sections 63 (Urgent health care), 63A (Life-sustaining measure in an acute emergency) and 64 (Minor, uncontroversial health care).

9.425 The re-ordering of the paragraphs in section 79(1) makes it clearer that:

- if the adult has consented to the health care, it is not necessary to obtain any other consent (whether under the *Guardianship and Administration Act 2000* (Qld) or any other Act) or authorisation for the health care; and
- the authorisation of health care without consent is an exception to the usual requirement for consent.

## RECOMMENDATIONS

### ***Eligibility for appointment as an attorney under an advance health directive***

9-1 Section 29(2)(a) of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that an eligible attorney for a matter under an advance health directive means, in addition to the categories of person currently mentioned in section 29(2)(a), a person who is not a service provider for a residential service where the principal is a resident.

9-2 Section 29(2)(b) of the *Powers of Attorney Act 1998* (Qld) should be omitted so that the Public Trustee is not an eligible attorney for a matter under an advance health directive.

### ***Operation of a direction in an advance health directive***

9-3 Section 36 of the *Powers of Attorney Act 1998* (Qld) should be amended in the following respects:

- (a) section 36(1)(b) should be amended so that it provides that a direction in an advance health directive is as effective as, *but no more effective than*, if:

- (i) the principal gave the direction when decisions about the matter needed to be made; and
  - (ii) the principal then had capacity for the matter;
- (b) new subsections should be inserted in section 36 to provide that:
- (i) a direction in an advance health directive does not operate if:
    - (A) the direction is uncertain; or
    - (B) circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate;
  - (ii) a direction in an advance health directive is not uncertain if its meaning can be ascertained by consultation with:
    - (A) an attorney appointed under the advance health directive; or
    - (B) if an attorney is not appointed under the advance health directive, but the advance health directive names an attorney for health matters appointed under the adult's enduring power of attorney — the named attorney.

9-4 Section 113 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that the court<sup>375</sup> may decide whether a direction in an advance health directive is operative (whether in relation to a particular situation or generally) and may make a declaration to that effect.

*The approved form*

9-5 Section 44 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that an advance health directive must be made in the approved form.

<sup>375</sup>

Note that s 109A of the *Guardianship and Administration Act 2000* (Qld) confers on the Tribunal the same jurisdiction and powers for enduring documents that the Supreme Court has.

- 9-6** The provision that gives effect to Recommendation 9-5 should apply only to an advance health directive made after the commencement of that provision.
- 9-7** The approved form for an advance health directive should be redrafted.
- 9-8** The redrafting of the approved form for an advance health directive should:
- (a)** ensure that the provisions in the form dealing with the appointment of an attorney refer to the appointment of an attorney for 'health matters' and not to an attorney for 'personal/health matters';
  - (b)** take account of the fact that, as a result of the Commission's recommendation in Chapter 11 to omit section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) (Recommendation 11-3), a direction to withhold or withdraw a life-sustaining measure will be able to operate outside the specific situations currently mentioned in section 36(2)(a) of the Act and listed in section 3 of the approved form;
  - (c)** include questions that draw the principal's attention to whether a direction refusing particular health care is intended to operate in unforeseen circumstances, where the need for the health care does not arise as a result of an existing condition of the adult or the natural progression of such a condition;
  - (d)** as well as making continued provision for a principal to give specific directions about specific health care, give consideration to incorporating the 'outcomes-based' approach recommended by the South Australian Advance Directives Review Committee;<sup>376</sup>
  - (e)** make provision for the principal to sign or initial each page that includes a statement or direction of the principal;
  - (f)** continue to encourage the principal to review the advance health directive periodically; and

376

See [9.94]–[9.95] above.

- (g) continue to include information about the various ways in which the principal may bring the existence of the advance health directive to the attention of relevant people.

#### ***Copies and proof***

9-9 Section 45(2) and (3) of the *Powers of Attorney Act 1998* (Qld) should be omitted and replaced by a new subsection to the effect that the copy of the enduring document must be certified to the effect that it is a true and complete copy of the original.

9-10 The explanatory notes for the approved form for an advance health directive should:

- (a) encourage the principal to give a *certified* copy of the form to the principal's doctor, attorney, family member or friend, and solicitor; and
- (b) explain how a copy of the advance health directive should be certified in order to comply with section 45 of the *Powers of Attorney Act 1998* (Qld).

#### ***Notification of advance health directives***

9-11 The *Guardianship and Administration Act 2000* (Qld) should include new provisions, based generally on a combination of section 49 of the *Powers of Attorney Act 2006* (ACT) and sections 13 and 14 of the *Medical Treatment (Health Directions) Act 2006* (ACT), to the effect that:

- (a) the person in charge of a health care facility (being a hospital, residential aged care facility or residential disability care facility) must take reasonable steps to ensure that:
  - (i) each person receiving care at the facility is asked whether the person has an advance health directive or an enduring power of attorney that applies to health matters; and
  - (ii) if a person has either of those documents:
    - (A) a copy of the enduring document is brought to the attention of the adult's health providers; or



***Protection of health provider who in good faith acts in reliance on an invalid or revoked enduring document***

**9-15** The *Powers of Attorney Act 1998* (Qld) should be amended (in either section 96 or 100) to define ‘invalidity, of an advance health directive’ and ‘know, of an advance health directive’s invalidity’ in the following terms:

*invalidity, of an advance health directive, means invalidity because—*

- (a) the document was made in another State and does not comply with the other State’s requirements; or
- (b) the document has been revoked.

*know, of an advance health directive’s invalidity, includes—*

- (a) know of the happening of an event that invalidates the document; or
- (b) have reason to believe the document is invalid.

**9-16** Section 100 of the *Powers of Attorney Act 1998* (Qld) should be amended so that it applies if a person other than an attorney in good faith and without knowing that:

- (a) an advance health directive or a power for a health matter under an enduring document is invalid; or
- (b) a direction in an advance health directive does not operate;

acts in reliance on the advance health directive, the purported exercise of power or the inoperative directive.

***Protection if health provider does not know of existence of advance health directive***

**9-17** Section 102 of the *Powers of Attorney Act 1998* (Qld) should be amended so that it applies to a health provider who ‘*acting in good faith*, does not know the adult has an advance health directive’.

***Protection of health provider for non-compliance with advance health directive***

**9-18** Section 103 of the *Powers of Attorney Act 1998* (Qld) should be amended in the following respects:

- (a) section 103(1) should be amended:
- (i) so that section 103 does not apply to a health provider who has reasonable grounds to believe that a direction in an advance health directive is inconsistent with good medical practice; and
  - (ii) to refer to ‘circumstances, including advances in medical science, have changed to the extent that *the adult, if he or she had known of the change in circumstances, would have considered that* the terms of the direction are inappropriate;
- (b) the protection given by section 103(2) should be clarified by inserting a new subsection to the effect that, if the health provider carries out health care that is not in accordance with the direction, the health provider is protected only to the extent that, if the direction had been inoperative under section 36 of the Act, the health care would have been authorised or the subject of consent; and
- (c) section 103(3) should be amended so that the requirement to consult applies in relation to:
- (i) an attorney appointed under the advance health directive; or
  - (ii) if an attorney is not appointed under the advance health directive, but the advance health directive names an attorney for health matters appointed under the adult’s enduring power of attorney — the named attorney.

9-19 Section 65 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 65(2) is subject to section 36 of the *Powers of Attorney Act 1998* (Qld).

9-20 Section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 66(2) is subject to section 36 of the *Powers of Attorney Act 1998* (Qld).<sup>377</sup>

377

See also the related recommendations that deal with the effect of s 66(3), (4) and (5) of the *Guardianship and Administration Act 2000* (Qld): Recommendations 10-7, 15-6, 16-10 of this Report.

***The power to remove and replace an attorney under an advance health directive or change or revoke an advance health directive***

**9-21** Section 116(a) and (b) of the *Powers of Attorney Act 1998* (Qld), in so far as those provisions apply to an attorney appointed under an advance health directive, should be amended so that:

- (a) section 116(a) does not empower the court to appoint a new attorney to replace an attorney who has been removed; and
- (b) section 116(b) does not empower the court to give a power that has been removed from an attorney to another attorney or to a new attorney.

**9-22** A majority of the Commission recommends that section 116(c) and (d) of the *Powers of Attorney Act 1998* (Qld), in so far as those provisions apply to an advance health directive, should be retained in their current form.

**9-23** A minority of the Commission recommends that:

- (a) section 116(c) of the *Powers of Attorney Act 1998* (Qld) should be amended so that it does not enable the court to change the terms of an advance health directive; and
- (b) section 116(d) of the *Powers of Attorney Act 1998* (Qld) should be amended so that it does not enable the court to revoke all or part of an advance health directive.

**9-24** A majority of the Commission recommends that section 117 of the *Powers of Attorney Act 1998* (Qld) should be amended so that it provides:

Without limiting the grounds on which the court may make an order changing the terms of a power of attorney, enduring power of attorney or advance health directive, or revoking all or part of 1 of these documents, the court may make the order if the court considers the principal's circumstances or other circumstances (including, for a health power, advances in medical science) have changed to the extent that *the adult, if he or she had known of the change in circumstances, would have considered that* 1 or more terms of the document are inappropriate.

**9-25** A minority of the Commission recommends that section 117 of the *Powers of Attorney Act 1998* (Qld) should be amended by omitting the current reference to an advance health directive.

***The effect of the guardianship legislation on the operation of a consent or refusal that would otherwise be effective at common law***

**9-26** Chapter 5 of the *Guardianship and Administration Act 2000* (Qld) should be amended to include a new provision that:

- (a) provides that nothing in that Act affects the operation at common law of an adult's consent to, or refusal of, health care given at a time when the adult had capacity to make decisions about the matter; and
- (b) includes a note referring to the similar provision in section 39 of the *Powers of Attorney Act 1998* (Qld).

**9-27** Section 39 of the *Powers of Attorney Act 1998* (Qld) should be amended:

- (a) to provide that nothing in that Act affects the operation at common law of an adult's consent to, or refusal of, health care given at a time when the adult had capacity to make decisions about the matter; and
- (b) to include a note referring to the similar provision in the *Guardianship and Administration Act 2000* (Qld) that gives effect to Recommendation 9-26.

**9-28** Section 79 of the *Guardianship and Administration Act 2000* (Qld) should be amended to make it clear that, in addition to the circumstances currently mentioned in section 79(1), it is not an offence to carry out health care of an adult with impaired capacity for the health matter concerned if the adult consented to the health care at a time when he or she had capacity to make decisions about the matter.

**9-29** Section 79(1) of the *Guardianship and Administration Act 2000* (Qld) should also be redrafted as follows to better reflect the usual requirements for consent:

- (1) It is an offence for a person to carry out health care of an adult with impaired capacity for the health matter concerned unless—
  - (a) the adult consented to the health care at a time when he or she had capacity to make decisions about the matter; or
  - (b) consent to the health care is given under this or another Act; or

- (c) **the health care is authorised by an order of the court made in its parens patriae jurisdiction; or**

*Editor's note—*

***Court*** means the Supreme Court—see schedule 4 (Dictionary). The parens patriae jurisdiction is based on the need to protect those who lack the capacity to protect themselves. It allows the Supreme Court to appoint decision makers for people who, because of mental illness, intellectual disability, illness, accident or old age, are unable to adequately safeguard their own interests.

- (d) **this or another Act provides the health care may be carried out without consent.**

*Editor's note—*

**See sections 63 (Urgent health care), 63A (Life-sustaining measure in an acute emergency) and 64 (Minor, uncontroversial health care).**

# Chapter 10

## Statutory health attorneys

INTRODUCTION .....	119
BACKGROUND.....	120
THE LAW IN QUEENSLAND .....	122
THE LAW IN OTHER JURISDICTIONS .....	124
ACHIEVING THE RIGHT BALANCE AND UNDERSTANDING THE ROLE .....	126
Discussion Paper .....	127
Submissions .....	127
The Commission's view .....	128
IDENTIFYING THE STATUTORY HEALTH ATTORNEY.....	128
Spouse .....	129
Carer .....	131
Close friend or relation .....	133
EXCLUSIONS AND LIMITATIONS .....	139
Discussion Paper .....	140
Submissions .....	140
The Commission's view .....	141
READILY AVAILABLE AND CULTURALLY APPROPRIATE.....	141
Discussion Paper .....	142
Submissions .....	143
The Commission's view .....	143
AN ORDER OF PRIORITY .....	144
Discussion Paper .....	144
Submissions .....	145
The Commission's view .....	146
SCOPE OF STATUTORY HEALTH ATTORNEY'S POWER .....	147
Discussion Paper .....	148
Submissions .....	148
The Commission's view .....	149
THE EFFECTIVENESS OF A DECISION MADE BY A STATUTORY HEALTH ATTORNEY. 150	
Background .....	150
The Commission's view .....	151
RECOMMENDATIONS .....	152

### INTRODUCTION

10.1 As part of its review of the law relating to decisions about health matters under the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld), the Commission's terms of reference specifically direct it to review 'the scope of the decision-making power of statutory health attorneys'.<sup>378</sup> The terms of reference also direct the Commission to have regard, among other

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378

The terms of reference are set out in Appendix 1.

things, to ‘the need to ensure that adults are not deprived of necessary health care because they have impaired capacity’.

10.2 A statutory health attorney has automatic authority under the *Powers of Attorney Act 1998* (Qld) to make health care decisions for the adult when there is no guardian or attorney with authority to do so. The role of statutory health attorney is conferred on spouses, carers, close friends and relations of the adult and, as a last resort, the Adult Guardian.

10.3 This chapter gives an overview of the role of statutory health attorneys in Queensland and outlines similar provisions in other jurisdictions. It then discusses some of the concerns that have been raised about the current provision for statutory health attorneys and makes some recommendations for reform.

## BACKGROUND

10.4 As discussed in Chapter 9, medical treatment ordinarily requires consent from the patient. If an adult lacks capacity, health care decisions will need to be made for the adult by someone else, such as an attorney appointed under an enduring document<sup>379</sup> or a guardian appointed by the Tribunal or the Court.<sup>380</sup> These are formal mechanisms for the giving or refusal of consent to health care for an adult with impaired capacity.

10.5 Although health care ‘is an area in which informal decision-making is commonplace’,<sup>381</sup> the common law does not recognise informal consent from next of kin.<sup>382</sup> In *Re T (Adult: Refusal of Treatment)*, for example, Lord Donaldson MR stated:<sup>383</sup>

There seems to be a view in the medical profession that in such emergency circumstances the next of kin should be asked to consent on behalf of the patient and that, if possible, treatment should be postponed until that consent has been obtained. This is a misconception because the next of kin has no legal right either to consent or to refuse consent.

10.6 Legislative provisions in Queensland for statutory health attorneys, and similar provisions in other jurisdictions, have sought to overcome this obstacle by empowering next of kin and others in close relationships with the adult to make

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379 An enduring document, made by the adult, means an enduring power of attorney or an advance health directive: *Powers of Attorney Act 1998* (Qld) s 28; *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of ‘enduring document’). Enduring powers of attorney are considered in Chapter 16 of this Report and advance health directives are considered in Chapter 9.

380 Consent from a substitute decision-maker is not required, however, if the adult has made a valid and applicable advance health directive.

381 R Creyke, *Who Can Decide? Legal Decision-Making for Others* (1995) 272.

382 Generally C Stewart, ‘Who decides when I can die? Problems concerning proxy decisions to forego medical treatment’ (1997) 4 *Journal of Law and Medicine* 386, 387–8.

383 [1993] Fam 95, 103.

health care decisions in certain circumstances.<sup>384</sup> In Queensland, the legislation gives automatic statutory power for health care decisions to spouses, carers, close friends and relations of the adult, in descending order of priority. The provision applies automatically when there is no advance health directive and no formally appointed substitute decision-maker to make the decision. The role of statutory health attorney is therefore not a formal appointment but operates as a default measure. If there is no-one in the statutory list who is readily available and culturally appropriate, the Adult Guardian becomes the adult's statutory health attorney.<sup>385</sup>

10.7 There are a number of advantages to the statutory recognition of health care decisions by next of kin and others in close relationships with the adult. Firstly, it minimises the need for resort to Court or Tribunal decisions or appointments which may involve considerable expense, delay and intrusion.<sup>386</sup> In this way, the legislation is more 'attuned to the informal environment of everyday life'.<sup>387</sup> Secondly, it is consistent with the 'socially accepted tradition'<sup>388</sup> of conferring authority on those who have 'a close and long-standing relationship' with, and intimate knowledge of, the adult.<sup>389</sup> Thirdly, it fills the gap when the adult has not made an advance health directive or appointed an attorney for health matters under an enduring document. Fourthly, it enhances the flexibility of the guardianship legislation and provides a least restrictive option so that the appointment of a guardian can be an option of last resort rather than the only option.<sup>390</sup>

10.8 There are also, however, some potential disadvantages to the conferral of decision-making authority on next of kin. The primary concern is that the informality of automatic recognition reduces the scope for scrutiny of the substitute

384 See the second reading speech of the Powers of Attorney Bill 1997 (Qld): Queensland, *Parliamentary Debates*, Legislative Assembly, 8 October 1997, 3688 (Denver Beanland, Attorney-General and Minister for Justice). Also the legislation empowers the Tribunal to ratify or approve the exercise of power by an informal decision-maker upon application by an interested person: *Guardianship and Administration Act 2000* (Qld) ss 82(1)(e), 115.

385 In the financial year 2006–07, most (298 or approximately 61 percent) of the 487 consents given to health care for an adult by the Adult Guardian were provided in the Adult Guardian's role as statutory health attorney: Adult Guardian, *Annual Report 2006–07* (2007) 35.

386 Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 333–4.

387 T Carney and P Keyzer, 'Planning for the Future: Arrangements for the Assistance of People Planning for the Future of People with Impaired Capacity' (2007) 7 *Queensland University of Technology Law and Justice Journal* 255, 273.

388 DW Meyers, 'Letting doctor and patient decide: The wisdom of Scots law' in *Comparative and Historical Essays in Scots Law* (1992) 101, quoted in C Stewart, 'Who decides when I can die? Problems concerning proxy decisions to forego medical treatment' (1997) 4 *Journal of Law and Medicine* 386, 387. Also Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 332.

389 C Stewart, 'Who decides when I can die? Problems concerning proxy decisions to forego medical treatment' (1997) 4 *Journal of Law and Medicine* 386, 389; Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 334.

390 T Carney and P Keyzer, 'Planning for the Future: Arrangements for the Assistance of People Planning for the Future of People with Impaired Capacity' (2007) 7 *Queensland University of Technology Law and Justice Journal* 255, 273.

decision-maker. While family members are often in the best position to understand the adult and his or her health care needs, this is not universal. Family members may be ‘well-meaning, but not qualitatively good at decision-making’, or they may have difficulty keeping their own interests separate from the adult’s.<sup>391</sup>

10.9 Many aspects of the legislative scheme for statutory health attorneys are intended to address these matters. For example, the legislation imposes particular obligations on the way in which statutory health attorneys make decisions for the adult and makes provision for oversight by the Tribunal on application by an interested person. The key features of the statutory health attorney provisions are described below.

## THE LAW IN QUEENSLAND

10.10 Section 66 of the *Guardianship and Administration Act 2000* (Qld) sets out the order of priority for dealing with an adult’s health matter for which consent is required.<sup>392</sup> If the matter is not dealt with by an advance health directive, and if there is no guardian or attorney appointed under an enduring power of attorney with authority to make decisions on the matter, consent may be given by the adult’s statutory health attorney.

10.11 The role of statutory health attorney is created in Chapter 4 of the *Powers of Attorney Act 1998* (Qld). A person becomes the adult’s statutory health attorney by operation of section 63 of that Act, and not by formal appointment.

10.12 Section 63 provides a hierarchical order of persons in particular relationships with the adult who will be the adult’s statutory health attorney for the specific health matter in question. It also provides for the Adult Guardian to act as an adult’s statutory health attorney when none of those persons is readily available or culturally appropriate. Section 63 provides:

### 63 Who is the statutory health attorney

- (1) For a health matter, an adult’s **statutory health attorney** is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the matter—
  - (a) a spouse of the adult if the relationship between the adult and the spouse is close and continuing;

<sup>391</sup> P Bartlett and R Sandland, *Mental Health Law Policy and Practice* (2000) 374.

<sup>392</sup> *Guardianship and Administration Act 2000* (Qld) s 66 is considered in Chapter 11 of this Report. See also s 70 of the *Powers of Attorney Act 1998* (Qld), which provides that, if a guardian has been appointed for the adult, a statutory health attorney may exercise power only to the extent authorised by the Tribunal; and s 24 of the *Guardianship and Administration Act 2000* (Qld), which protects a statutory health attorney from liability if the attorney purports to exercise power for a matter without knowing that the power has been given by the Tribunal to a guardian.

Not all health care requires consent. In certain circumstances, urgently required health care and health care that is minor and uncontroversial can be given without consent: *Guardianship and Administration Act 2000* (Qld) ss 63, 64. In addition, first aid treatment, non-intrusive examination for diagnostic purposes, and administration of certain non-prescription pharmaceutical drugs are not characterised as ‘health care’ for which consent is required under the legislation: *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(3).

- (b) a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult;
  - (c) a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.<sup>62</sup>
- (2) If no-one listed in subsection (1) is readily available and culturally appropriate to exercise power for a matter, the adult guardian is the adult's **statutory health attorney** for the matter.
- (3) Without limiting who is a **person who has the care of the adult**, for this section, a person has the care of an adult if the person—
- (a) provides domestic services and support to the adult; or
  - (b) arranges for the adult to be provided with domestic services and support.
- (4) If an adult resides in an institution (for example, a hospital, nursing home, group home, boarding-house or hostel) at which the adult is cared for by another person, the adult—
- (a) is not, merely because of this fact, to be regarded as being in the care of the other person; and
  - (b) remains in the care of the person in whose care the adult was immediately before residing in the institution.

62 If there is a disagreement about which of 2 or more eligible people should be the statutory health attorney or how the power should be exercised, see the *Guardianship and Administration Act 2000*, section 42 (Disagreement about health matter).

10.13 The first category under section 63(1) is a spouse of the adult if the relationship between the adult and the spouse is close and continuing. The term 'spouse' is defined in section 36 of the *Acts Interpretation Act 1954* (Qld) to include a de facto partner.<sup>393</sup>

10.14 Under section 62 of the *Powers of Attorney Act 1998* (Qld), a statutory health attorney has authority, if the adult has impaired capacity for the health matter, to make any decision about the matter that the adult could lawfully make if he or she had capacity for the matter. Consent given by a statutory health attorney has the same effect as if the consent had been given by the adult and the adult had capacity to do so.<sup>394</sup>

10.15 When making a decision about the adult's health care, the statutory health attorney has a right to the information necessary to make informed decisions for the adult,<sup>395</sup> and must apply the General Principles and the Health Care Principle.<sup>396</sup>

393 Under s 32DA of the *Acts Interpretation Act 1954* (Qld), a reference to 'de facto partner' means a reference to either one of two persons living together as a couple on a genuine domestic basis but who are not married to each other or related by family. Gender is irrelevant.

394 *Powers of Attorney Act 1998* (Qld) s 101; *Guardianship and Administration Act 2000* (Qld) s 80.

395 *Powers of Attorney Act 1998* (Qld) s 81; *Guardianship and Administration Act 2000* (Qld) s 76(2). This issue is examined in Chapter 30 of this Report.

The Health Care Principle provides, for example, that power for an adult's health matters should be exercised in the way that is least restrictive of the adult's rights, and only if it is either necessary and appropriate to maintain or promote the adult's health or wellbeing, or if it is in the adult's best interests.<sup>397</sup> It also requires the adult's views and wishes, and information from the health provider, to be taken into account. The General Principles are discussed in Chapter 4 and the Health Care Principle in Chapter 5.

10.16 Statutory health attorneys are also under an obligation to maintain confidential information,<sup>398</sup> and to consult with any guardian, administrator or other attorney for the adult.<sup>399</sup>

10.17 The guardianship legislation also contains provisions addressing the extent to which statutory health attorneys will be held liable for a breach of the legislation<sup>400</sup> and includes provisions to protect health providers who rely on consent given by a statutory health attorney, or a purported consent, in certain circumstances.<sup>401</sup>

10.18 In addition, the legislation enables the adult or any interested person<sup>402</sup> to make an application to the Tribunal for a declaration, order, direction, recommendation or advice in relation to a statutory health attorney.<sup>403</sup>

## THE LAW IN OTHER JURISDICTIONS

10.19 A number of Australian jurisdictions include provisions equivalent to those in Queensland for statutory health attorneys. In New South Wales, Tasmania, Victoria and Western Australia, the legislation makes provision for a hierarchy of

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396 *Powers of Attorney Act 1998* (Qld) s 76; *Guardianship and Administration Act 2000* (Qld) s 11(1).

397 *Powers of Attorney Act 1998* (Qld) sch 1 s 12.

398 *Powers of Attorney Act 1998* (Qld) s 74. The confidentiality provisions of the legislation were the subject of recommendations in stage one of the Commission's review: Queensland Law Reform Commission, *Public Justice, Private Lives: A New Approach to Confidentiality in the Guardianship System*, Report No 62 (2007) vol 1.

399 *Powers of Attorney Act 1998* (Qld) s 79.

400 *Powers of Attorney Act 1998* (Qld) s 105 (Relief from personal liability); *Guardianship and Administration Act 2000* (Qld) s 24 (Protection if unaware of appointment). Also *Guardianship and Administration Act 2000* (Qld) s 78 (Offence to exercise power for adult if no right to do so).

401 *Powers of Attorney Act 1998* (Qld) ss 101 (No less protection than if adult gave health consent), 104 (Protection for person carrying out forensic examination with consent); *Guardianship and Administration Act 2000* (Qld) ss 77 (Protection of health provider), 80 (No less protection than if adult gave health consent).

402 An interested person is defined as a person with a sufficient and continuing interest in the adult: *Powers of Attorney Act 1998* (Qld) sch 3; *Guardianship and Administration Act 2000* (Qld) sch 4.

403 *Powers of Attorney Act 1998* (Qld) ss 109A, 110(1)–(2); *Guardianship and Administration Act 2000* (Qld) ss 82(1)(d)(ii), (3), 115. The monitoring role of the Tribunal was supported as an important safeguard in the context of substitute decision-making by statutory health attorneys: eg Queensland Advocacy Incorporated, *Newsletter July 1998*, 10, 15 <[http://www.qai.org.au/documents/doc\\_82.doc](http://www.qai.org.au/documents/doc_82.doc)> at 11 May 2010. See also s 97 of the *Powers of Attorney Act 1998* (Qld) (Protection if court advice, directions or recommendations).

'persons responsible' for medical or dental treatment decisions.<sup>404</sup> In South Australia, the legislation provides for an 'appropriate authority' to give consent to medical or dental treatment.<sup>405</sup>

10.20 There are differences between the provisions but, in general terms, the legislation in each of those jurisdictions gives authority to people in specified relationships with the adult when there is no formally appointed decision-maker with authority to decide. This is consistent with the position in Queensland.

10.21 For example, in South Australia, if there is no medical agent for the adult (the equivalent of an attorney appointed under an enduring power of attorney for medical matters), medical decisions are to be made by the adult's guardian or, if there is no guardian, a relative of the adult or the Tribunal.

10.22 The equivalent decision-makers recognised by the legislation in New South Wales and Tasmania are the same as Queensland. Authority is given to the adult's spouse, carer or close friend or relation, in that order, when there is no formally appointed decision-maker for the matter.

10.23 The position in Victoria and Western Australia is also similar to Queensland. In Victoria, the person responsible when there is no appointed decision-maker is, in order of priority, the adult's spouse or domestic partner, the adult's primary carer, or the adult's nearest relative. In Western Australia, authority is given, in the listed order, to the adult's spouse or de facto partner, the nearest relative of the adult who is in a close personal relationship with the adult, the adult's primary carer, or another person in a close personal relationship with the adult.

10.24 The legislation in South Australia differs. When there is no appointed decision-maker, authority is conferred on a relative of the adult or the Tribunal. A relative is defined as the adult's spouse or domestic partner, a parent, a person charged with overseeing the ongoing day-to-day supervision, care and well-being of the person, an adult sibling or an adult child. Unlike the other jurisdictions, however, there is no order of priority or hierarchy specified as between any of those persons.

10.25 Most of these jurisdictions also provide for the way in which decisions about medical treatment are to be made by persons responsible. In Tasmania and Victoria, the person responsible must act in the adult's best interests.<sup>406</sup> In South Australia, paramount consideration is to be given to the adult's wishes.<sup>407</sup> In New South Wales, the person responsible must take into account the adult's views, the information provided by the health provider and the objects of Part 5 of the legislation; namely, to ensure that the adult is not deprived of necessary medical or

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404 *Guardianship Act 1987* (NSW) ss 33A(4), 36; *Guardianship and Administration Act 1995* (Tas) ss 4(1)(c), 39; *Guardianship and Administration Act 1986* (Vic) ss 37, 39; *Guardianship and Administration Act 1990* (WA) s 110ZD.

405 *Guardianship and Administration Act 1993* (SA) ss 3 (definition of 'relative'), 59.

406 *Guardianship and Administration Act 1995* (Tas) s 43; *Guardianship and Administration Act 1986* (Vic) ss 38, 42H(2).

407 *Guardianship and Administration Act 1993* (SA) s 5.

dental treatment and that treatment is carried out to promote and maintain the adult's health and wellbeing.<sup>408</sup>

10.26 In each of the jurisdictions, consent given by the person responsible has effect as if the adult had been capable of giving consent and the treatment had been carried out with the adult's consent.<sup>409</sup>

10.27 The legislation in Victoria also allows the person responsible to apply to the Tribunal for directions, orders or advisory opinions about the scope or exercise of his or her authority to give consent.<sup>410</sup> In Western Australia, a person may apply to the Tribunal for a declaration about who the person responsible for the adult is.<sup>411</sup>

10.28 The approach of the Australian jurisdictions is similar to that taken in a number of Canadian provinces. For example, the legislation in Ontario provides a list of persons, in order of priority, who may give or refuse consent for an adult: the adult's guardian, attorney, representative, spouse or partner, child or parent, sibling or any other relative of the adult.<sup>412</sup> If no person in that list meets the requirements of the legislation, the Public Guardian and Trustee shall make the decision.

10.29 This approach differs substantially, however, from the approach adopted in the United Kingdom and Scotland. In those jurisdictions, the legislation confers general authority on the health provider to do what he or she considers is in the adult's best interests.<sup>413</sup>

## ACHIEVING THE RIGHT BALANCE AND UNDERSTANDING THE ROLE

10.30 The role of statutory health attorney was created to fill a gap in the scheme for consent to health care for adults with impaired capacity when there is no formally appointed decision-maker. The role operates without a formal appointment or order. Statutory health attorneys are authorised under the legislation to make health care decisions as the need arises.

408 *Guardianship Act 1987* (NSW) s 40(3).

409 *Guardianship Act 1987* (NSW) s 46(1); *Guardianship and Administration Act 1993* (SA) s 59(1); *Guardianship and Administration Act 1995* (Tas) s 47; *Guardianship and Administration Act 1986* (Vic) s 40; *Guardianship and Administration Act 1990* (WA) s 110ZK(2).

410 *Guardianship and Administration Act 1986* (Vic) ss 42I, 42N.

411 *Guardianship and Administration Act 1990* (WA) s 110ZG.

412 *Health Care Consent Act*, SO 1996, c 2, sch A, s 20. Similar provision is made in British Columbia and Manitoba: *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 16; *Mental Health Act*, CCSM, c M110, s 28.

413 Under s 5 of the *Mental Capacity Act 2005* (UK), a person may do an act 'in connection with the care or treatment' of an adult without incurring liability if the person reasonably believes that the adult lacks capacity in relation to the matter and that it will be in the adult's best interests to do the act. Under s 47 of the *Adults with Incapacity (Scotland) Act 2000*, the medical practitioner with primary responsibility for the adult's medical treatment has general authority 'to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the adult'.

10.31 Conferral of automatic statutory authority minimises the need for applications to the Tribunal or the Court, allows decisions to be made in a timely manner, and helps ensure adults are not deprived of necessary health care. The legislation also includes safeguards against abuse, neglect and exploitation. For example, it requires statutory health attorneys to apply the General Principles and the Health Care Principle when making decisions for the adult. The statutory health attorney provisions are thus generally consistent with the principles enunciated in the *Convention on the Rights of Persons with Disabilities*.<sup>414</sup>

## Discussion Paper

10.32 In the Discussion Paper, the Commission sought submissions about whether the current scheme for the exercise of power by statutory health attorneys achieves the right balance.<sup>415</sup> The Commission noted that flexibility and timeliness are important when making decisions about health care, but safeguards against inappropriate substitute decision-making are also important considerations.<sup>416</sup>

10.33 As it has been suggested that the name ‘statutory health attorney’ may be confusing since the word ‘attorney’ is used to describe a person who is appointed under an enduring power of attorney,<sup>417</sup> the Commission also sought submissions about whether the name ‘statutory health attorney’ should be changed to something else which better reflects the operation of the role as one that is automatically conferred, rather than the subject of a specific appointment.<sup>418</sup>

## Submissions

10.34 Several respondents, including the Adult Guardian and the Department of Communities, considered that the current scheme for the exercise of power by statutory health attorneys achieves the right balance.<sup>419</sup>

10.35 The Christian Science Committee on Publication for Queensland was not aware of any difficulties in practice with the existing balance. It also noted the importance of a hierarchy which supports those who are closest to the individual

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414 The United Nations Convention provides, among other things, that measures to support the exercise of an adult’s capacity should be proportional and tailored to the person’s circumstances and should apply for the shortest time possible. It also recognises the right of persons with disabilities to enjoy the highest attainable standard of health without discrimination on the basis of disability. The Convention also recognises the need for people with disabilities to be protected from neglect, abuse or exploitation. See United Nations, *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 13 December 2006, arts 12(4), 25, 16.

415 Queensland Law Reform Commission, *A Review of Queensland’s Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 219.

416 Ibid [10.32].

417 Submission C87B.

418 Queensland Law Reform Commission, *A Review of Queensland’s Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 219.

419 Submissions 164, 169, 177.

and who are familiar with his or her religious and cultural preferences.<sup>420</sup>

10.36 One respondent considered that the name 'statutory health attorney' is appropriate.<sup>421</sup> On the other hand, Queensland Health suggested that the name should be changed to reflect the operation of the role as one which is conferred on a person who acts informally as a decision-maker for health care decisions.<sup>422</sup> Another respondent suggested, as an alternative, the name 'representative at large'.<sup>423</sup>

### The Commission's view

10.37 The current scheme for statutory health attorneys under the *Powers of Attorney Act 1998* (Qld) is an important component of the legislative framework for substitute decision-making in Queensland. The Act authorises the adult's immediate family and others in close relationships with the adult to make health care decisions for the adult where there is no formally appointed substitute decision-maker for those decisions. This fills a gap in the legislation and facilitates the continuation of informal decision-making arrangements in other areas. The Act also requires statutory health attorneys, when making health care decisions for the adult, to apply both the General Principles and the Health Care Principle and provides a mechanism for the resolution of disputes. The Commission is of the view that this scheme generally achieves an appropriate balance between the flexibility and timeliness of a mechanism for providing substitute consent to health care and the need for safeguards against abuse.

10.38 The Commission is aware that some people may consider that the name 'statutory health attorney' may be confusing as a consequence of the word 'attorney' being used to describe a person who is appointed under an enduring power of attorney. However, the Commission is of the view that the name 'statutory health attorney' should not be changed. The *Powers of Attorney Act 1998* (Qld), under which a statutory health attorney is authorised to make health care decisions, has been in force for more than a decade. If the Act were amended to change the name 'statutory health attorney', it may create additional confusion. It would be preferable to deal with any issues about the name 'statutory health attorney' through other means, for example, community education.

### IDENTIFYING THE STATUTORY HEALTH ATTORNEY

10.39 Section 63 of the *Powers of Attorney Act 1998* (Qld) provides that the statutory health attorney for the adult is the first person who is readily available and culturally appropriate to exercise power for the matter in the listed order of the adult's spouse, a person who has the care of the adult, and a close friend or

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420 Submission 151.

421 Submission 177.

422 Submission C87B.

423 Submission 165.

relation of the adult. If no-one in that list is readily available and culturally appropriate, the Adult Guardian is the statutory health attorney.

10.40 The list of persons set out in section 63 may raise a number of issues for consideration. In particular, complex family dynamics and cultural differences may mean there are difficulties in identifying the statutory health attorney. The terms used in section 63 may require further clarification. This may be important since the provisions, which are intended to operate automatically, need to be easily comprehended by health providers, family members and others in the community.

## Spouse

10.41 The first person listed in section 63(1) of the *Powers of Attorney Act 1998* (Qld) is the adult's spouse. As explained earlier, by virtue of the *Acts Interpretation Act 1954* (Qld), a spouse includes a de facto partner, including a same-sex partner.<sup>424</sup> By way of clarification, it may be useful for a reference to this to be included in a footnote to section 63.

10.42 The Act limits the circumstances in which a spouse will be considered the statutory health attorney under section 63(1)(a). It includes a spouse 'if the relationship between the adult and the spouse is close and continuing'. This restriction also appears in the legislation of most of the other jurisdictions.<sup>425</sup> In contrast, the Western Australian legislation specifies that the spouse must be 'living with the patient'.<sup>426</sup>

10.43 The requirements for a 'close and continuing' relationship are not defined in the legislation and the Tribunal has given its meaning only limited consideration. *Re MV*<sup>427</sup> appears to be one of the few cases in which the Tribunal has specifically considered whether a spouse had a close and continuing relationship with the adult in deciding whether the spouse should act as the adult's statutory health attorney. In that case, the Tribunal declared that the adult's daughter was the statutory health attorney, finding that the adult's wife did not have a close and continuing relationship with him:<sup>428</sup>

[Mr MV] has been married for 37 years to Mrs M who is eighty. Mr MV has been suffering from Parkinson's Disease for at least ten years and has been in the care of Dr Silburn a specialist neurologist for the last seven years. He now resides at a Home for the Aged having lived at his home until late 2004 with his

424 *Acts Interpretation Act 1954* (Qld) s 36. See [10.13] above.

425 *Guardianship Act 1987* (NSW) s 33A(4)(c); *Guardianship and Administration Act 1995* (Tas) s 4(5)(a); *Guardianship and Administration Act 1986* (Vic) s 37(4). Also in British Columbia and Manitoba, the person is not qualified to give consent unless he or she has been in contact with the adult in the preceding 12 months: *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 16(2); *Mental Health Act*, CCSM, c M110, s 28(3).

426 *Guardianship and Administration Act 1990* (WA) s 110ZD(3)(a), (5).

427 [2005] QGAAT 46.

428 *Re MV* [2005] QGAAT 46, [1], [83]–[85]. See also, for example, *ZS and ZT v Public Guardian* [2007] NSWADT 57, [10] in which weight was given to the wife's 'frequent and long visits' with the adult.

wife. Mr MV has a daughter Mrs TR from his first marriage and Mrs M has one daughter from her first marriage, Mrs TN.

...

The *Powers of Attorney Act 1998* actually sets up a regime allowing informal decision makers, called statutory health attorneys, to make decisions for adults when they have lost capacity. However, for this regime to successfully operate it is necessary for the Tribunal to declare who is Mr MV's statutory health attorney because under section 63 of that Act, Mr MV's statutory health attorney would normally be his spouse. However this priority to the spouse is defeated if the relationship is not a close and continuing relationship.

In this regard therefore the Tribunal makes the following findings:

- (a) Mrs M and Mr MV have been physically separated since November 2004.
- (b) Mrs M has only had infrequent contact with Mr MV during this time.
- (c) Mr MV's expressed wish is that he does not want contact with Mrs M and he does not want her to make any decisions for him.
- (d) There is continuing conflict between Mrs M and Mrs TR as to who should be making health decisions for Mr MV.
- (e) The decision as to where Mr MV should receive high care assistance is a health decision which a statutory health attorney may make once Mr MV has lost capacity.

### Conclusion

The Tribunal therefore declares that Mrs TR is Mr MV's statutory health attorney and she should be the one who makes decisions for Mr MV when he is no longer able to make health decisions for himself.

10.44 From this decision, it appears that the frequency of contact, how recently contact had occurred, and the adult's expressed wishes about contact, were important factors in determining whether the relationship is close and continuing. This is consistent with comments made by the Tribunal in different contexts. For example, in *Re EJC*, the Tribunal was satisfied that the adult's daughter was appropriate for appointment as administrator partly on the basis that she had a 'close and continuing relationship' with the adult:<sup>429</sup>

by living with her for some 20 years, continuing to visit her regularly in the nursing home and by their liquid assets being jointly held in bank accounts.

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[2000] QGAAT 3, [35]. See also *Re HG* [2006] QGAAT 26, [72] in which the Tribunal described the adult's paid carer as having a 'close and continuing relationship' with the adult when considering the carer's evidence with respect to whether or not the adult would have wanted the life-sustaining treatment to be withdrawn:

SG has been a paid carer with the support service five days a week for the past five years and she has developed a close and continuing relationship with HG which goes beyond the provision of paid services. HG has become a friend and part of her family.

### **Discussion Paper**

10.45 In the Discussion Paper, the Commission sought submissions about whether section 63 of the *Powers of Attorney Act 1998* (Qld) should attempt to define the term ‘close and continuing relationship’, or whether that term is sufficiently flexible to cover the range of people to whom it is intended to apply.<sup>430</sup> The Commission also sought submissions about how, if the Act were to include a definition, it should be framed.<sup>431</sup>

### **Submissions**

10.46 The Adult Guardian commented that, in the practice of her Office, this issue is rarely contentious.<sup>432</sup>

10.47 One respondent considered the term ‘close and continuing relationship’ is sufficiently flexible for its purpose.<sup>433</sup> Another respondent suggested that a new definition may have the effect of being too restrictive.<sup>434</sup>

### **The Commission’s view**

10.48 In the Commission’s view, it is unnecessary for section 63 of the *Powers of Attorney Act 1998* (Qld) to attempt to define the term ‘close and continuing relationship’. Such a measure would be overly prescriptive and difficult to achieve. The term ‘close and continuing relationship’ is sufficiently flexible to cover the range of people to whom it is intended to apply. As shown by the Tribunal’s decisions in *Re MV* and *Re EJC*, mentioned above, there are a range of factors that may be relevant in determining whether a relationship is close and continuing. It is desirable that, when making such a determination, the Tribunal has the flexibility to make such finding as it considers appropriate in the circumstances.

10.49 For the sake of clarity, the Commission also considers that a footnote reference to section 36 of the *Acts Interpretation Act 1954* (Qld), which defines the term ‘spouse’ to include a de facto partner (regardless of gender), should be inserted in section 63(1)(a) of the *Powers of Attorney Act 1998* (Qld).

### **Carer**

10.50 The second person recognised under section 63(1) of the *Powers of Attorney Act 1998* (Qld) is a person, 18 years or older, who has the care of the

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430 Queensland Law Reform Commission, *A Review of Queensland’s Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 222.

431 Ibid.

432 Submission 164.

433 Submission 177.

434 Submission 165.

adult and is not a paid carer<sup>435</sup> for the adult. This is consistent with the legislation in the other jurisdictions.<sup>436</sup>

10.51 Section 63(3)–(4) clarifies when a person is taken to have the care of an adult:

- (3) Without limiting who is a *person who has the care of the adult*, for this section, a person has the care of an adult if the person—
  - (a) provides domestic services and support to the adult; or
  - (b) arranges for the adult to be provided with domestic services and support.
- (4) If an adult resides in an institution (for example, a hospital, nursing home, group home, boarding-house or hostel) at which the adult is cared for by another person, the adult—
  - (a) is not, merely because of this fact, to be regarded as being in the care of the other person; and
  - (b) remains in the care of the person in whose care the adult was immediately before residing in the institution.

10.52 The legislation in New South Wales, Tasmania and Victoria includes similar provisions as to when a person is considered a carer for the adult.<sup>437</sup> However, each of those jurisdictions provides that a carer is someone who *regularly* provides or arranges domestic services and support for the adult. An issue to consider is whether a similar condition should be included in the Queensland definition. This may help ensure that authority is conferred on a carer only when he or she has an ongoing involvement with the adult.<sup>438</sup>

### Discussion Paper

10.53 In the Discussion Paper, the Commission sought submissions about whether section 63(3) of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that a person who has the care of the adult is someone who regularly

<sup>435</sup> A 'paid carer' is defined in the legislation as someone who performs services for the adult's care and receives remuneration for the services, other than from a Commonwealth or State carer payment or benefit or remuneration attributable to the adult that damages may be awarded by a court for voluntary services performed for the adult: *Powers of Attorney Act 1998* (Qld) sch 3.

<sup>436</sup> *Guardianship Act 1987* (NSW) s 33A(4)(c); *Guardianship and Administration Act 1993* (SA) ss 59(2)(b)(i), 3(c)(ii) (definition of 'relative'); *Guardianship and Administration Act 1995* (Tas) s 4(1)(c)(iii); *Guardianship and Administration Act 1986* (Vic) s 37(1)(g); *Guardianship and Administration Act 1990* (WA) s 110ZD(3)(c).

<sup>437</sup> *Guardianship Act 1987* (NSW) s 3D; *Guardianship and Administration Act 1995* (Tas) s 4(3)–(4); *Guardianship and Administration Act 1986* (Vic) s 37(2)–(3).

<sup>438</sup> Carers are not separately included in the equivalent scheme for health care consent in British Columbia, Ontario or Manitoba. In those jurisdictions, the decision-makers are limited to spouses and family members and relatives. In British Columbia and Manitoba, those persons cannot make a health care decision unless, among other things, they have been in contact with the adult in the preceding 12 months: *Health Care (Consent) and Care Facility (Admission) Act*, RSCB 1996, c 181, s 16(2); *Mental Health Act*, CCSM, c M110, s 28(3).

provides or arranges domestic services and support for the adult.<sup>439</sup>

### **Submissions**

10.54 The Adult Guardian was not aware of this issue causing any particular problems.<sup>440</sup> Another respondent considered that the insertion of the word 'regularly' in section 63(3) may be useful.<sup>441</sup>

### **The Commission's view**

10.55 The Commission is of the view that section 63(3) of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that a person who has the care of the adult is someone who *regularly* provides or arranges domestic services and support for the adult. As noted above, this qualification would help ensure that a carer who falls within this category of statutory health attorney has an ongoing interest in the adult and is likely to be in a position to know the adult's views and wishes (if any).

### **Close friend or relation**

10.56 The final category of persons recognised under section 63(1) of the *Powers of Attorney Act 1998* (Qld) is 'a close friend or relation of the adult who is not a paid carer'<sup>442</sup> for the adult'.<sup>443</sup>

### **Relation**

10.57 The *Powers of Attorney Act 1998* (Qld) includes the following definition of 'relation':<sup>444</sup>

**relation**, of a person, means—

- (a) a spouse of the first person; or
- (b) a person who is related to the first person by blood, marriage or adoption or because of a de facto relationship, foster relationship or a relationship arising because of a legal arrangement; or

*Example of legal arrangement—*

- 1 court order for custody
- 2 trust arrangement between trustee and beneficiary

<sup>439</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 223.

<sup>440</sup> Submission 164.

<sup>441</sup> Submission 177.

<sup>442</sup> 'Paid carer' is defined in the legislation. See n 435 above.

<sup>443</sup> *Powers of Attorney Act 1998* (Qld) s 63(1)(c).

<sup>444</sup> *Powers of Attorney Act 1998* (Qld) sch 3.

- (c) a person on whom the first person is completely or mainly dependent;  
or
- (d) a person who is completely or mainly dependent on the first person; or
- (e) a person who is a member of the same household as the first person.

10.58 This definition is not specific to section 63 of the Act but also applies in relation to a number of other provisions. For example, it applies for the purpose of section 44(7) of the Act under which a doctor is excluded from attesting to the principal's capacity to make an advance health directive if he or she is a relation of the principal or of an attorney of the principal. It also applies for the purpose of section 73 of the Act in relation to an attorney's duty to avoid conflict transactions.<sup>445</sup>

10.59 A question that arises for consideration is whether the current definition of 'relation' is appropriate for the purpose of section 63(1)(c) of the *Powers of Attorney Act 1998* (Qld).<sup>446</sup>

10.60 For example, 'relation' of a person is defined to include a spouse of that person. As explained earlier, section 63(1)(a) of that Act lists as the first category of statutory health attorney 'a spouse of the adult if the relationship between the adult and the spouse is close and continuing'. The effect of also including a spouse in the definition of 'relation' for section 63(1)(c) is that, if there is not a close and continuing relationship between the adult and his or her spouse (for example, where the adult and his or her spouse have separated), the spouse may nevertheless be a statutory health attorney for the adult.

10.61 Another issue is whether it is appropriate for a trustee or beneficiary in relation to property of the adult to have authority to make health care decisions for the adult on the basis solely of that legal relationship. Further, a person who is completely or mainly dependent on the adult may not necessarily be suitable for the role of statutory health attorney.

10.62 Another question for consideration is whether the definition of 'relation' for section 63(1) of the *Powers of Attorney Act 1998* (Qld) should be consistent with the definition of 'senior available next of kin' under the *Transplantation and Anatomy Act 1979* (Qld). Under that Act, authority to consent to the removal of tissue from the body of a deceased person for donation is conferred on the senior available next of kin.<sup>447</sup> For an adult, the senior available next of kin is defined

<sup>445</sup> Also *Powers of Attorney Act 1998* (Qld) ss 31 (Meaning of eligible witness), 87 (Presumption of undue influence), 88 (Gifts).

<sup>446</sup> Also the reference in paragraph (b) of the definition to a 'court order for custody' does not reflect the contemporary nomenclature of the *Family Law Act 1975* (Cth).

<sup>447</sup> *Transplantation and Anatomy Act 1979* (Qld) ss 22, 23. The guardianship legislation makes specific provision for consent to certain types of special health care, including removal of tissue from an adult while alive for donation to someone else: *Powers of Attorney Act 1998* (Qld) sch 2 s 7. A statutory health attorney does not, however, have authority to give consent to special health care: s 62.

as:<sup>448</sup>

- (b) ... the first of the following persons who, in the following order of priority, is reasonably available—
  - (i) the spouse of the person;
  - (ii) a son or daughter, who has attained the age of 18 years, of the person;
  - (iii) a parent of the person;
  - (iv) a brother or sister, who has attained the age of 18 years, of the person.

10.63 However, the hierarchy of ‘senior available next-of-kin’ under the *Transplantation and Anatomy Act 1979* (Qld) is a rigid hierarchy, reflecting the difference between the nature of decisions made under that Act and decisions made by a statutory health attorney. In the case of the *Transplantation and Anatomy Act 1979* (Qld), a decision is usually a one-off decision that has to be made quickly close to the time of an adult’s death. In the context of the guardianship legislation, however, it may be more appropriate to ensure that a decision about the adult’s health care is made by a person who has a close relationship with the adult, and who is therefore likely to know if the adult has any views and wishes in relation to the decision. Further, the inclusion of a spouse of the adult in the definition of ‘relation’ as is provided for in the definition of ‘senior available next-of-kin’ under the *Transplantation and Anatomy Act 1979* (Qld), would have the same effect as noted at [10.60] above.

### **Close friend**

10.64 The *Powers of Attorney Act 1998* (Qld) also includes a definition of ‘close friend’:<sup>449</sup>

**close friend**, of a person, means another person who has a close personal relationship with the first person and a personal interest in the first person’s welfare.

10.65 As with the definition of ‘relation’, this definition applies to section 63 as well as to several other provisions in the Act.<sup>450</sup>

10.66 An issue to consider is whether the current definition of ‘close friend’ is sufficient for the purpose of section 63(1)(c). The legislation in New South Wales and Tasmania, for example, includes a similar, but more detailed, definition. Section 4(5)(b)–(e) of the *Guardianship and Administration Act 1995* (Tas) provides, for example:

448 *Transplantation and Anatomy Act 1979* (Qld) s 4.

449 *Powers of Attorney Act 1998* (Qld) sch 3.

450 *Powers of Attorney Act 1998* (Qld) ss 73 (Avoid conflict transaction), 87 (Presumption of undue influence), 88 (Gifts).

(5) For the purposes of this section—

...

- (b) a person is taken to be a close friend or relative of another person if the person maintains both a close personal relationship with the other person through frequent personal contact and a personal interest in the other person's welfare; and
- (c) a person is taken not to be a close friend or relative if the person is receiving remuneration (whether from the person or some other source) for any services that he or she performs for the other person in relation to the person's care; and
- (d) a reference to remuneration is to be read as not including a reference to a carer's pension; and
- (e) the President may issue guidelines, not inconsistent with this section, specifying the circumstances in which a person is to be regarded as a close friend or relative of another person.

10.67 This definition includes the requirement of frequent personal contact. An issue to consider is whether similar provision should be made in Queensland.

### ***Discussion Paper***

10.68 In the Discussion Paper, the Commission sought submissions on the issue of whether the definition of 'relation' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) should apply to the reference to a 'close friend or relation' in section 63 of the Act.<sup>451</sup> The Commission also sought submissions on whether, alternatively, any of the following categories of persons in the definition of 'relation' should be excluded for the purpose of section 63.<sup>452</sup>

- a spouse of the first person;
- a person who is related to the first person by blood, marriage or adoption or because of a de facto relationship, foster relationship or a relationship arising because of a legal arrangement such a parenting order or a trust arrangement between trustee and beneficiary;
- a person on whom the first person is completely or mainly dependent;
- a person who is completely or mainly dependent on the first person; and
- a person who is a member of the same household as the first person.

10.69 The Commission also sought submissions in relation to whether, as a further alternative, a new definition of 'relation', based on the definition of 'senior

<sup>451</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 226.

<sup>452</sup> *Ibid* 226–7.

available next of kin' in the *Transplantation and Anatomy Act 1979* (Qld), should apply to section 63 of the *Powers of Attorney Act 1998* (Qld) and, if so, whether the definition should be modified to exclude the reference to a spouse.<sup>453</sup>

10.70 The Commission also sought submissions on whether the definition of 'close friend' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) is sufficient for the purpose of section 63 of the Act and, if not, how the definition, to the extent it applies to section 63, should be modified.<sup>454</sup>

### **Submissions**

#### *Relation*

10.71 The Adult Guardian did not perceive that the definition of 'relation' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) raised difficulties in practice.<sup>455</sup> However, she commented that, if the definition were amended for the purposes of section 63 of the Act, it should be modified to exclude a spouse (who is already listed in the hierarchy), relationships of dependency and financial decision-makers.

10.72 One respondent considered that the definition of 'relation' as applied in section 63 of the Act should not include a person who is in a relationship arising because of a legal relationship or a person who is completely or mainly dependent on the first person.<sup>456</sup> This respondent considered that a person who is a member of the same household should be able to act as an adult's statutory health attorney unless that household is an institutional group home.

10.73 One person at a community forum suggested that within the category of 'relation' only a 'close and significant' relation should be eligible to be a statutory health attorney.<sup>457</sup>

10.74 Another respondent considered the definition of 'relation' should be applied consistently within the Act.<sup>458</sup>

#### **Close friend**

10.75 Several respondents, including the Adult Guardian, considered the definition of 'close friend' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) is sufficient for its purpose.<sup>459</sup>

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453 Ibid 227.

454 Ibid.

455 Submission 164.

456 Submission 177.

457 Forum 9.

458 Submission 165.

459 Submissions 164, 165, 177.

### ***The Commission's view***

#### *Relation*

10.76 The Commission considers that the current definition of 'relation' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) should not apply to the reference to a 'close friend or relation' in section 63 of the Act.

10.77 The current definition, which has a wider application under the Act, would appear to be unsuitable for use in the particular context of the scheme for statutory health attorneys in several respects. Given that a spouse who is in a close and continuing relationship with the adult is given the highest priority in the statutory hierarchy, it is questionable whether the definition of 'relation' should enable a spouse who is *not* in a close and continuing relationship with the adult to become a statutory health attorney. It is also difficult to see how some of the other categories of person listed in the definition of 'relation' would be appropriate to make health care decisions for an adult; for example, a person who is completely or mainly dependent on the adult or a person who is related to the adult by a relationship arising because of a legal arrangement.

10.78 In light of these issues, the Commission considers that, for the purposes of section 63 of the *Powers of Attorney Act 1998* (Qld), the definition of 'relation' should be reformulated to include the following categories of person:

- a person who is related to the first person by blood, marriage or adoption or because of a de facto relationship or a foster relationship;
- for an Aboriginal person — includes a person who, under Aboriginal tradition, is regarded as a relative mentioned in the first paragraph;
- for a Torres Strait Islander — includes a person who, under Island custom, is regarded as a relative mentioned in the first paragraph.

10.79 The definition proposed by the Commission is broader than the kinship relationships referred to in the definition of 'senior available next of kin' in the *Transplantation and Anatomy Act 1979* (Qld). However, in the context of the scheme for statutory health attorneys, it is essential to ensure that the definition of 'relation' reflects a broad range of family and other close personal relationships and cultural considerations rather than a hierarchy which is limited to immediate family relationships.

#### *Close friend*

10.80 The Commission considers that the definition of 'close friend' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) is appropriate for the purpose of section 63 of the Act and should not be modified. The definition is sufficiently flexible to take into account a wide range of close relationships and circumstances.

## EXCLUSIONS AND LIMITATIONS

10.81 Section 63(1) of the *Powers of Attorney Act 1998* (Qld) imposes some restrictions on the persons who may be recognised as a statutory health attorney. For example, a spouse is not recognised unless he or she has a close and continuing relationship with the adult,<sup>460</sup> and a carer or close friend or relation must be at least 18 years old and must not be a paid carer for the adult.

10.82 In the majority of cases, decision-making by family members and others in personal relationships with the adult will be preferable to decision-making by a statutory agency. Restrictions on who can be a statutory health attorney are, however, an important safeguard against potential conflicts of interest and abuse. Care should also be taken that the provisions are not so restrictive as to significantly limit their utility. An issue to consider is whether the current restrictions are appropriate.

10.83 In Queensland, a carer or a close friend or relation will be recognised as a statutory health attorney only if he or she is at least 18 years old. This does not apply to a spouse under section 63(1)(a). An issue to consider is whether a spouse should be recognised only if he or she is at least 18 years old. This would be consistent with the position in Western Australia<sup>461</sup> and with the provisions for the appointment of an attorney under an enduring document<sup>462</sup> which require the attorney to be at least 18 years old.<sup>463</sup>

10.84 A number of jurisdictions also recognise the spouse only if he or she is not a person under guardianship.<sup>464</sup> Similarly, in Western Australia the legislation specifies that the person responsible must be 'of full legal capacity'.<sup>465</sup> An issue to consider is whether the legislation in Queensland should provide that a person is not a statutory health attorney if he or she has a guardian appointed for his or her personal matters, or, although the person does not have a guardian for personal matters, the person nevertheless has impaired capacity for the health care decision.

10.85 Section 29 of the *Powers of Attorney Act 1998* (Qld) imposes limitations on the eligibility of a person for appointment as an adult's attorney under an enduring document. For example, a health provider is precluded from being an attorney under an enduring document, and a service provider for a residential service at which the adult resides is excluded from being an attorney under an advance health directive.

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<sup>460</sup> Unless he or she is recognised as a close friend or relation under *Powers of Attorney Act 1998* (Qld) s 63(1)(c).

<sup>461</sup> *Guardianship and Administration Act 1990* (WA) s 110ZD(3).

<sup>462</sup> An enduring document means an enduring power of attorney or an advance health directive: *Powers of Attorney Act 1998* (Qld) s 28.

<sup>463</sup> *Powers of Attorney Act 1998* (Qld) s 29(1)(a), (2)(a)(i).

<sup>464</sup> *Guardianship Act 1987* (NSW) s 33A(4)(b); *Guardianship and Administration Act 1995* (Tas) s 4(5)(a); *Guardianship and Administration Act 1986* (Vic) s 37(4).

<sup>465</sup> *Guardianship and Administration Act 1990* (WA) s 110ZD(2)(a).

10.86 An issue to consider is whether similar exclusions should apply in relation to statutory health attorneys. At present, nothing in section 63 prevents a health provider for the adult from being recognised as a statutory health attorney if he or she is the adult's spouse, carer or close friend or relation, provided he or she is not a paid carer. While section 63(4) of the Act does limit the circumstances in which a residential service provider can be recognised as the adult's carer, the legislation does not prevent such a person being recognised as a close friend or relation.

### Discussion Paper

10.87 In the Discussion Paper, the Commission sought submissions about whether section 63 of the *Powers of Attorney Act 1998* (Qld) should be amended to clarify that:<sup>466</sup>

- a person will not be recognised as the statutory health attorney if he or she is a health provider for the adult;
- a person will not be recognised as the statutory health attorney if he or she is a service provider for a residential service where the adult resides; and
- the adult's spouse will be recognised as the statutory health attorney only if he or she is at least 18 years old.

### Submissions

10.88 The Adult Guardian commented that, due to the limitations on the circumstances in which a person can marry if they are less than 18 years old, the issue of the age of the adult's spouse is rarely likely to arise except in the de facto or same-sex context.<sup>467</sup> She also commented that:

The role of the life partner shouldn't be limited because of age. If the partner is not making decisions which are in accordance with the legislative framework, the Adult Guardian can provide assistance in decision making and in appropriate circumstances override the decision. This isn't an issue which the Adult Guardian has ever seen arise in practice.

10.89 However, the Adult Guardian considered that section 63 of the *Powers of Attorney Act 1998* (Qld) should be amended to clarify that a person will not be recognised as the statutory health attorney if he or she is a health provider for the adult or a service provider for a residential service where the adult resides.

10.90 One respondent supported the amendment of section 63 to clarify the limitations on recognising a health provider, service provider or spouse (who is

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<sup>466</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 230.

<sup>467</sup> Submission 164.

under 18 years) as the adult's statutory health attorney,<sup>468</sup> while another respondent considered that no amendment is necessary.<sup>469</sup>

### The Commission's view

10.91 The Commission is of the view that section 63 of the *Powers of Attorney Act 1998* (Qld) should be amended to clarify that:

- the adult's spouse will be recognised as the statutory health attorney only if he or she is at least 18 years old;
- a person will not be recognised as the statutory health attorney if he or she is a health provider for the adult; and
- a person will not be recognised as the statutory health attorney if he or she is a service provider for a residential service where the adult resides.

10.92 These changes are consistent with the eligibility requirements for a guardian or an attorney appointed under an enduring document. The imposition of a minimum age of 18 for the adult's spouse is consistent with the eligibility requirements for a guardian or an attorney under an enduring power of attorney. The exclusion of a person who is a health provider for the adult or a service provider for a residential service where the adult resides would help to minimise any potential conflict of interest between the statutory health attorney and the adult. It is also consistent with the approach taken to the eligibility of an attorney appointed under an enduring document.

### READILY AVAILABLE AND CULTURALLY APPROPRIATE

10.93 Section 63(1) of the *Powers of Attorney Act 1998* (Qld) provides that the statutory health attorney is the first person in the list who is 'readily available and culturally appropriate to exercise power for the matter'.

10.94 Similar provisions are included in some of the other jurisdictions. In Victoria, the person responsible is the first person in the listed order who is 'responsible for the patient and who, in the circumstances, is reasonably available and willing and able to make a decision'.<sup>470</sup> In Western Australia, the legislation nominates the first person in the list who is 'reasonably available' and is 'willing to make a treatment decision in respect of the treatment'.<sup>471</sup>

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468 Submission 177.

469 Submission 165.

470 *Guardianship and Administration Act 1986* (Vic) s 37(1).

471 *Guardianship and Administration Act 1990* (WA) s 110ZD(2). Similarly, the legislation in Ontario provides that the person must be capable with respect to the treatment and available and willing to assume responsibility for giving or refusing consent: *Health Care Consent Act*, SO 1996, c 2, Sch A, s 20(2). A requirement of willingness is also included in British Columbia and Manitoba: *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 16(2); *Mental Health Act*, CCSM, c M110, s 28(3).

10.95 An issue to consider is whether the legislation in Queensland should also include a requirement that the person is not just available but is also *willing* to exercise power for the matter. Making decisions about an adult's health care is an important and serious responsibility. It may be helpful to clarify that a person is not required to accept decision-making authority if he or she is not willing to assume the responsibility.<sup>472</sup>

10.96 Section 63(1) of the Act also provides that the statutory health attorney must be 'culturally appropriate' to exercise power. None of the other jurisdictions include a similar specification.

10.97 Cultural differences may have a significant impact on the persons who are considered appropriate substitute decision-makers for an adult. Recent research in the Northern Territory has found, for example, that for Indigenous Australians, the focus is on family and community rather than the individual when consent to health care is sought.<sup>473</sup> Consent may need to be sought from appropriate people in the extended family or the community. Failure to follow this course may lead to hostility or conflict.

10.98 While section 63(1) provides that the statutory health attorney is the first person in the list who is culturally appropriate, an issue to consider is whether the current list of persons is wide enough to include those who would be culturally appropriate in the given circumstances, for example, members of the extended family or persons in a position of tribal authority.<sup>474</sup>

## Discussion Paper

10.99 The Commission sought submissions in the Discussion Paper about whether section 63(1) of the *Powers of Attorney Act 1998* (Qld):<sup>475</sup>

- should be amended to provide that the statutory health attorney is the first person in the listed order who is readily available and willing to exercise power for the matter;
- adequately provides for the complexities of Indigenous family and community relationships and, if not, how this could be addressed; and

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In *Re RAA* [2007] QGAAT 17, [38], for example, the Tribunal appointed a guardian for health matters on the basis that the family member did not want to be involved in the adult's health matters:

As RAA's brother does not wish to be RAA's statutory health attorney, as there are no other family members who are statutory health attorneys, and as RAA has ongoing medical issues in respect of which decisions need to be made, the Tribunal considers that there is a need for an appointment of a guardian for health care decisions.

In that case, the Adult Guardian was appointed as guardian for accommodation, health and service provision matters.

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P McGrath and E Phillips, 'Western Notions of Informed Consent and Indigenous Cultures: Australian Findings at the Interface' (2008) 5 *Bioethical Inquiry* 21.

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This issue was noted in the parliamentary debate accompanying the Powers of Attorney Bill 1997: Queensland, *Parliamentary Debates*, Legislative Assembly, 22 April 1998 (Anna Bligh) 842.

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Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 230.

- adequately provides for the range of relationships of importance in different cultural contexts and, if not, how this could be addressed.

## Submissions

### *Readily available*

10.100 The Adult Guardian commented that this issue raises no particular difficulties in practice.<sup>476</sup> Nevertheless, the Adult Guardian supported the amendment of section 63(1) of the *Powers of Attorney Act 1998* (Qld) to provide that the statutory health attorney is the first person in the listed order who is readily available and willing to exercise power for the matter. One respondent agreed with that approach,<sup>477</sup> while another respondent considered it unnecessary to make such an amendment.<sup>478</sup>

### *Culturally appropriate*

10.101 The Adult Guardian and another respondent considered that section 63(1) of the *Powers of Attorney Act 1998* (Qld) is sufficiently flexible to provide for the complexities of Indigenous family and community relationships (including the range of relationships of importance in different cultural contexts).<sup>479</sup> The Adult Guardian noted that in practice these considerations are often resolved by an informal consensus amongst the relevant persons.

10.102 Another respondent did not consider section 63 was sufficiently flexible in this regard.<sup>480</sup>

## The Commission's view

10.103 The Commission does not consider it necessary to amend section 63(1) of the *Powers of Attorney Act 1998* (Qld) to provide that the statutory health attorney is the first person in the listed order who is readily available and willing to exercise power for the matter. The term 'readily available' is broad enough to encompass the concept of willingness. A person may not be 'readily available' to act as a statutory health attorney if he or she is unwilling to do so.

10.104 The Commission is of the view that section 63(1) of the *Powers of Attorney Act 1998* (Qld) adequately provides for the complexities of Indigenous family and community relationships and for the range of relationships of importance in different cultural contexts.

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476 Submission 164.

477 Submission 177.

478 Submission 165.

479 Submissions 164, 177.

480 Submission 165.

10.105 The statutory health attorney is the first person in an order of priority who is readily available and culturally appropriate. It may be that, in a particular cultural context, the spouse or carer is not the person who would be considered the most appropriate person to make health care decisions. However, this may not necessarily be a difficulty if the definition of 'relation' is wide enough to encompass a range of relationships that are important in different cultural contexts (as the Commission has recommended in this Report), or otherwise if the definition of 'close friend' applies. In that case, the first person who is readily available and culturally appropriate may be a person on the third level of the statutory hierarchy, that is, a person who is a relation or close friend of the adult.

## AN ORDER OF PRIORITY

10.106 Section 63(1) of the *Powers of Attorney Act 1998* (Qld) provides that the statutory health attorney for the adult is the first person in the listed order who is readily available and culturally appropriate. It thus establishes an order of priority so that the first person in the list who is readily available and culturally appropriate is taken to be the statutory health attorney even if there is another person later in the list who is also available and appropriate.

10.107 This is consistent with the legislation in most of the other jurisdictions.<sup>481</sup>

10.108 When it recommended a provision for statutorily authorised health care decision-makers in its original 1996 Report, the Queensland Law Reform Commission proposed that the list of decision-makers should not be hierarchical:<sup>482</sup>

this approach could lead to difficulties identifying and locating the person authorised to consent and ... there may also be circumstances in which the hierarchical order would not reflect the reality of the person's support networks or the person's lifestyle.

## Discussion Paper

10.109 In the Discussion Paper, the Commission sought submissions about whether the list of persons who may be the adult's statutory health attorney under section 63 of the *Powers of Attorney Act 1998* (Qld) should continue to be in an order of priority.<sup>483</sup> It noted that, on the one hand, the rigidity of a hierarchical order may mean that the most appropriate person is overlooked in favour of someone else. It might also make identification of the statutory health attorney difficult if an

<sup>481</sup> *Guardianship Act 1987* (NSW) s 33A(4); *Guardianship and Administration Act 1995* (Tas) s 4(1)(c); *Guardianship and Administration Act 1986* (Vic) s 37(1); *Guardianship and Administration Act 1990* (WA) s 110ZD(2), (3). It is also consistent with the provisions in British Columbia, Ontario and Manitoba: *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, s 16; *Health Care Consent Act*, SO 1996, c 2, sch A, s 20; *Mental Health Act*, CCSM, c M110, s 28(1).

<sup>482</sup> Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 335.

<sup>483</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 231.

individual fits into more than one category. On the other hand, the absence of an order of priority may significantly increase the likelihood of disputes.<sup>484</sup>

10.110 The Commission also sought submissions about whether the current order of priority is appropriate or should be changed.<sup>485</sup> The Commission noted that it may be more appropriate, for example, for a relation to have higher priority than a close friend. It might also be appropriate for particular relatives, such as adult children or a parent, to have a higher priority than other relatives.<sup>486</sup>

10.111 The Commission also sought submissions on the issue of whether, and to what extent, the hierarchy should be consistent with that under the *Transplantation and Anatomy Act 1979* (Qld).<sup>487</sup> It noted that consistency may be of particular value to health professionals when trying to identify the appropriate person from whom to seek consent.<sup>488</sup> Spouses are first in order of priority under both schemes, although the *Powers of Attorney Act 1998* (Qld) gives preference to a spouse who is in a close and continuing relationship with the adult. The remaining next of kin specified under the *Transplantation and Anatomy Act 1979* (Qld) are also eligible as statutory health attorneys under the category 'close friend or relation'. However, under the statutory health attorney provisions, an 'unpaid carer' is higher in the hierarchy than the next of kin, who have the same priority as 'close friends'. In addition, there is no priority ranking between different relatives as is the case under the *Transplantation and Anatomy Act 1979* (Qld).

## Submissions

10.112 The Adult Guardian was unaware of any difficulties with the current statutory list in section 63 of the *Powers of Attorney Act 1998* (Qld). She commented that the list seems both formal and flexible enough to deal with any relevant issues.<sup>489</sup> The Adult Guardian also considered that the adoption of a statutory list based on the hierarchy under the *Transplantation and Anatomy Act 1979* (Qld) may have some merit because 'it establishes a common framework across both pieces of legislation which is helpful for medical practitioners'. She also commented that the hierarchy under the *Transplantation and Anatomy Act 1979* (Qld) 'would seem to be most appropriate in Anglo communities' but was unable to comment upon its cultural relevance within other communities.

10.113 Two other respondents considered that the current order of priority in section 63 is suitable.<sup>490</sup>

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484 Ibid [10.71].

485 Ibid 231.

486 Ibid [10.73].

487 Ibid. See [10.62] above.

488 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, [10.73].

489 Submission 164.

490 Submissions 165, 177.

10.114 There was general support in the community forums to retain the current statutory hierarchy for statutory health attorneys.<sup>491</sup> In some cases, it was suggested that some modification might be made to certain aspects of the hierarchy.<sup>492</sup>

10.115 The community forum groups generally supported the retention of the spouse at the apex of the hierarchy.<sup>493</sup> Several people suggested that the adult's spouse and other members of the adult's immediate family should be ranked equally.<sup>494</sup>

10.116 Several people who attended the community forums considered that the adult's close family members should rank higher than the adult's carer.<sup>495</sup>

### The Commission's view

10.117 In the Commission's view, the list of persons who may be the adult's statutory health attorney under section 63 of the *Powers of Attorney Act 1998* (Qld) should continue to be listed in an order of priority. This approach facilitates the identification of the adult's statutory health attorney in a timely manner.

10.118 The Commission also considers that the current order of priority is appropriate. In contrast to the hierarchy under the *Transplantation and Anatomy Act 1979* (Qld), which is limited to immediate family relationships, the current order of priority generally places more reliance on closeness and continuity of contact as well as culturally appropriate decision-making. This approach ensures that the adult's statutory health provider is drawn from a range of persons who are culturally appropriate and who are likely to know the views and wishes of the adult and understand the adult's health care needs.

10.119 It has been suggested by some respondents that the order of priority should be changed to give an immediate family member of the adult (for example, a parent or adult child) a higher priority in the hierarchy. This approach assumes that an immediate family member will always have a close personal relationship with the adult and be in a position to know the adult's views and wishes and to understand the adult's health care needs. However, while this may often be the case, there may be circumstances where this may not actually reflect the adult's support network or the adult's lifestyle. The Commission also notes that, where the adult has no spouse who may take precedence as the adult's statutory health attorney, the adult's carer (who in many cases will be an immediate family member) is next in order of priority.

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491 Forums 9, 10, 11, 12, 13.

492 Forums 9, 10.

493 Forums 9, 10.

494 Forums 12, 13.

495 Forums 9, 10, 14.

10.120 The Commission notes that it is possible for a person to fall within several categories in the hierarchy, but does not consider this to be a significant issue. In this situation, the person's eligibility as the adult's statutory health attorney would be determined on the basis of the highest category for which the person qualifies.

## SCOPE OF STATUTORY HEALTH ATTORNEY'S POWER

10.121 Section 62 of the *Powers of Attorney Act 1998* (Qld) authorises statutory health attorneys to make decisions about an adult's health matters, including the withholding or withdrawal of life-sustaining measures.<sup>496</sup> Statutory health attorneys do not, however, have power to make decisions about other personal matters, such as where the adult lives. Only the Tribunal has power to make decisions about special health matters, such as sterilisation or special medical research or experimental health care.<sup>497</sup>

10.122 This is similar to the position in the other jurisdictions. In New South Wales, South Australia, Tasmania and Victoria, the person responsible, or the appropriate authority, can give consent to medical or dental treatment, not including special or prescribed treatment such as termination of pregnancy or sterilisation.<sup>498</sup> In Victoria, the person responsible may also give consent to medical research procedures.<sup>499</sup>

10.123 In Western Australia, the person responsible can consent or refuse consent to medical or surgical treatment, including life-sustaining measures or palliative care, or dental treatment or other health care.<sup>500</sup> The person responsible cannot, however, consent to sterilisation.<sup>501</sup>

10.124 A question that arises is whether the scope of the statutory health attorney's power requires clarification. It may not be clear, for example, whether certain activities are part of the adult's health care or are ancillary to it and therefore outside the scope of the statutory health attorney's power. This might include clinical assessments such as an aged care assessment in relation to the adult's

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A health matter relates to the adult's health care. This is defined as care or treatment of, or a service or a procedure for, the adult to diagnose, maintain or treat the adult's physical or mental condition carried out by or under the supervision of a health provider. Health care does not include special health care such as sterilisation, termination of pregnancy, tissue donation, participation in special medical research or experimental health care or electroconvulsive therapy or psychosurgery. See *Powers of Attorney Act 1998* (Qld) sch 2 ss 4 (Health matter), 5 (Health care), 6 (Special health matter), 7 (Special health care). The scope of health matters and special health matters is examined in Chapter 6.

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*Guardianship Act 1987* (NSW) s 68. Under s 74 of that Act, the Tribunal may appoint one or more persons who are eligible for appointment as a guardian or guardians for the adult and give the guardian or guardians power to consent for the adult to continuation of the special health care or the carrying out on the adult of similar special health care.

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*Guardianship Act 1987* (NSW) ss 33(1), 36(1); *Guardianship Regulation 2005* (NSW) s 8; *Guardianship and Administration Act 1993* (SA) ss 3(1), 59(1); *Guardianship and Administration Act 1995* (Tas) ss 3(1), 39(1); *Guardianship and Administration Act 1986* (Vic) ss 3(1), 39(1)(b), 42H(1).

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*Guardianship and Administration Act 1986* (Vic) ss 3(1), 42S(2). This issue is considered in Chapter 13 of this Report.

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*Guardianship and Administration Act 1990* (WA) ss 3(1), 110ZD(1).

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*Guardianship and Administration Act 1990* (WA) s 110ZD(7).

residential or community care needs. It may be appropriate for consent to such assessments, if the adult has impaired capacity, to be sought from the adult's statutory health attorney if there is no guardian or attorney.

10.125 It may also be appropriate for decision-making power to be given to the adult's statutory health attorney for other matters ancillary to health care. This might include personal matters such as decisions about where the adult should live. The need for decisions in relation to residential or nursing home care, for example, may often arise in the context of health care decisions.

10.126 While such decisions can be made informally for an adult, institutions and professionals may be hesitant to accept an informal decision-maker's authority. The conferral of statutory power may help minimise such difficulties and ensure timely decisions for the adult can be made without resort to public guardianship proceedings. This would be consistent with the principle of least restrictive interference with the adult's rights. On the other hand, appointment of a guardian for personal matters may ensure a greater degree of scrutiny as a safeguard against abuse, neglect or exploitation.

## Discussion Paper

10.127 In the Discussion Paper, the Commission sought submissions on whether section 62 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that a statutory health attorney has power to consent to clinical assessments such as an aged care assessment in relation to the adult's residential or community care needs.<sup>502</sup>

10.128 The Commission also sought submissions on whether section 62 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that a statutory health attorney has power to consent to other matters ancillary to the adult's health care and, if so, what those matters should be.<sup>503</sup>

## Submissions

10.129 Several respondents, including the Adult Guardian, considered that section 62 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that a statutory health attorney has power to consent to other matters ancillary to the adult's health care.<sup>504</sup>

10.130 The Adult Guardian proposed that section 62 be amended to provide that a statutory health attorney has power to consent to an aged care placement for an adult:<sup>505</sup>

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502 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 233.

503 Ibid.

504 Submissions 164, 165, 177.

505 Submission 164.

Within the practice of the Office of the Adult Guardian, appointments to be guardian for health care and decisions as statutory health attorney are generally different in nature. As guardian with authority to make decisions for health care the Adult Guardian takes a proactive approach to enquire into health care globally, to obtain assessments, to plan, and to implement healthcare decisions and strategies. As statutory health attorney, our role is reactive ie to respond to a request for a decision and either to consent or not to consent to healthcare. The only manner in which a proactive role is taken is in respect to both authorisation of ACAT assessments and to making aged care placements provided that the placement is not controversial. If the placement is of a controversial nature the Adult Guardian prefers an appointment to be made so that all options can be fully investigated before a decision is made and implemented.

10.131 Another respondent suggested that the conferral of an ancillary power should be limited to the power to consent to a clinical assessment.<sup>506</sup>

### The Commission's view

10.132 The scope of a statutory health attorney's authority will depend on whether the decision being made falls within the definition of 'health matter' — that is, a matter *relating to* adult's health care.<sup>507</sup> This will be the case where there is a sufficient connection between the decision to be made and the adult's health care.

10.133 The example raised by in the Adult Guardian in her submission — that is, a decision to transfer an adult who is receiving medical treatment in a hospital to a high-level care home — is arguably a decision relating to the adult's health care, and therefore within the statutory health attorney's authority. On the other hand, a decision about where the adult lives, which is not sufficiently connected with the adult's health care, will not be characterised as a decision about 'health care' but as another type of personal matter, for which a statutory health attorney does not have authority.

10.134 The other example raised above by the Commission — a clinical assessment of an adult made in the context of the adult's health care — may be made for various reasons. A clinical assessment of an adult conducted for the purpose of making a medical diagnosis for the adult clearly falls within the scope of the statutory health attorney's authority. Whether a clinical assessment conducted for another reason falls within the scope of the statutory health attorney's authority will depend on whether there is a sufficient connection between the clinical assessment and the adult's health care.

10.135 In the Commission's view, the *Powers of Attorney Act 1998* (Qld) should not be amended to make special provision to authorise a statutory health attorney to make decisions about matters ancillary to the adult's health care. If the matter relates to the adult's health care, the statutory health attorney will already have power for the matter. If the matter does not relate to health care, it will be a

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506 Submission 177.

507 See the definition of 'health care' set out at n 496 above. The effect of the words 'relating to' and similar phrases is discussed in Chapter 6 of this Report.

personal matter. If there is a guardian or an attorney appointed for the matter, the guardian or administrator may exercise the power. If there is no guardian or attorney appointed for the matter, the decision may be made by a member of the adult's support network (who may or may not be the person who is acting as the statutory health attorney). If the informal decision-maker's authority is not sufficient in the circumstances, a formal appointment may be sought.

## THE EFFECTIVENESS OF A DECISION MADE BY A STATUTORY HEALTH ATTORNEY

### Background

10.136 Section 62(1) of the *Powers of Attorney Act 1998* (Qld) authorises a statutory health attorney for an adult's health matter 'to make any decision about the health matter that the adult could lawfully make if the adult had capacity for the matter'. The situation can arise where an adult's statutory health attorney demands health care for the adult that the adult's health provider considers is inconsistent with good medical practice. This raises the issue of the effectiveness of a decision made by a statutory health attorney.

10.137 As a matter of construction, it would seem that a decision by an adult's substitute decision-maker, in this case, a statutory health attorney, could not be more effective than one made by the adult if he or she had capacity. As explained in Chapter 9 of this Report, a competent adult does not ordinarily have the power at common law to compel the provision of health care that has not been offered.<sup>508</sup> As a result, the fact that an adult may demand a particular treatment does not create a duty for the health provider to give the treatment. As the English Court of Appeal explained in *R (Burke) v General Medical Council*:<sup>509</sup>

In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.

10.138 However, section 66(5) of the *Guardianship and Administration Act 2000* (Qld) provides that, if subsection (2) to (4) do not apply, 'the matter may only be dealt with by the statutory health attorney'.

10.139 In Chapter 9, the Commission referred to the similar situation that may arise where an adult's advance health directive gives a direction requiring particular health care and the adult's health provider considers that the required health care would be inconsistent with good medical practice. The Commission observed that, while section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld) does not give a direction requiring health care any greater effect than such a direction would have at common law if given by a competent adult, some ambiguity arises from the terms of sections 65(2) and 66(2) of the *Guardianship and Administration Act 2000* (Qld). Those sections provide that, if the adult has made an advance health directive

<sup>508</sup> See [9.28]–[9.31] above.

<sup>509</sup> [2006] QB 273, 296.

giving a direction about the matter, the matter may only be dealt with in accordance with the direction.<sup>510</sup>

10.140 The Commission made several recommendations to avoid the tension between section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld) and sections 65 and 66 of the *Guardianship and Administration Act 2000* (Qld).

10.141 To emphasise the limitations that apply to a demand for treatment made by a competent adult, the Commission recommended that section 36(1)(b) of the *Powers of Attorney Act 1998* (Qld) be amended so that it provides that a direction in an advance health directive is as effective as, *but no more effective than*, if the matters in section 36(1)(b)(i) and (ii) apply.<sup>511</sup>

10.142 The Commission also recommended that:<sup>512</sup>

- section 65 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 65(2) is subject to section 36 of the *Powers of Attorney Act 1998* (Qld); and
- section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 66(2) is subject to section 36 of the *Powers of Attorney Act 1998* (Qld).

10.143 The Commission considered that an advantage of this approach was that it could be adapted to address the similar situation that may arise where an adult's substitute decision-maker requests health care for the adult that the health provider considers is inconsistent with good medical practice.

### The Commission's view

10.144 To avoid any ambiguity about the effect of section 66(5) of the *Guardianship and Administration Act 2000* (Qld) on a statutory health attorney's powers under section 62 of the *Powers of Attorney Act 1998* (Qld), section 62 of the latter Act should be amended by inserting a new subsection to the effect that:<sup>513</sup>

510 See [9.324]–[9.327] above.

511 See Recommendation 9-3(a) of this Report.

512 See Recommendations 9-19, 9-20 of this Report.

513 The proposed provision is similar in effect to s 110ZD(9) of the *Guardianship and Administration Act 1990* (WA), which provides:

**110ZD Circumstances in which person responsible may make treatment decision**

...

(9) A treatment decision made by the person responsible for the patient has effect as if—

- (a) the treatment decision had been made by the patient; and
- (b) the patient were of full legal capacity.

A statutory health attorney's decision about a health matter for the adult is as effective as, but no more effective than, if:

- (a) the adult made the decision when decisions about the matter needed to be made; and
- (b) the adult then had capacity for the matter.

10.145 Further, section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 66(5) is subject to section 62 of the *Powers of Attorney Act 1998* (Qld).

## RECOMMENDATIONS

### ***When a person has the care of an adult for the purposes of section 63***

**10-1** Section 63(1)(a) of the *Powers of Attorney Act 1998* (Qld) should include a footnote reference to the definition of 'spouse' in section 36 of the *Acts Interpretation Act 1954* (Qld).

**10-2** Section 63(3) of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that a person has the care of an adult if the person *regularly* provides or arranges domestic services and support for the adult.

### ***The definition of 'relation' for the purposes of section 63***

**10-3** The definition of 'relation' in schedule 3 of the *Powers of Attorney Act 1998* (Qld) should not apply to the reference to a 'close friend or relation' in section 63 of the Act.

**10-4** For the purposes of section 63 of the *Powers of Attorney Act 1998* (Qld), the definition of 'relation' should be reformulated for the purpose of section 63 of the Act to include the following categories of person:

- (a) a person who is related to the first person by blood, marriage or adoption or because of a de facto relationship or a foster relationship;
- (b) for an Aboriginal person — includes a person who, under Aboriginal tradition, is regarded as a relative mentioned in the first paragraph;
- (c) for a Torres Strait Islander — includes a person who, under Island custom, is regarded as a relative mentioned in the first paragraph.

***Exclusions and limitations***

**10-5 Section 63 of the *Powers of Attorney Act 1998* (Qld) should be amended to clarify that:**

- (a) the adult's spouse will be recognised as the statutory health attorney only if he or she is at least 18 years old;**
- (b) a person will not be recognised as the statutory health attorney if he or she is a health provider for the adult; and**
- (c) a person will not be recognised as the statutory health attorney if he or she is a service provider for a residential service where the adult resides.**

***The effectiveness of a decision made by a statutory health attorney***

**10-6 Section 62 of the *Powers of Attorney Act 1998* (Qld) should be amended by inserting a new subsection to the effect that:**

A statutory health attorney's decision about a health matter for the adult is as effective as, but no more effective than, if:

- (a) the adult made the decision when decisions about the matter needed to be made; and**
- (b) the adult then had capacity for the matter.**

**10-7 Section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that section 66(5) is subject to section 62 of the *Powers of Attorney Act 1998* (Qld).<sup>514</sup>**

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See also Recommendations 15-6 and 16-10, which deal with the similar issue that arises in relation to the effect of s 66(3) and (4) of the *Guardianship and Administration Act 2000* (Qld).



# Chapter 11

## The withholding and withdrawal of life-sustaining measures

INTRODUCTION .....	156
BACKGROUND.....	157
The emergence of legal and ethical issues in relation to life-sustaining measures .....	157
The common law.....	161
OVERVIEW OF THE QUEENSLAND LEGISLATION .....	167
Withholding or withdrawal: a ‘health matter’ .....	167
Withholding or withdrawal under an advance health directive.....	167
Withholding or withdrawal by an adult’s substitute decision-maker.....	169
The priority for decisions about the withholding or withdrawal of life-sustaining measures.....	169
Withholding or withdrawal of a life-sustaining measure in an acute emergency .....	170
Certification in clinical records.....	171
The Adult Guardian’s role in relation to the withholding or withdrawal of life-sustaining measures.....	172
THE DEFINITION OF ‘HEALTH CARE’ .....	173
The law in Queensland .....	173
Submissions .....	174
The Commission’s view .....	174
THE DEFINITION OF ‘LIFE-SUSTAINING MEASURE’ .....	175
The law in Queensland .....	175
The law in other jurisdictions.....	176
Discussion Paper .....	177
Submissions .....	177
The Commission’s view .....	178
WITHHOLDING OR WITHDRAWAL OF A LIFE-SUSTAINING MEASURE UNDER AN ADVANCE HEALTH DIRECTIVE.....	179
The law in Queensland .....	179
The requirement that the adult’s medical condition falls within one of four categories.....	181
The requirement that the commencement or continuation of artificial nutrition or hydration would be inconsistent with good medical practice .....	190
The requirement that the adult has no reasonable prospect of regaining capacity for health matters .....	194
The requirement that the commencement or continuation of the life-sustaining measure would be inconsistent with good medical practice .....	197
CONSENT TO THE WITHHOLDING OR WITHDRAWAL OF A LIFE-SUSTAINING MEASURE BY AN ADULT’S SUBSTITUTE DECISION-MAKER.....	203
The law in Queensland .....	203
The law in other jurisdictions.....	206
Issue for consideration .....	211
Discussion Paper .....	212
Submissions .....	212
The Commission’s view .....	214
THE EFFECT OF THE CONSENT REQUIREMENTS WHERE THE LIFE-SUSTAINING MEASURE IS ‘MEDICALLY FUTILE’ .....	223

Background .....	223
Discussion Paper .....	232
Submissions .....	232
The Commission's view .....	236
THE EFFECT OF AN ADULT'S OBJECTION TO THE COMMENCEMENT OR CONTINUATION, OR WITHHOLDING OR WITHDRAWAL, OF A LIFE-SUSTAINING MEASURE .....	239
The law in other jurisdictions .....	243
Discussion Paper .....	244
Submissions .....	245
The Commission's view .....	245
THE TRIBUNAL'S POWERS IN RELATION TO THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING MEASURES .....	252
Background .....	252
The current provisions .....	253
Discussion Paper .....	255
Submissions .....	256
The Commission's view .....	256
The need for the Tribunal's function of consenting to the withholding or withdrawal of life-sustaining measures .....	257
POTENTIAL CRIMINAL RESPONSIBILITY FOR WITHHOLDING OR WITHDRAWING A LIFE-SUSTAINING MEASURE .....	260
Introduction .....	260
The law in Queensland .....	260
The law in other jurisdictions .....	270
Discussion Paper .....	274
Submissions .....	274
The Commission's view .....	274
RECOMMENDATIONS .....	278

## INTRODUCTION

11.1 The Commission's terms of reference direct it to review the law relating to the withholding and withdrawal of life-sustaining measures under the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld).<sup>515</sup>

11.2 This chapter gives an overview of the current legislative scheme for the withholding and withdrawal of life-sustaining measures in Queensland. It considers the two primary mechanisms by which decisions can be made about the withholding or withdrawal of life-sustaining measures if an adult has impaired capacity for the decision (namely by an advance health directive and through the consent of a substitute decision-maker),<sup>516</sup> as well as the Tribunal's powers in relation to the withholding or withdrawal of life-sustaining measures. The chapter also considers the approaches taken in other jurisdictions and makes recommendations about a number of issues arising under the legislation.

<sup>515</sup> The terms of reference are set out in Appendix 1.

<sup>516</sup> In this chapter, the term 'substitute decision-maker' is used to refer to a guardian with power for health matters, an attorney appointed under an enduring document with power for health matters or a statutory health attorney.

11.3 For the reasons explained in Chapter 9 of this Report, the Commission's recommendations are necessarily confined to the legal issues that arise under the guardianship legislation in relation to the withholding and withdrawal of life-sustaining measures.<sup>517</sup>

11.4 The discussion in this chapter is limited to the lawful withholding or withdrawal of a life-sustaining measure and does not extend to the separate issues of euthanasia and physician-assisted suicide of patients.<sup>518</sup> These issues are not within the Commission's terms of reference.

## BACKGROUND

### The emergence of legal and ethical issues in relation to life-sustaining measures

11.5 Developments in medicine over the last 60 years have given rise to many difficult questions about the prolongation and cessation of life:<sup>519</sup>

Since World War II dramatic advances in the power of medicine to sustain life have led to profound changes in the types of illness from which people die. At one time pneumonia, influenza, and other communicable diseases were the most common causes of death. Today chronic, degenerative diseases such as cancer, heart disease, and cerebrovascular disease have become predominant, accounting for approximately seventy percent of all deaths in the United States. This in turn has shifted the locus of dying. Whereas at the turn of the century most patients died at home, today nearly eighty percent of deaths occur in hospitals. Patients with degenerative diseases can be kept biologically alive for long periods of time through the use of drugs and machines, though sensate and functional life has gone forever. As a consequence, in the language of one court, '[q]uestions of fate have ... become matters of choice raising profound "moral, social, technological, philosophical, and legal questions ..."' What is the role of the patient's preferences in cases where he has made a competent current choice, where he has made an earlier choice, where he has made no choice? These questions, thrust upon us by advances in medical technology, raise doubts about the continued validity of some of our most deeply held moral beliefs about life and death. (notes omitted)

11.6 These developments in medicine were referred to by the House of Lords in *Airedale NHS Trust v Bland*,<sup>520</sup> a case that involved the issue of the discontinuance of artificial nutrition and hydration from a patient in a persistent vegetative state.<sup>521</sup>

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517 See [9.5] above.

518 The Queensland guardianship legislation provides that these Acts do not authorise euthanasia or affect particular provisions of the Criminal Code (Qld): *Guardianship and Administration Act 2000* (Qld) s 238; *Powers of Attorney Act 1998* (Qld) s 37. See [11.409]–[11.410] below.

519 SH Kadish, 'Letting Patients Die: Legal and Moral Reflections' (1992) *California Law Review* 857.

520 *Airedale NHS Trust v Bland* [1993] AC 789, 867 (Lord Goff).

521 *Ibid.*

It is of course the development of modern medical technology, and in particular the development of life support systems, which has rendered cases such as the present so much more relevant than in the past. Even so, where, for example, a patient is brought into hospital in such a condition that, without the benefit of a life support system, he will not continue to live, the decision has to be made whether or not to give him that benefit, if available. That decision can only be made in the best interests of the patient. No doubt, his best interests will ordinarily require that he should be placed on a life support system as soon as necessary, if only to make an accurate assessment of his condition and a prognosis for the future. But, if he neither recovers sufficiently to be taken off it nor dies, the question will ultimately arise whether he should be kept on it indefinitely. As I see it, that question (assuming the continued availability of the system) can only be answered by reference to the best interests of the patient himself, having regard to established medical practice. Indeed, if the justification for treating a patient who lacks the capacity to consent lies in the fact that the treatment is provided in his best interests, it must follow that the treatment may, and indeed ultimately should, be discontinued where it is no longer in his best interests to provide it. The question which lies at the heart of the present case is, as I see it, whether on that principle the doctors responsible for the treatment and care of Anthony Bland can justifiably discontinue the process of artificial feeding upon which the prolongation of his life depends.

11.7 In *Auckland Area Health Board v Attorney General*,<sup>522</sup> Thomas J expressed a similar view:<sup>523</sup>

The problem arises when life passes into death but obscurely. It is a problem made acute by the enormous advances made in technology and medical science in recent decades. With the use of sophisticated life-support systems, life may be perpetuated well beyond the reach of the natural disease. The process of living can become the process of dying so that it is unclear whether life is being sustained or death being deferred.

11.8 Decisions about the withholding and withdrawal of life-sustaining measures raise a number of medical, legal and ethical issues. The considerations that underpin decision-making by, and for, adults in relation to end-of-life decisions can sometimes conflict. Within the community, too, there are divergent views about how these issues should be resolved in individual cases.

11.9 If an adult has previously had capacity and expressed a view about what should happen if he or she loses capacity at the end of life,<sup>524</sup> the withholding or withdrawal of treatment will generally be seen as a recognition of the adult's right of self-determination. In that situation, the issue is how to recognise the adult's expressed view, while at the same time safeguarding the interests of the adult now that he or she has lost capacity and is vulnerable. However, it may be that an adult has never expressed any views about what should happen if he or she loses capacity,<sup>525</sup> or has never had capacity. In that situation, a balance must be sought

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522 [1993] 1 NZLR 235.

523 Ibid 245.

524 See eg *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88.

525 See eg *Airedale NHS Trust v Bland* [1993] AC 789, 797 (Sir Stephen Brown P).

between allowing another appropriate person to make decisions for the adult and the need to safeguard the interests of the adult.

11.10 There appears to be community support in favour of people having the ability, generally, to make health care decisions in anticipation of a future time when they lose capacity.<sup>526</sup> In particular, research indicates that there is support for enabling adults to make advance health directives (sometimes referred to as 'living wills') in relation to terminal care.<sup>527</sup>

The desire for greater involvement in decision-making on health issues is even more pronounced in relation to the area of terminal care:

Australian opinion polls show that community attitudes are moving strongly towards wanting more control over the terminal stage of life, and the Public Health Association of Australia supports legislation to allow people to prepare enforceable living wills rejecting excessive medical treatment in the event of terminal illness.<sup>528</sup> (note in original)

11.11 Advance health directives that provide for the withholding or withdrawal of life-sustaining measures are seen as an important component of advance care planning generally in which informed discussions about treatment preferences for end-of-life care can take place between patients, family and health providers.<sup>529</sup> Competent adults may wish to put these measures in place to relieve family members of the potential burden of life or death decision-making on their behalf in the event that they later lose capacity.<sup>530</sup>

11.12 Although it has been suggested that advance directives tend to have a low take-up rate,<sup>531</sup> one commentator has made the point that:<sup>532</sup>

the fact that most people have not made an advance directive does not mean that they do not want the *right* to make one. Many of the important civil rights in Australia are never exercised by the majority of the population but they are fundamental rights which Australians expect to have access to if needed, for example, rights to trial, rights to freedom of movement and rights to protest. The right to make an advance directive is also a fundamental right and for that reason it is worthy of our respect.

526 S Ellison et al, *Access to Justice and Legal Needs: The Legal Needs of Older People in New South Wales*, Law and Justice Foundation of New South Wales (2004) 156.

527 Ibid. In relation to 'living wills', see [9.11] above.

528 C Cartwright, 'End of Life Decision Making: Practical and Ethical Decisions for Health Professionals' (2001) 20 *Australasian Journal on Ageing* 7 n 4.

529 C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal on Ageing* (June Supplement) S25, S28.

530 Health forum 2.

531 A Fagerlin and CE Schneider, 'Enough: The Failure of the Living Will' (2004) 34 *Hastings Center Report* 32–3; T Beauchamp and J Childress, *Principles of Biomedical Ethics* (6th ed, 2009) 186–7.

532 C Stewart, 'The Australian experience of advance directives and possible future directions' (2005) 24 *Australasian Journal on Ageing* (June Supplement) S25, S28.

11.13 During the Commission's consultations for this review, it was suggested that, in Queensland, advance health directives are most commonly made by the elderly and by adults with a terminal or chronic illness, whose illnesses have a reasonably predictable trajectory.<sup>533</sup>

11.14 However, the use of advance health directives in relation to the withholding and withdrawal of life-sustaining measures has also been criticised. Given the irreversible consequences involved, there is a view that advance health directives are an inadequate tool to reflect accurately the wishes of an adult at the time when the health care is to be withheld or withdrawn.<sup>534</sup> It has also been suggested that advance health directives are open to abuse, with vulnerable persons potentially being pressured into completing advance health directives to refuse life-sustaining measures.<sup>535</sup> It has been suggested that this pressure may be in the form of direct coercion from a person who is close to the adult but may also be in the form of 'social' pressure.<sup>536</sup>

For people with disability, the social pressure not to be a 'burden' can be great and, in the absence of other protective measures which guard against both overt duress on an individual and the more general social coercion, people with disability may believe they have an obligation to die.

11.15 Other arguments against the use of advance health directives for end-of-life decision-making are that:<sup>537</sup>

- people do not know enough about illnesses and treatments to make prospective life-or-death decisions about them;
- evidence suggests that people can change their treatment preferences over short periods of time; and
- it may be difficult to interpret what is meant by an instruction in an advance health directive.

11.16 One consideration is whether the existing legislative safeguards in relation to end-of-life decision-making need to be strengthened to protect adults with impaired capacity from inappropriate or improper decisions. There are also concerns that it may be dangerous to allow some forms of life-sustaining measures to be withheld or withdrawn because it may eventually result in society's tolerance of the inappropriate withholding and withdrawal of life-sustaining measures from

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533 Health forum 6.

534 Queensland Advocacy Incorporated, *Submission on 'Rethinking Life-Sustaining Measures: Questions for Queensland'* (4 July 2005) 10 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 17 August 2010.

535 Ibid 7–8, 11–13.

536 Ibid 12.

537 A Fagerlin and CE Schneider, 'Enough: The Failure of the Living Will' (2004) 34 *Hastings Center Report* 33–4; T Beauchamp and J Childress, *Principles of Biomedical Ethics* (6th ed, 2009) 186–7.

vulnerable adults. Commentators have described some of the concerns in relation to the withholding or withdrawal of artificial nutrition and hydration:<sup>538</sup>

The controlling idea is that policies of not providing [medically administered nutrition and hydration] will lead to adverse consequences because society will lose its ability to limit decisions about [medically administered nutrition and hydration] to legitimate cases, especially under pressures of cost containment in health care. Whereas 'death with dignity' first emerged as a compassionate response to the threat of overtreatment, patients now face the threat of undertreatment because of the pressures to contain the escalating costs of health care ... Some fear that the 'right to die' will be transformed into the 'obligation to die,' perhaps against the patient's wishes and interests.

11.17 This view is consistent with the United Nations *Convention on the Rights of Persons with Disabilities*, which provides that States Parties shall 'prevent discriminatory denial of health care ... on the basis of disability'.<sup>539</sup>

11.18 On the other hand, there is a view that, in order to give effect to an adult's autonomy, legislation should more easily facilitate the carrying out of an adult's previously expressed wishes about the withholding or withdrawal of life-sustaining measures.

## The common law

11.19 Before considering the Queensland legislation in relation to the withholding and withdrawal of life-sustaining measures, it is useful to consider the common law in relation to the refusal of life-sustaining medical treatment.

11.20 The common law recognises that an adult with capacity may refuse any medical treatment that is offered, even if the adult's refusal of the treatment may lead to his or her death.<sup>540</sup> In *Brightwater Care Group (Inc) v Rossiter*,<sup>541</sup> Martin CJ observed that this principle had been established by decisions in each of the major common law jurisdictions, including the United States, Canada, the United Kingdom, New Zealand and Australia.<sup>542</sup>

<sup>538</sup> T Beauchamp and J Childress, *Principles of Biomedical Ethics* (6th ed, 2009) 161.

<sup>539</sup> United Nations, *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 13 December 2006, art 25(f). The Convention is discussed in Chapter 3 of this Report. See also the comments in *R (Burke) v General Medical Council* [2005] QB 424, [83]: 'people ... are entitled to have confidence that they will be treated properly and in accordance with good practice, and that they will not be ignored or patronised because of their disability' (Lord Phillips MR, Waller and Wall LJ).

<sup>540</sup> *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [23]–[26] (Martin CJ); *Re B* [2002] 2 All ER 449, 455–6 (Butler-Sloss P); *Re MB* [1997] 2 FLR 426, 432 (Butler-Sloss LJ); *Airedale NHS Trust v Bland* [1993] AC 789, 857 (Lord Keith).

<sup>541</sup> [2009] WASC 229.

<sup>542</sup> *Ibid* [26], citing *Bouvia v Superior Court of Los Angeles County* 179 Cal App 3d 1127 (1986), 1137 and 1139–41; *Nancy B v Hotel-Dieu Quebec* (1992) 86 DLR (4th) 385; *Malette v Shulman* (1990) 67 DLR (4th) 321, 328; *Airedale NHS Trust v Bland* [1993] AC 789, 857 (Lord Keith), 864 (Lord Goff); *Ms B v An NHS Hospital Trust* (2002) 2 FCR 1, [16]–[21]; *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 245; *Hunter and New England Area Health Service v A* [2009] NSWSC 761, [9]–[15] (see now (2009) 74 NSWLR 88, 91–2).

11.21 An adult's 'right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent'.<sup>543</sup> However, 'the lack of any discernible basis for a decision to refuse treatment may be something to take into account in assessing the competence or validity of the decision.'<sup>544</sup>

11.22 In *Airedale NHS Trust v Bland*,<sup>545</sup> the House of Lords considered the relationship between two potentially conflicting principles: the sanctity of human life and a competent adult's right to self-determination. Lord Goff observed that, at common law, where these principles conflict, the principle of the sanctity of human life must yield to the principle of self-determination:<sup>546</sup>

But this principle [the sanctity of human life], fundamental though it is, is not absolute. Indeed, there are circumstances in which it is lawful to take another man's life, for example by a lawful act of self-defence, or (in the days when capital punishment was acceptable in our society) by lawful execution. We are not however concerned with cases such as these. We are concerned with circumstances in which it may be lawful to withhold from a patient medical treatment or care by means of which his life may be prolonged. But here too there is no absolute rule that the patient's life must be prolonged by such treatment or care, if available, regardless of the circumstances.

First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so: see *Schloendorff v Society of New York Hospital* (1914) 105 NE 92, 93 per Cardozo J; *S v McC (or se S) and M (DS Intervener)*; *W v W* [1972] AC 24, 43 per Lord Reid; and *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 882 per Lord Scarman. To this extent, the principle of the sanctity of human life must yield to the principle of self-determination (see ante ... per Hoffmann LJ), and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified. On this basis, it has been held that a patient of sound mind may, if properly informed,<sup>547</sup> require that life support should be discontinued: see *Nancy B v Hôtel-Dieu de Québec* (1992) 86 DLR (4th) 385. (note added)

11.23 Lord Goff also referred to the situation where the refusal of treatment was expressed at an earlier time, before the patient lost capacity:<sup>548</sup>

543 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102 (Lord Donaldson MR). See also *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 (Martin CJ), [23]–[26]; *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 92 (McDougall J).

544 *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 92 (McDougall J).

545 [1993] AC 789.

546 *Ibid* 864.

547 But see the discussion commencing at [9.123] above of whether it necessary for an adult to be fully informed in order to make an advance refusal of health care.

548 [1993] AC 789, 864.

Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred: see, eg *In re T (Adult: Refusal of Treatment)* [1993] Fam 95.

11.24 Lord Goff emphasised that, 'in cases of this kind, there is no question of the patient having committed suicide, or therefore of the doctor having aided or abetted him in doing so'.<sup>549</sup> In his Lordship's view:<sup>550</sup>

It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient's wishes.

11.25 Lord Goff held that there was no absolute rule that a doctor must provide life-prolonging treatment in all circumstances, and considered that this must also be the case where a patient lacked capacity:<sup>551</sup>

I am of the opinion that there is ... no obligation upon the doctor who has the patient in his care to prolong his life, regardless of the circumstances. Indeed, it would be most startling, and could lead to the most adverse and cruel effects upon the patient, if any such absolute rule were held to exist. It is scarcely consistent with the primacy given to the principle of self-determination in those cases in which the patient of sound mind has declined to give his consent, that the law should provide no means of enabling treatment to be withheld in appropriate circumstances where the patient is in no condition to indicate, if that was his wish, that he did not consent to it. The point was put forcibly in the judgment of the Supreme Judicial Court of Massachusetts in *Superintendent of Belchertown State School v Saikewicz* (1977) 370 NE 2d 417, 428, as follows:

'To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.'

11.26 In *Re T (Adult: Refusal of Treatment)*,<sup>552</sup> Lord Donaldson MR commented on the resolution of the conflicting principles that arise in this area, including the approach that should be taken where there is doubt about the adult's wishes:<sup>553</sup>

The patient's interest consists of his right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human

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549 Ibid.

550 Ibid.

551 Ibid 865. A similar view has been expressed in a number of Australian cases: see *Re Application by Herrington; Re King* [2007] VSC 151; *Messiha v South East Health* [2004] NSWSC 1061; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197.

552 [1993] Fam 95.

553 Ibid 112, cited with approval in *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff) and *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 91 (McDougall J).

life is sacred and that it should be preserved if at all possible. It is well-established that in the ultimate the right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms.

11.27 The tension between these principles was also considered by McDougall J in *Hunter and New England Area Health Service v A*.<sup>554</sup> His Honour stated:<sup>555</sup>

Were it necessary to resolve the tension, I would conclude ... that a proper understanding of society's interest in the preservation of life cannot be considered without taking into account the constituents, or attributes, of life. In a free and democratic society those attributes include the right of autonomy or self-determination.

11.28 The reasons for a competent adult's refusal of life-sustaining measures are likely to be complex and may be influenced by personal, cultural or religious views or opinions. In *Re B*,<sup>556</sup> a 43 year old woman with tetraplegia sought a declaration that the hospital where she was a patient had treated her unlawfully by refusing her request to turn off her ventilator. Dame Butler-Sloss P emphasised that an adult with a serious disability has the same rights to personal autonomy as a fit adult:<sup>557</sup>

Unless the gravity of the illness has affected the patient's capacity, a seriously disabled patient has the same rights as the fit person to respect for personal autonomy. There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient.

11.29 Dame Butler-Sloss P acknowledged that a patient's values may differ from those of his or her doctors, and cautioned against such a difference in values being interpreted by the doctors as a lack of capacity:<sup>558</sup>

If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision.

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554 (2009) 74 NSWLR 88.

555 Ibid 92.

556 [2002] 2 All ER 449.

557 Ibid 472.

558 Ibid 474.

11.30 The courts have recognised that the medical staff who have been treating a patient may have a conscientious objection to discontinuing treatment or may find it difficult to give effect to the patient's decision to discontinue treatment. Lord Goff addressed this issue in *Airedale NHS Trust v Bland*:<sup>559</sup>

It is not to be forgotten ... that doctors who for conscientious reasons would feel unable to discontinue life support in such circumstances can presumably, like those who have a conscientious objection to abortion, abstain from involvement in such work.

11.31 In *Re B*,<sup>560</sup> Dame Butler-Sloss P acknowledged the close relationship that had developed between the adult and the medical and nursing staff, but referred to the steps that the hospital should have taken to resolve the conflict between the adult and her doctors:<sup>561</sup>

The clinicians had clearly become emotionally involved. That situation was entirely understandable. They had with the nursing staff kept Ms B alive and looked after her in every respect including her most intimate requirements. Obviously a relationship built up and it was, in my view, unjust to the team in the ICU that the burden of decision and responsibility for Ms B largely remained in their hands. Although the issue of capacity may be a grey area, it is one capable of resolution by one means or another. The [NHS Hospital Trust] had a duty to do something effective to resolve the dilemma and to do so with some degree of urgency for the sake of all concerned. This they consistently failed to do up to the hearing of the case in court. It fell to Ms B to initiate proceedings to get the issue resolved.

It is important to draw a careful distinction between the duties of the dedicated team in the ICU of the hospital caring for Ms B and the trust responsible for the working of the hospital. In my view, the latter should have taken steps to deal with the issue.

11.32 By way of guidance, Dame Butler-Sloss P commented that, if 'there is no disagreement about competence but the doctors are for any reason unable to carry out the wishes of the patient, their duty is to find other doctors who will do so'.<sup>562</sup>

11.33 However, the common law 'draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end'.<sup>563</sup> Lord Goff stated:<sup>564</sup>

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559 [1993] AC 789, 874.

560 [2002] 2 All ER 449.

561 *Ibid* 473–4.

562 *Ibid* 475.

563 *Airedale NHS Trust v Bland* [1993] AC 789, 865 (Lord Goff).

564 *Ibid*.

the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be ... So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia—actively causing his death to avoid or to end his suffering.

11.34 Lord Goff examined this distinction:<sup>565</sup>

At the heart of this distinction lies a theoretical question. Why is it that the doctor who gives his patient a lethal injection which kills him commits an unlawful act and indeed is guilty of murder, whereas a doctor who, by discontinuing life support, allows his patient to die, may not act unlawfully—and will not do so, if he commits no breach of duty to his patient? Professor Glanville Williams has suggested ... that the reason is that what the doctor does when he switches off a life support machine 'is in substance not an act but an omission to struggle', and that 'the omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case.'

I agree that the doctor's conduct in discontinuing life support can properly be categorised as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive step to bring the life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support in the first place. In each case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition; and as a matter of general principle an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient. I also agree that the doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine because, although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with life-prolonging treatment then being administered by the doctor. Accordingly, whereas the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life and such conduct cannot possibly be categorised as an omission.

11.35 Lord Goff concluded:<sup>566</sup>

The distinction appears, therefore, to be useful in the present context in that it can be invoked to explain how discontinuance of life support can be differentiated from ending a patient's life by lethal injection. But in the end the reason for that difference is that, whereas the law considers that discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony.

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565 Ibid 866.

566 Ibid.

## OVERVIEW OF THE QUEENSLAND LEGISLATION

### Withholding or withdrawal: a ‘health matter’

11.36 Chapter 5 of the *Guardianship and Administration Act 2000* (Qld) provides for a scheme of decision-making in relation to health matters and special health matters for adults with impaired capacity.

11.37 The *Guardianship and Administration Act 2000* (Qld) defines a ‘health matter’, for an adult as ‘a matter relating to health care, other than special health care, of the adult’.<sup>567</sup> The *Powers of Attorney Act 1998* (Qld) includes a similar definition.<sup>568</sup>

11.38 Significantly, ‘health care, of an adult’ is defined to include:<sup>569</sup>

withholding or withdrawal of a life-sustaining measure<sup>570</sup> for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice. (note added)

11.39 Neither Act defines special health care to include the withholding or withdrawal of a life-sustaining measure.<sup>571</sup> Accordingly, under both Acts, a decision about the withholding or withdrawal of a life-sustaining measure is a health matter, rather than a special health matter.

### Withholding or withdrawal under an advance health directive

11.40 The *Powers of Attorney Act 1998* (Qld) makes provision for an adult to make an advance health directive giving directions about his or her future health care.<sup>572</sup> Under section 42 of the Act, an adult may make an advance health directive only if he or she understands each of the following matters:

- the nature and the likely effects of each direction in the advance health directive;
- that a direction in an advance health directive operates only while the principal has impaired capacity for the matter covered by the direction;
- that the principal may revoke a direction at any time the principal has capacity for the matter covered by the direction; and

<sup>567</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 4.

<sup>568</sup> *Powers of Attorney Act 1998* (Qld) sch 2 s 4.

<sup>569</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(2). The *Powers of Attorney Act 1998* (Qld) includes a similar definition of ‘health care’, except that it refers to ‘a principal’, rather than to ‘an adult’: *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2).

<sup>570</sup> The definition of ‘life-sustaining measure’ is set out at [11.69] below.

<sup>571</sup> This was not always the case: see [11.152]–[11.154] below.

<sup>572</sup> *Powers of Attorney Act 1998* (Qld) s 35(1).

- that at any time the principal is not capable of revoking a direction, the principal is unable to effectively oversee the implementation of the direction.

11.41 It is not sufficient that an adult is *capable* of understanding these matters; an adult must *actually* understand these matters to have the capacity to make an advance health directive. Further, in Chapter 8 of this Report, the Commission has made two recommendations to strengthen the requirements for capacity to make an advance health directive.

11.42 The first recommendation is that section 42 of the *Powers of Attorney Act 1998* (Qld) be amended to provide that a principal has capacity to make an advance health directive only if, in addition to the matters currently listed in section 42(1), the principal understands the nature and effect of the advance health directive and is capable of making the advance health directive freely and voluntarily.<sup>573</sup>

11.43 The second recommendation is that section 42 of the Act be amended so that the list of the matters that a principal must understand to have the capacity to make an advance health directive is expressed as a non-exhaustive list.<sup>574</sup>

11.44 An advance health directive may include a direction to withhold or withdraw a life-sustaining measure.<sup>575</sup> Generally, if a competent adult has given a direction in an advance health directive about his or her end-of-life health care, the matter must be dealt with in accordance with the direction if the adult later loses capacity.<sup>576</sup> In this respect, the legislation gives effect to the principle of self-determination.

11.45 However, if the direction relates to the withholding or withdrawal of a life-sustaining measure, the direction operates only if it satisfies the requirements of section 36(2) of the Act, namely:<sup>577</sup>

- that the adult's medical condition falls into one of the following categories:
  - the adult has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a doctor treating the principal and another doctor, the adult may reasonably be expected to die within one year;
  - the adult is in a persistent vegetative state — that is, the adult has a condition involving severe and irreversible brain damage which, however, allows some or all of the adult's vital bodily functions to continue, including, for example, heart beat or breathing;

<sup>573</sup> See Recommendations 8-3, 8-6 of this Report.

<sup>574</sup> See Recommendation 8-4 of this Report.

<sup>575</sup> *Powers of Attorney Act 1998* (Qld) s 36(2)(b).

<sup>576</sup> *Guardianship and Administration Act 2000* (Qld) s 66(2).

<sup>577</sup> These requirements are considered in detail at [11.87]–[11.150] below.

- the adult is permanently unconscious — that is, the adult has a condition involving brain damage so severe that there is no reasonable prospect of the principal regaining consciousness; or
- the adult has an illness or injury of such severity that there is no reasonable prospect that the adult will recover to the extent that his or her life can be sustained without the continued application of life-sustaining measures;
- for a direction to withhold or withdraw artificial nutrition or artificial hydration — that the commencement or continuation of the measure would be inconsistent with good medical practice; and
- that the adult has no reasonable prospect of regaining capacity for health matters.

### **Withholding or withdrawal by an adult's substitute decision-maker**

11.46 Because the withholding or withdrawal of a life-sustaining measure is a health matter, a decision to withhold or withdraw a life-sustaining measure for an adult may, subject to the effect of section 66A of the *Guardianship and Administration Act 2000* (Qld), be made by the adult's substitute decision-maker (that is, by the adult's guardian, attorney or statutory health attorney). Because of the gravity of such a decision, section 66A of the Act provides that, in certain circumstances, a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure does not operate.<sup>578</sup>

11.47 In making a decision about the withholding or withdrawal of a life-sustaining measure, an adult's substitute decision-maker must apply the General Principles and the Health Care Principle.<sup>579</sup> Under the Health Care Principle, the power may be exercised only if, in all the circumstances, it is in the adult's best interests.<sup>580</sup>

### **The priority for decisions about the withholding or withdrawal of life-sustaining measures**

11.48 Section 66 of the *Guardianship and Administration Act 2000* (Qld) sets out an order of priority for decision-making about health matters for an adult with impaired capacity, and therefore applies to a decision about the withholding or withdrawal of a life-sustaining measure. Section 66 provides:

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<sup>578</sup> *Guardianship and Administration Act 2000* (Qld) s 66A is considered at [11.179] below.

<sup>579</sup> *Guardianship and Administration Act 2000* (Qld) s 34; *Powers of Attorney Act 1998* (Qld) s 76. The General Principles and the Health Care Principle are considered in Chapters 4 and 5 of this Report.

<sup>580</sup> *Guardianship and Administration Act 2000* (Qld) sch 1 s 12(1)(b)(ii); *Powers of Attorney Act 1998* (Qld) sch 1 s 12(1)(b)(ii). This requirement has not been retained in the redrafted Health Care Principle: see Recommendation 5-2 of this Report.

**66 Adult with impaired capacity—order of priority in dealing with health matter**

- (1) 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.
- (2) If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.
- (3) If subsection (2) does not apply and the tribunal has appointed 1 or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian or guardians or under the order.

*Editor's note—*

If, when appointing the guardian or guardians, the tribunal was unaware of the existence of an enduring document giving power for the matter to an attorney, see section 23 (Appointment without knowledge of enduring document), particularly subsection (2).

- (4) If subsections (2) and (3) do not apply and the adult has made 1 or more enduring documents appointing 1 or more attorneys for the matter, the matter may only be dealt with by the attorney or attorneys for the matter appointed by the most recent enduring document.
- (5) If subsections (2) to (4) do not apply, the matter may only be dealt with by the statutory health attorney.
- (6) This section does not apply to a health matter relating to health care that may be carried out without consent under division 1.

11.49 The effect of section 66 is that an adult's substitute decision-maker may make a decision about the withholding or withdrawal of a life-sustaining measure only if the adult does not have an advance health directive that gives a direction about the matter.

**Withholding or withdrawal of a life-sustaining measure in an acute emergency**

11.50 The *Guardianship and Administration Act 2000* (Qld) includes a number of provisions that authorise a health provider, in limited circumstances, to carry out particular types of health care without consent. Section 63A deals with the withholding or withdrawal of a life-sustaining measure, without consent, in an acute emergency or, more accurately, when the decision to withhold or withdraw the measure must be taken immediately.<sup>581</sup> It provides:

**63A Life-sustaining measure in an acute emergency**

- (1) A life-sustaining measure may be withheld or withdrawn for an adult without consent if the adult's health provider reasonably considers—

<sup>581</sup>

Note, s 63 of the *Guardianship and Administration Act 2000* (Qld), which authorises a health provider, in specified circumstances, to carry out health care 'urgently' without consent, does not apply to the withholding or withdrawal of a life-sustaining measure for an adult: s 63(5).

- (a) the adult has impaired capacity for the health matter concerned; and
  - (b) the commencement or continuation of the measure for the adult would be inconsistent with good medical practice; and
  - (c) consistent with good medical practice, the decision to withhold or withdraw the measure must be taken immediately.
- (2) However, the measure may not be withheld or withdrawn without consent if the health provider knows the adult objects to the withholding or withdrawal.

*Editor's note—*

**Object** is defined in schedule 4 (Dictionary).

- (3) The health provider must certify in the adult's clinical records as to the various things enabling the measure to be withheld or withdrawn because of this section.
- (4) For this section, artificial nutrition and hydration is not a **life-sustaining measure**.

11.51 The intention of this provision was said to be to ensure that, in an emergency situation, 'adults with impaired capacity do not have to be subjected to invasive or unnecessary treatments when good medical practice demands that such treatment should cease immediately'.<sup>582</sup> However, the section does not authorise the withholding or withdrawal of a life-sustaining measure without consent if the health provider knows that the adult objects to the withholding or withdrawal of the measure.<sup>583</sup>

### Certification in clinical records

11.52 Generally, if a life-sustaining measure is to be withheld or withdrawn, section 66B of the *Guardianship and Administration Act 2000* (Qld) requires the adult's health provider to certify in the adult's medical records the authority for withholding or withdrawing the measure — that is, whether the measure was withheld or withdrawn:

- on the basis of the adult's advance health directive under section 66(2) of the *Guardianship and Administration Act 2000* (Qld) and section 36 of the *Powers of Attorney Act 1998* (Qld); or

<sup>582</sup> Queensland, *Parliamentary Debates*, Legislative Assembly, 17 October 2001, 2909 (Rod Welford, Attorney-General and Minister for Justice).

<sup>583</sup> *Guardianship and Administration Act 2000* (Qld) s 63A(2).

- with the consent of the adult's substitute decision-maker under section 66(3), (4) or (5) and section 66A of the *Guardianship and Administration Act 2000* (Qld).<sup>584</sup>

11.53 A different certification requirement applies if the withholding or withdrawal of the life-sustaining measure is authorised to be carried out without consent under section 63A of the *Guardianship and Administration Act 2000* (Qld).<sup>585</sup>

### **The Adult Guardian's role in relation to the withholding or withdrawal of life-sustaining measures**

11.54 The *Guardianship and Administration Act 2000* (Qld) includes two provisions that enable the Adult Guardian to exercise power for a health matter for an adult even though the Adult Guardian is not the adult's guardian, attorney or statutory health attorney. Although these provisions apply to health matters generally, and are not limited to the withholding or withdrawal of a life-sustaining measure, the Adult Guardian's powers in this regard are especially important when exercised in this context.

11.55 Section 42 of the *Guardianship and Administration Act 2000* (Qld) applies if there is a disagreement between an adult's substitute decision-makers about a health matter for the adult and the disagreement cannot be resolved by mediation by the Adult Guardian. In that situation, the Adult Guardian may 'exercise the power for the health matter'.<sup>586</sup> Where the health matter involves the proposed withholding or withdrawal of a life-sustaining measure, section 42 enables the Adult Guardian to consent to the withholding or withdrawal of the measure or to the provision of the measure.<sup>587</sup>

11.56 Section 43 of the *Guardianship and Administration Act 2000* (Qld) applies if an adult's substitute decision-maker refuses to make, or makes, a decision about a health matter for an adult and the refusal, or the decision, is contrary to the Health Care Principle. In that situation, the Adult Guardian may exercise power for the health matter.<sup>588</sup>

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584 *Guardianship and Administration Act 2000* (Qld) s 66B(2).

585 *Guardianship and Administration Act 2000* (Qld) ss 63A(3), 66B(1).

586 *Guardianship and Administration Act 2000* (Qld) s 42(1).

587 *Guardianship and Administration Act 2000* (Qld) s 42 is considered in Chapter 23 of this Report.

588 *Guardianship and Administration Act 2000* (Qld) s 43(1). Section 43 is considered in Chapter 23 of this Report.

## THE DEFINITION OF ‘HEALTH CARE’

### The law in Queensland

11.57 The *Guardianship and Administration Act 2000* (Qld) defines ‘health care’, relevantly, in the following terms:<sup>589</sup>

#### 5 Health care

- (1) **Health care**, of an adult, is care or treatment of, or a service or a procedure for, the adult—
- (a) to diagnose, maintain, or treat the adult’s physical or mental condition; and
  - (b) carried out by, or under the direction or supervision of, a health provider.
- (2) **Health care**, of an adult, includes withholding or withdrawal of a life-sustaining measure<sup>590</sup> for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice. (note added; emphasis added)

11.58 The *Powers of Attorney Act 1998* (Qld) includes a similar definition of ‘health care’, except that it refers to ‘a principal’, rather than to ‘an adult’.<sup>591</sup>

11.59 Section 5(2) of the definition in each Act extends the definition of health care to include the withholding or withdrawal of a life-sustaining measure, but only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>592</sup> The effect of the limitation is twofold.

11.60 First, although a guardian, attorney or statutory health attorney may exercise power for a health matter, he or she may consent to the withholding or withdrawal of a life-sustaining measure only if the commencement or continuation of the measure would be inconsistent with good medical practice. If it would not be inconsistent with good medical practice to commence or continue the measure, the withholding or withdrawal of the measure will not constitute health care and the adult’s substitute decision-maker will not have power for the matter.

11.61 Secondly, a direction in an advance health directive to withhold or withdraw a life-sustaining measure will constitute a direction about a health matter only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>593</sup> If it would not be inconsistent with good medical practice to commence or continue the measure, the withholding or withdrawal of

589 *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(1)–(2).

590 The definition of ‘life-sustaining measure’ is set out at [11.69] below.

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

592 The background to the insertion of s 5(2) is considered at [11.152] below.

593 *Powers of Attorney Act 1998* (Qld) s 35(1)(a), (2)(b), sch 2 ss 5(2), 5A(1).

the measure will not constitute health care and will not therefore be a matter about which a direction can be given in an advance health directive.<sup>594</sup>

11.62 The threshold issue is whether the limitation in section 5(2) of the definition of 'health care' in the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be retained in the definition of 'health care'. If that limitation should not be imposed by way of the definition of 'health care', the further issue to be decided is whether the limitation should nevertheless be included:

- in the *Guardianship and Administration Act 2000* (Qld) as an additional limitation on the operation of a consent to the withholding or withdrawal of a life-sustaining measure; or
- in section 36(2) of the *Powers of Attorney Act 1998* (Qld) as an additional limitation on the operation of a direction in an advance health directive to withhold or withdraw a life-sustaining measure.

## Submissions

11.63 The Commission did not specifically seek submissions on the limitation that applies in section 5(2) of the definition of 'health care'. However, the Adult Guardian commented that it is not appropriate that a direction in an advance health directive to withhold or withdraw a life-sustaining measure is effective only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>595</sup>

## The Commission's view

11.64 As explained earlier, section 5(2) of the definition of 'health care' in schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and schedule 2 of the *Powers of Attorney Act 1998* (Qld) provides that health care includes the withholding or withdrawal of a life-sustaining measure 'if the commencement or continuation of the measure would be inconsistent with good medical practice'.

11.65 The inclusion of that limitation in the definition of health care means that a significant limitation is separated from the other, perhaps more obvious, limitations that apply to the withholding or withdrawal of a life-sustaining measure — namely, the limitations currently found in section 66A of the *Guardianship and Administration Act 2000* (Qld) and section 36(2) of the *Powers of Attorney Act 1998* (Qld).<sup>596</sup> This must inevitably make it more difficult for users of the legislation to identify the matters that are relevant to determining whether a consent given for the withholding or withdrawal of a life-sustaining measure, or a direction in an advance health directive to withhold or withdraw a life-sustaining measure, is valid.

<sup>594</sup> *Powers of Attorney Act 1998* (Qld) s 35(1)(a), sch 2 s 5(2).

<sup>595</sup> Submission 164.

<sup>596</sup> See [11.45] above, [11.179]–[11.180] below.

11.66 The inclusion of this limitation in the definition of ‘health care’ also has a significant effect on the operation of the offence provision that applies in relation to health care. Section 79 of the *Guardianship and Administration Act 2000* (Qld) provides that it is an offence for a person to carry out health care of an adult with impaired capacity unless the health care has been authorised, or consent has been given to the health care, in one of the ways specified in the section.<sup>597</sup> Because section 79 applies in relation to ‘health care’ as defined under the Act, the section does not apply to the withholding or withdrawal of a life-sustaining measure where it would not be inconsistent with good medical practice to commence or continue the measure. As a result, if a health provider withheld or withdrew a life-sustaining measure without authorisation or consent and the commencement or continuation of the measure would *not* be inconsistent with good medical practice, the health provider would not commit an offence under section 79.

11.67 For these reasons, the Commission considers that it is not appropriate to impose, by way of a definition, the kind of limitation found in section 5(2) of the definition of health care that applies under the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld). The words ‘if the commencement or continuation of the measure would be inconsistent with good medical practice’ should therefore be omitted from section 5(2) of the definition in each Act.

11.68 Later in this chapter, the Commission considers whether such a limitation should be included in the substantive provisions that apply to the operation of:

- a direction in an advance health directive to withhold or withdraw a life-sustaining measure;<sup>598</sup> or
- consent given to the withholding or withdrawal of a life-sustaining measure.<sup>599</sup>

## THE DEFINITION OF ‘LIFE-SUSTAINING MEASURE’

### The law in Queensland

11.69 Both the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) include the following definition of ‘life-sustaining measure’:<sup>600</sup>

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597 *Guardianship and Administration Act 2000* (Qld) s 79 is considered further at [11.260]–[11.261] below.

598 See [11.169]–[11.172] below.

599 See [11.221]–[11.224] below.

600 *Guardianship and Administration Act 2000* (Qld) sch 2 s 5A; *Powers of Attorney Act 1998* (Qld) sch 2 s 5A.

## 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**.

11.70 Although antibiotics and dialysis are not specifically mentioned in section 5A(2), it appears that, in some circumstances, they may constitute life-sustaining measures.<sup>601</sup>

11.71 Section 5A(3) excludes a blood transfusion from the definition of life-sustaining measure. The reason for this exclusion was not mentioned in either the Explanatory Notes or the Second Reading Speech for the Powers of Attorney Bill 1997 (Qld) or the Guardianship and Administration Bill 2000 (Qld). However, the effect of the exclusion is that the provisions of the guardianship legislation that apply specifically to the withholding and withdrawal of life-sustaining measures do not apply to blood transfusions.<sup>602</sup> In particular, section 36(2) of the *Powers of Attorney Act 1998* (Qld), which limits the circumstances in which a direction in an advance health directive to withhold or withdraw a life-sustaining measure can operate,<sup>603</sup> does not apply to a direction in an advance health directive to refuse a blood transfusion.

## The law in other jurisdictions

11.72 The equivalent expressions in the interstate legislation do not exclude a blood transfusion. They are generally defined in terms similar to section 5A(1) of the Queensland definition of 'life-sustaining measure'.

11.73 In the Northern Territory, the *Natural Death Act* (NT) includes the following definition of 'extraordinary measures'.<sup>604</sup>

<sup>601</sup> See *Re MHE* [2006] QGAAT 9 (dialysis); *Re RWG* [2000] QGAAT 2, [23] (antibiotics). In the latter decision, the Tribunal expressed the view that it was only in very rare instances that antibiotics would be a life-sustaining measure: at [78].

<sup>602</sup> See eg *Guardianship and Administration Act 2000* (Qld) ss 63A, 66A, 66B; *Powers of Attorney Act 1998* (Qld) s 36(2).

<sup>603</sup> See [11.87] below. The limitations in s 36(2) of the *Powers of Attorney Act 1998* (Qld) are considered in greater detail at [11.92]–[11.150] below.

<sup>604</sup> *Natural Death Act* (NT) s 3.

**extraordinary measures** means medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation; ...

11.74 Similarly, the definition of 'life-sustaining measures' in the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides:<sup>605</sup>

**life sustaining measures** means medical treatment that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation, and includes assisted ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation; ...

11.75 The *Guardianship and Administration Act 1990* (WA) includes a similar definition of 'life-sustaining measure':<sup>606</sup>

**life sustaining measure** means a medical, surgical or nursing procedure directed at supplanting or maintaining a vital bodily function that is temporarily or permanently incapable of independent operation, and includes assisted ventilation and cardiopulmonary resuscitation; ...

## Discussion Paper

11.76 In the Discussion Paper, the Commission noted that it had been suggested that the exclusion of blood transfusions from the definition was counter-intuitive.<sup>607</sup> The Commission sought submissions on whether the definition of 'life-sustaining measure' in the guardianship legislation is appropriate or should be changed in some way.<sup>608</sup>

## Submissions

11.77 One respondent was of the view that the current definition of 'life-sustaining measure' was appropriate.<sup>609</sup>

11.78 However, other respondents suggested a number of different changes to the definition.

11.79 A legal academic with expertise in health law and guardianship law commented that the definition of 'life-sustaining measure' should not exclude a blood transfusion.<sup>610</sup> A similar view was expressed at a forum of health

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605 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4.

606 *Guardianship and Administration Act 1990* (WA) s 3(1).

607 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, [12.69], referring to Submission C93.

608 *Ibid* 296.

609 Submission 161.

610 Submission 144.

professionals.<sup>611</sup>

11.80 The Adult Guardian also expressed the view that the definition of 'life-sustaining measure' should not exclude a blood transfusion.<sup>612</sup>

The practice within the office of the Adult Guardian reveals no particular issues with the definition except that it would be preferable to withdraw the reference to a blood transfusion as not being a life-sustaining measure. What is a life sustaining measure is, to some extent, determined by the context in which the patient presents and in appropriate circumstances it may include a blood transfusion.

11.81 Another respondent suggested that the definition should be amended to include antibiotics and dialysis.<sup>613</sup>

11.82 Right to Life Australia disagreed with the inclusion of artificial nutrition and hydration in the definition of life-sustaining measure.<sup>614</sup>

We strongly reject the inclusion of the provision of nutrition and hydration, by any appropriate means, with other life-sustaining measures. The provision of food and water should not be classified as a medical procedure even if it is done by means other than by mouth. It is just normal and essential care that should not be withheld or withdrawn from anyone except in the circumstances of the terminal stage of a terminal illness.

### The Commission's view

11.83 If section 5A(3) of the definition of 'life-sustaining measure' did not specifically exclude a blood transfusion, a blood transfusion would fall within section 5A(1) of that definition. The purpose of excluding a blood transfusion appears to have been to avoid the application of the various provisions of the guardianship legislation that apply specifically to life-sustaining measures, in particular, section 36(2) of the *Powers of Attorney Act 1998* (Qld).

11.84 If the limitations imposed by section 36(2) on the operation of a direction to withhold or withdraw a life-sustaining measure are considered too restrictive to apply to the refusal of a blood transfusion, that is an argument for reconsidering the limitations imposed by that section. In the Commission's view, the more principled and transparent approach is for any concern about the application of section 36(2) to a direction refusing a blood transfusion to be addressed in the specific context of that provision, rather than by excluding blood transfusions from the definition of life-sustaining measure. Consequently, the Commission recommends that section 5A(3) of the definition of 'life-sustaining measure' in schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be omitted.

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611 Health forum 5.

612 Submission 164.

613 Submission 165.

614 Submission 149.

11.85 Although one submission was of the view that the definition of ‘life-sustaining measure’ should not include artificial nutrition and hydration, the express inclusion of artificial nutrition and hydration in the definition is consistent with judicial authority<sup>615</sup> and medical opinion<sup>616</sup> that artificial nutrition and hydration is a form of medical treatment or therapy. The Commission accepts that artificial nutrition and hydration are very different from the provision of food and water to a patient by non-medical means, and that the definition of ‘life-sustaining measure’ should continue to include artificial nutrition and hydration. The separate issue of whether the withholding or withdrawal of artificial nutrition or hydration should be treated differently from the withholding or withdrawal of other forms of life-sustaining measures is considered later in this chapter.<sup>617</sup>

## WITHHOLDING OR WITHDRAWAL OF A LIFE-SUSTAINING MEASURE UNDER AN ADVANCE HEALTH DIRECTIVE<sup>618</sup>

### The law in Queensland

11.86 The *Powers of Attorney Act 1998* (Qld) provides that an adult (called the ‘principal’) may, by an advance health directive, give directions about health matters and special health matters for his or her future health care.<sup>619</sup> In particular, the Act provides that a principal may give a direction ‘requiring, in the circumstances specified, a life-sustaining measure to be withheld or withdrawn’.<sup>620</sup>

11.87 Section 36 of the *Powers of Attorney Act 1998* (Qld) deals with the operation of an advance health directive, including the operation of a direction in an advance health directive to withhold or withdraw a life-sustaining measure. It provides:

#### **36 Operation of advance health directive**

- (1) A direction in an advance health directive—
- (a) operates only while the principal has impaired capacity for the matter covered by the direction; and
  - (b) is as effective as if—
    - (i) the principal gave the direction when decisions about the matter needed to be made; and

<sup>615</sup> See *Re BWV; Ex parte Gardner* (2003) 7 VR 487, 504 (Morris J); *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [35] (Martin CJ); *Airedale NHS Trust v Bland* [1993] AC 789, 858 (Lord Keith), 869–70 (Lord Goff). Artificial nutrition and hydration are considered in more detail at [11.121] below.

<sup>616</sup> See eg MR Gillick, ‘Rethinking the Role of Tube Feeding in Patients with Advanced Dementia’ (2000) 342 *New England Journal of Medicine* 206.

<sup>617</sup> See [11.121]–[11.135] below.

<sup>618</sup> Advance health directives are considered in Chapter 9 of this Report.

<sup>619</sup> *Powers of Attorney Act 1998* (Qld) s 35(1)(a).

<sup>620</sup> *Powers of Attorney Act 1998* (Qld) s 35(2)(b).

- (ii) the principal then had capacity for the matter.<sup>36</sup>
- (2) A direction to withhold or withdraw a life-sustaining measure<sup>37</sup> can not operate unless—
  - (a) 1 of the following applies—
    - (i) the principal has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a doctor treating the principal and another doctor, the principal may reasonably be expected to die within 1 year;
    - (ii) the principal is in a persistent vegetative state, that is, the principal has a condition involving severe and irreversible brain damage which, however, allows some or all of the principal's vital bodily functions to continue, including, for example, heart beat or breathing;
    - (iii) the principal is permanently unconscious, that is, the principal has a condition involving brain damage so severe that there is no reasonable prospect of the principal regaining consciousness;<sup>38</sup>
    - (iv) the principal has an illness or injury of such severity that there is no reasonable prospect that the principal will recover to the extent that the principal's life can be sustained without the continued application of life-sustaining measures; and
  - (b) for a direction to withhold or withdraw artificial nutrition or artificial hydration—the commencement or continuation of the measure would be inconsistent with good medical practice; and
  - (c) the principal has no reasonable prospect of regaining capacity for health matters.

36 See also section 101 (No less protection than if adult gave health consent).

37 Defined in schedule 2, section 5A.

38 This is sometimes referred to as 'a coma'.

11.88 Section 36(1)(b) provides that a direction in an advance health directive is as effective as if the principal gave the direction when decisions about the matter needed to be made and the principal then had capacity for the matter.<sup>621</sup> If the direction is to withhold or withdraw a life-sustaining measure, this means that, subject to the potential operation of section 36(2), the direction is as effective as a refusal of health care by an adult with capacity. Consequently, if, contrary to a direction in the advance health directive of an adult with impaired capacity, a health

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To emphasise the limitations that apply to a consent given by a competent adult, the Commission has recommended in Chapter 9 that s 36(1)(b) be amended to provide that a direction in an advance health directive is as effective as, *but no more effective than*, if the principal gave the direction when decisions about the matter needed to be made and the principal then had capacity for the matter: see Recommendation 9-3(a) of this Report.

provider provides a life-sustaining measure to the adult, the provision of the life-sustaining measure will amount to a tort unless the health provider is protected by either section 102 or 103 of the *Powers of Attorney Act 1998* (Qld).<sup>622</sup> It may also amount to an assault under the Criminal Code (Qld).

11.89 Because of the significant consequences of a direction to withhold or withdraw a life-sustaining measure, section 36(2) of the *Powers of Attorney Act 1998* (Qld) provides that a direction in an advance health directive to withhold or withdraw a life-sustaining measure cannot operate unless certain conditions are satisfied. For a direction to withhold or withdraw a life-sustaining measure to operate, it is necessary for the requirements in section 36(2)(a) and (c) to be satisfied. If the direction is to withhold or withdraw artificial nutrition or artificial hydration, the additional requirement in section 36(2)(b) — that is, that the commencement or continuation of the measure would be inconsistent with good medical practice — must also be satisfied.

11.90 The approach taken by the *Powers of Attorney Act 1998* (Qld) in relation to the effectiveness of a direction to withhold or withdraw a life-sustaining measure is different from the position at common law, where the effectiveness of an adult's refusal of life-sustaining health care is not restricted in this way.<sup>623</sup>

11.91 As mentioned previously, section 5(2) of the definition of 'health care' in schedule 2 of the *Powers of Attorney Act 1998* (Qld) includes 'withholding or withdrawal of a life-sustaining measure for the principal *if the commencement or continuation of the measure for the principal would be inconsistent with good medical practice*'.<sup>624</sup> As a result of that limitation, if the commencement or continuation of the measure would *not* be inconsistent with good medical practice, a direction to withhold or withdraw the measure will not be a direction about a health matter and will not therefore be a direction that may be given under the Act.<sup>625</sup> Earlier in this chapter, the Commission has recommended that this limitation should not be included in the definition of 'health care'.<sup>626</sup> Whether the limitation should apply as an additional limitation under section 36(2) is considered below, together with the other limitations in section 36(2).

## **The requirement that the adult's medical condition falls within one of four categories**

### ***Issues for consideration***

11.92 An issue for consideration is whether the current limitation in section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) is appropriate. That section provides that a direction in an advance health directive to withhold or withdraw a

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622 *Powers of Attorney Act 1998* (Qld) ss 102, 103 are considered in Chapter 9 of this Report.

623 See [11.20]–[11.23] above.

624 *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2) (emphasis added).

625 See B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 73–6.

626 See [11.67] above.

life-sustaining measure does not operate unless one of the following conditions relating to the gravity of the adult's illness is satisfied, namely, that:<sup>627</sup>

- the adult has a terminal illness or condition that is incurable or irreversible and as a result of which, in the opinion of a doctor treating the adult and another doctor, the adult may reasonably be expected to die within one year;
- the adult is in a persistent vegetative state — that is, the adult has a condition involving severe and irreversible brain damage which, however, allows some or all of the adult's vital bodily functions to continue, including, for example, heart beat or breathing;
- the adult is permanently unconscious — that is, the adult has a condition involving brain damage so severe that there is no reasonable prospect of the adult regaining consciousness; or
- the adult has an illness or injury of such severity that there is no reasonable prospect that the adult will recover to the extent that his or her life can be sustained without the continued application of life-sustaining measures.

11.93 There may be circumstances where none of the four conditions in section 36(2)(a) applies, and yet the adult does not want any life-sustaining measures to be provided. For example, an adult with cancer may have provided in an advance health directive that he or she does not want any life-sustaining measures to be provided in the event that he or she loses capacity. In particular, the adult might refuse cardiac pulmonary resuscitation ('CPR') on the basis that he or she would prefer to die from a heart attack than from cancer. If the adult cannot satisfy section 36(2)(a)(i) (because it is not reasonably expected that the adult will die within a year), the direction will not operate unless the adult is in a persistent vegetative state, is permanently unconscious, or has no prospect of recovering to the extent that his or her life can be sustained without the continued application of life-sustaining measures. If the adult's medical condition does not fall into any of those other categories and the adult has a heart attack, the adult's direction that he or she is not to receive CPR will not operate.

### ***The law in other jurisdictions***

11.94 With the exception of New South Wales and Tasmania, the other Australian jurisdictions have statutory provisions dealing with advance health directives (or their equivalent).<sup>628</sup> The legislation either provides expressly for the refusal of life-sustaining measures (or the equivalent) by the principal<sup>629</sup> or is

<sup>627</sup> *Powers of Attorney Act 1998* (Qld) s 36(2) is set out at [11.87] above.

<sup>628</sup> See [9.48]–[9.55] of this Report.

<sup>629</sup> See *Natural Death Act* (NT) s 4(1); *Guardianship and Administration Act 1990* (WA) ss 3(1) (definitions of 'treatment', 'treatment decision'), 110P.

framed in terms that are sufficiently wide to encompass the refusal of such measures.<sup>630</sup>

*Jurisdictions with restrictions relating to the gravity of the adult's medical condition*

11.95 In the Northern Territory, the legislation enables an adult to make a direction that he or she is not to be subjected to 'extraordinary measures' in the event that he or she has a terminal illness.<sup>631</sup> The legislation includes the following definition of 'terminal illness':<sup>632</sup>

**terminal illness** means such an illness, injury or degeneration of mental or physical faculties:

- (a) that death would, if extraordinary measures were not undertaken, be imminent; and
- (b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.

11.96 Similarly, in South Australia an adult may give a direction about the medical treatment that he or she wants, or does not want, if at some future time the adult is 'in the terminal phase of a terminal illness, or in a persistent vegetative state' and is 'incapable of making decisions about medical treatment when the question of administering the treatment arises'.<sup>633</sup>

11.97 However, the South Australian Advance Directives Review Committee has recommended that 'the personal advance directive not be limited to the terminal phase of a terminal illness or a persistent vegetative state but allow for instructions to be written to apply to any period of lost or diminished capacity'.<sup>634</sup> It emphasised that quality of life is very much an individual concept.<sup>635</sup>

Treatment may be intrusive, burdensome and futile at other stages of life, not just when a person is in the terminal phase of a terminal illness. The Consent Act is not clear about who assesses whether an intervention is intrusive, burdensome and futile, or who assesses whether a given outcome preserves or improves quality of life. These concepts are very personal, and likely to be regarded differently by each individual. Only the patient, or someone who knows them well, could decide what intervention is intrusive for them. Some people would find a breathing mask intrusive because it stifles communication. Others would tolerate that but not a feeding tube. Likewise, what is burdensome is a personal rather than a medical decision. Some people would

630 See *Medical Treatment (Health Directions) Act 2006* (ACT) s 7(1); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Medical Treatment Act 1988* (Vic) s 5.

631 *Natural Death Act* (NT) s 4(1).

632 *Natural Death Act* (NT) s 3.

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

634 Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: First Report of the Review of South Australia's Advance Directives, Proposed Changes to Law and Policy* 43 <[http://www.agd.sa.gov.au/news/pdfs/2009/AG\\_Report\\_1\\_final\\_300808.pdf](http://www.agd.sa.gov.au/news/pdfs/2009/AG_Report_1_final_300808.pdf)> at 18 August 2010.

635 *Ibid* 72.

find being confined to a wheelchair burdensome, while others would tolerate that so long as they were not incontinent. The notion of burden is linked closely with personal dignity, which is a very individual matter.

11.98 The Review Committee therefore recommended that:<sup>636</sup>

it be recognised that competent adults decide for themselves what circumstances are burdensome, intolerable, intrusive or unacceptable and what they consider constitutes an appropriate quality of life, and can record such decisions in an advance directive.

11.99 In rejecting the limitation currently imposed by the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*, the Review Committee also considered that it was sometimes extremely difficult to determine if someone was in the terminal phase of a terminal illness or in a persistent vegetative state.<sup>637</sup>

The Review Committee considered extending the scope of the personal [advance directive] to times other than the terminal phase of a terminal illness or a persistent vegetative state, but retaining a limit for its application. However, requiring the person to be suffering from a terminal illness (but not be in the terminal stage) or to be in a coma (but not [a persistent vegetative state]) before a personal [advance directive] could be activated did not satisfy the needs of people as indicated in many submissions, and did not solve the current challenges to medical practitioners and ambulance officers. Emergency medicine specialists and senior ambulance personnel advised the Review Committee that it is often impossible, especially in an emergency, to diagnose whether someone is in the terminal phase of a terminal illness and therefore approaching death. Even when seriously ill, it is notoriously hard to predict when a person might die. Making a quick decision about whether a person's symptoms indicate their illness is terminal can be similarly problematic. Differentiating between a persistent vegetative state (or post-coma unresponsiveness) and other causes of deep unconsciousness is similarly fraught. The National Health & Medical Research Council guidelines require at least six months of investigations before post-coma unresponsiveness is diagnosed.

11.100 The Review Committee also referred to anomalies between a refusal of treatment made in an anticipatory direction under the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* and a refusal of treatment by an enduring guardian (the equivalent of an attorney for personal matters in Queensland) under the *Guardianship and Administration Act 1993 (SA)*.<sup>638</sup>

A person may have capacity but find her life intolerable, such as an elderly woman in a high care facility who has mental capacity but finds her life painful and undignified. She has a cardiac arrest and has written that her preference is not to be resuscitated because she finds her current level of functioning unacceptable and does not want interventions that would simply continue her life in its current state or worse. ... If she had completed an Anticipatory Direction, it would not apply because she is not in the terminal phase of a terminal illness. ... she would be resuscitated against her will. An Enduring

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636 Ibid 74.

637 Ibid 40.

638 Ibid 71.

Guardian could however advise that she would have refused CPR and so should not be resuscitated.

*Jurisdictions without restrictions relating to the gravity of the adult's medical condition*

11.101 In the ACT, there appear to be no restrictions on when a 'health direction' can operate.<sup>639</sup> Similarly, in Western Australia, the *Guardianship and Administration Act 1990* (WA) allows an advance health directive to be made in relation to life-sustaining measures<sup>640</sup> without limitations of the kind referred to in section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld).

11.102 In Victoria, an adult may make a refusal of treatment certificate refusing medical treatment, or treatment of a particular kind, for a 'current condition'<sup>641</sup> — that is, a condition that the adult has at the time that he or she makes the refusal of treatment certificate. However, the legislation does not restrict the operation of a decision in the certificate to a time when the adult's condition has reached a particular stage.

**Discussion Paper**

11.103 In the Discussion Paper, the Commission sought submissions on whether it is appropriate that section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) provides that a direction in an advance health directive to withhold or withdraw a life-sustaining measure does not operate unless, in addition to the other requirements of section 36(2), one of the following circumstances applies:<sup>642</sup>

- the adult has a terminal illness or condition that is incurable and irreversible and as a result of which, in the opinion of a doctor treating the adult and another doctor, the adult may reasonably be expected to die within one year;
- the adult is in a persistent vegetative state;
- the adult is permanently unconscious and has brain damage so severe that there is no reasonable prospect of the adult regaining consciousness; or
- the adult has an illness or injury of such severity that there is no reasonable prospect that the adult will recover to the extent that his or her life can be sustained without the continued application of life-sustaining measures.

639 See *Medical Treatment (Health Directions) Act 2006* (ACT).

640 See *Guardianship and Administration Act 1990* (WA) pt 9B. *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) s 11, inserted pt 9B (Advance Health Directives) into the *Guardianship and Administration Act 1990* (WA), commencing 15 February 2010.

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

642 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 301.

### Submissions

11.104 Two respondents considered that the requirements of section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) were broadly appropriate.<sup>643</sup>

11.105 Family Voice Australia also commented generally that the legislation contains ‘appropriate provisions to ensure that advance health directives ... that could result in the unnecessary or untimely death of the adult are not acted upon recklessly’.<sup>644</sup>

11.106 A geriatrician at one of the Commission’s health forums suggested that the period of one year that is referred to in section 36(2)(a)(i) of the *Powers of Attorney Act 1998* (Qld) was ‘a bit long’<sup>645</sup> — that is, that the provision should limit the operation of the direction to where the principal may reasonably be expected to die within a shorter (unspecified) period than the current period of 12 months.

11.107 However, another doctor at that forum could envisage circumstances where a direction to withhold or withdraw a life-sustaining measure should be capable of being effective even though the person was not reasonably expected to die within one year. He gave, as an example, a person with a degenerative disease, such as motor neurone disease, who might make an advance health directive refusing assisted ventilation. It was suggested at the forum, however, that even if a person in this situation did not satisfy the requirements of section 36(2)(a)(i), the person would probably satisfy the requirement in section 36(2)(a)(iv) that there is no reasonable prospect that the principal will recover to the extent that the person’s life can be sustained without the continued application of life-sustaining measures.

11.108 A legal academic with expertise in health law and guardianship law expressed the view that there is no justification for the limitations in section 36(2)(a):<sup>646</sup>

They are an unjustifiable erosion of personal autonomy, and no equivalent restrictions exist at common law.

11.109 The Christian Science Committee on Publication for Queensland expressed a similar view:<sup>647</sup>

We do not believe the stated conditions for withholding or withdrawing a life-sustaining measure under an advance health directive are appropriate, and have the potential to grossly contravene an individual’s express declarations for their care.

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643 Submissions 161, 165.

644 Submission 157.

645 Health forum 6.

646 Submission 144.

647 Submission 151.

11.110 The Adult Guardian did not comment directly on whether section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) should be retained, but referred to the resulting anomaly between the effect of a refusal given contemporaneously and a refusal given by an advance health directive.<sup>648</sup>

The Adult Guardian makes no submission on this point except to say that it seems inconsistent that a person who has capacity can decline [a life-sustaining measure] regardless of whether the circumstances that are stipulated in s 36 PAA apply, but once an adult loses capacity if relying on a legislative instrument their wishes are only operative if the conditions stated apply.

11.111 Right to Life Australia commented that the term ‘persistent vegetative state’, which is used in section 36(2)(a)(ii) of the *Powers of Attorney Act 1998* (Qld), is degrading and should be replaced with a term such as ‘persistent non-responsive state’.<sup>649</sup>

### ***The Commission’s view***

11.112 Two main concerns have been raised about the use of advance health directives in relation to the withholding and withdrawal of life-sustaining measures:<sup>650</sup>

- The first concern is the potential for the advance health directive mechanism to be open to abuse in the form of a vulnerable person being pressured into making an advance health directive that includes directions for the withholding or withdrawal of life-sustaining measures.
- The second concern is the risk that the terms of the advance health directive might operate in circumstances that were not genuinely within the contemplation of the adult when making the advance health directive. This could occur because the adult had inadequate knowledge at the time he or she made the advance health directive or because the adult did not accurately foresee the different circumstances that might arise or what his or her attitude might be in those circumstances. It could also be that the adult did not foresee improvements in medical practice between the time of making the advance health directive and when it came into effect.

11.113 In deciding whether section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) should be retained, it is important to consider the extent to which that provision operates as a safeguard in terms of these concerns.

11.114 Section 36(2)(a) of the *Powers of Attorney Act 1998* (Qld) does not respond directly to these concerns. It does not protect an adult from being pressured into making an advance health directive; nor does it address the risk that a direction might operate in a situation not contemplated by the adult. However,

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648 Submission 164.

649 Submission 149.

650 See [11.14]–[11.15] above.

because section 36(2)(a) limits the circumstances in which an adult's direction to withhold or withdraw a life-sustaining measure may operate, it necessarily limits the potential for such a direction to operate in circumstances that were not contemplated by the adult, although it does so in a blunt and arbitrary way and not in a way that is consistent with the recognition of the adult's autonomy.

11.115 Because section 36(2)(a) requires the adult's medical condition to fall within one of four categories, the section represents a significant limitation on the autonomy of an adult. What constitutes 'quality of life' for a person will vary from person to person.<sup>651</sup> It is understandable that different people will have different views about the type or extent of the treatment that is acceptable to them.

11.116 The requirement to fall within one of the four categories mentioned in section 36(2)(a) means that, in some cases, an adult's direction refusing a life-sustaining measure will not be able to operate simply because the adult is not reasonably expected to die within one year and does not meet any of the other conditions specified in section 36(2)(a)(ii)–(iv). In addition, it may be difficult to determine with any certainty whether an adult may reasonably be expected to die within a year.<sup>652</sup>

11.117 Earlier in this chapter, the Commission has recommended that the definition of 'life-sustaining measure' should be amended so that it does not exclude a blood transfusion.<sup>653</sup> The recommended definition of life-sustaining measure highlights the current conflict in the Act — whether the Act should continue to enable an adult to make an advance health directive refusing a blood transfusion (or any other life-sustaining measure) even though the adult's medical condition does not fall within any of the categories in section 36(2)(a) or whether the legislation should authorise a direction to withhold or withdraw a blood transfusion (or any other life-sustaining measure) only if the adult's medical condition falls within one of the categories in section 36(2)(a).

11.118 Refusals of blood transfusions are usually made on religious grounds. The *Powers of Attorney Act 1998* (Qld) currently accommodates the wish of adults with capacity to refuse a blood transfusion by excluding a blood transfusion from the definition of 'life-sustaining measure'. In the Commission's view, it is appropriate that the Act enables an adult with capacity, by an advance health directive, to refuse a future blood transfusion. This is consistent with the common law's recognition of the primacy of self-determination.<sup>654</sup> However, the Commission considers that, in singling out blood transfusions as a special case for self-determination, the Act fails to recognise the importance of self-determination in relation to other life-sustaining measures.

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651 See [11.97] above.

652 See [11.99] above.

653 See [11.84] above.

654 See [11.20]–[11.23] above.

11.119 The decision to give a direction to withhold or withdraw a life-sustaining measure is a significant decision. However, the *Powers of Attorney Act 1998* (Qld) includes a number of safeguards, which have been enhanced by the Commission's recommendations in this Report, to ensure the integrity of the process of making an advance health directive, to promote informed decision-making by adults making advance health directives, to guard against the risk that a direction will operate in circumstances not intended by the adult, and to deal with disputes about capacity or concerns about the effect of a direction:

- Section 42 of the Act sets out a rigorous test for capacity to make an advance health directive. It requires the adult to actually understand a number of specified matters, including the nature and likely effect of each direction in the advance health directive. The Commission has recommended in Chapter 8 that section 42 of the Act be amended:<sup>655</sup>
  - to provide that an adult has capacity to make an advance health directive only if the adult understands the nature and effect of the advance health directive and is capable of making the advance health directive freely and voluntarily; and
  - so that the list of the matters that must be understood by a principal in order to make an advance health directive is expressed as a non-exhaustive list.
- Section 44 of the Act requires an advance health directive to be in writing but does not currently require it to be made in the approved form. The Commission has recommended in Chapter 9 that the Act be amended to require an advance health directive to be made in the approved form. That recommendation is intended to increase the likelihood that the important instructions contained in the approved form will come to the attention of an adult making an advance health directive.<sup>656</sup> The Commission has also recommended that the approved form be redrafted so as to encourage an adult who is refusing health care to consider the circumstances in which the direction is to apply, in particular, whether the direction is intended to operate if the health care is required as the result of an unforeseen event that is not related to the adult's illness.<sup>657</sup>
- Section 44 of the Act also requires an advance health directive to be witnessed, and to include certificates by both the witness and a doctor to the effect that the principal appeared to have the capacity necessary to make the advance health directive. The Commission has recommended in Chapter 8 that the definition of 'eligible witness' in section 31 of the Act be amended to exclude a commissioner for declarations on the basis that commissioners for declarations, unlike justices of the peace (magistrates

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655 See Recommendations 8-3, 8-4 of this Report.

656 See Recommendation 9-5 of this Report.

657 See Recommendation 9-8(c) of this Report.

court) and justices of the peace (qualified), are not required to undertake training in relation to their duties.<sup>658</sup>

- In Chapter 9, the Commission has recommended that section 36 of the Act be amended to provide that a direction in an advance health directive does not operate if:<sup>659</sup>
  - the direction is uncertain; or
  - circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate;
- The Act also provides for the resolution of disputes about an adult's capacity or the validity of an advance health directive.<sup>660</sup> The Commission has further recommended in Chapter 9 that section 113 of the Act be amended to enable the Supreme Court and the Tribunal to decide whether a direction in an advance health directive is operative and to make a declaration to that effect.<sup>661</sup>

11.120 These provisions of the *Powers of Attorney Act 1998* (Qld), as amended in accordance with the Commission's recommendations, provide a better safeguard against the concerns expressed at [11.112] above than does section 36(2)(a) of the Act. They respond more directly to the concerns that have been raised, and do so in a way that does not conflict with the adult's autonomy. Given that they address those concerns in a satisfactory way, the Commission is of the view that section 36(2)(a) is an unjustified limitation on the autonomy of an adult and should be omitted.

### **The requirement that the commencement or continuation of artificial nutrition or hydration would be inconsistent with good medical practice**

11.121 The decision to provide artificial nutrition and hydration arises when patients have difficulty swallowing or lose interest in eating. Artificial nutrition and artificial hydration may include nasogastric feeding and subcutaneous hydration. However, when artificial nutrition and hydration are required on more than a short-term basis, they are delivered by a percutaneous endoscopic gastrostomy ('PEG'). This involves an incision in the abdominal wall so that the permanent gastrostomy tube can be threaded into the stomach and pulled through the abdominal wall.<sup>662</sup>

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658 See Recommendations 8-8 of this Report.

659 See Recommendation 9-3(b)(i) of this Report.

660 See *Powers of Attorney Act 1998* (Qld) ss 111 (Determination of capacity), 113 (Declaration about validity).

661 See Recommendation 9-4 of this Report.

662 See eg MR Gillick, 'Rethinking the Role of Tube Feeding in Patients with Advanced Dementia' (2000) 342 *New England Journal of Medicine* 206.

For patients with advanced dementia, PEG feeding commonly requires restraint to avoid them pulling the tube out.<sup>663</sup>

11.122 It has been suggested that the provision of nutrition and hydration by any means is qualitatively different from the provision of other life-sustaining measures.<sup>664</sup>

11.123 On the other hand, it has been observed that, while the feeding of a person who is vulnerable has an emotional significance attached to it, artificial nutrition and hydration can nevertheless be equated with other forms of life-sustaining measures:<sup>665</sup>

feeding has an emotional significance. As infants we could breathe without assistance, but we were dependent on others for our lifeline of nourishment. Even more, feeding is an expression of nurturing and caring, certainly for infants and children, and in many cases for adults as well.

Once one enters the realm of complex, high technology medical care, it is hard to shed the 'emotional symbolism' of food. However, artificial feeding such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle feeding or spoon feeding — they are medical procedures with inherent risks and possible side effects, instituted by skilled health care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.

11.124 In *Re BWV; Ex parte Gardner*,<sup>666</sup> Morris J of the Victorian Supreme Court agreed with the following analysis:<sup>667</sup>

One such request by patients that healthcare professionals and families often find difficult to respect — and which some people vehemently oppose implementing — is that to withdraw artificial hydration and nutrition when a person's life is dependent on them. Images of a person dying of dehydration and starvation come to mind. This situation can be viewed differently, however, if we think of the terminally ill person as suffering from a failed alimentary system and the withdrawal of artificial hydration and nutrition as withdrawal of artificial alimentary system support. In short, respecting a refusal of [artificial nutrition and hydration] is no different from accepting a person's refusal of respiratory support for a failed respiratory system. We have tended to see these situations differently because of values and symbolism attached to the provision of food and drink for those in our care, especially babies and young children. We have wrongly equated artificial hydration and nutrition (a medical

663 Ibid.

664 Eg Queensland Advocacy Incorporated, *Submission on 'Rethinking Life-Sustaining Measures: Questions for Queensland'* (4 July 2005) 16 <[http://www.qai.org.au/images/stories/docs/doc\\_179.doc](http://www.qai.org.au/images/stories/docs/doc_179.doc)> at 18 August 2010; Submission C128.

665 *Re BWV; Ex parte Gardner* (2003) 7 VR 487, 508 (Morris J), citing *Re Conroy* 486 A 2d 1209 (NJ 1985) 1236 (Schreiber J).

666 (2003) 7 VR 487.

667 Ibid 506, quoting M Somerville, *The Ethical Canary, Science, Society and the Human Spirit* (2000) 163.

life-support treatment) with natural food and drink and, thereby, have mistakenly equated the withholding of them. I hasten to add that I am not suggesting we are always justified in withholding or withdrawing artificial hydration and nutrition. Rather, the basis on which this decision should be made is the ethics of the withholding or withdrawal of artificial life-support treatment, not that of food and water. (note omitted)

### **Issue for consideration**

11.125 The issue for consideration is whether the operation of a direction to withhold or withdraw artificial nutrition or artificial hydration should require, as is presently the case under section 36(2)(b) of the *Powers of Attorney Act 1998* (Qld), that 'the commencement or continuation of the measure would be inconsistent with good medical practice'.<sup>668</sup> If it cannot be established that the commencement or continuation of artificial nutrition or artificial hydration would be inconsistent with good medical practice, a direction to withhold or withdraw artificial nutrition or artificial hydration will not operate, even though the requirements of section 36(2)(a) and (c) may be satisfied.<sup>669</sup>

### **Discussion Paper**

11.126 In the Discussion Paper, the Commission sought submissions on whether it is appropriate that section 36(2)(b) of the *Powers of Attorney Act 1998* (Qld) provides that a direction in an advance health directive to withhold or withdraw artificial nutrition or artificial hydration does not operate unless, in addition to the other requirements of section 36(2), the commencement or continuation of artificial nutrition or artificial hydration would be inconsistent with good medical practice.<sup>670</sup>

### **Submissions**

11.127 Family Voice Australia considered that the limitation in section 36(2)(b) of the *Powers of Attorney Act 1998* (Qld) is appropriate.<sup>671</sup> Another respondent was also of that view.<sup>672</sup>

11.128 Although Right to Life Australia commented that advance health directives should not be legally binding, it appeared to support the inclusion of a specific limitation in relation to the withholding or withdrawal of artificial nutrition or artificial hydration:<sup>673</sup>

<sup>668</sup> *Powers of Attorney Act 1998* (Qld) s 36(2) is set out at [11.87] above. The expression 'good medical practice' is considered at [11.181]–[11.187] below.

<sup>669</sup> As discussed below, this requirement may also apply to the withholding or withdrawal of other life-sustaining measures: see [11.151] below.

<sup>670</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 302.

<sup>671</sup> Submission 157.

<sup>672</sup> Submission 165.

<sup>673</sup> Submission 149.

The provision of food and water should not be classified as a medical procedure even if it is done by means other than by mouth. It is just normal and essential care that should not be withheld or withdrawn from anyone except in the circumstances of the terminal stage of a terminal illness.

11.129 However, the Adult Guardian considered that artificial nutrition and hydration should not be treated differently from any other life-sustaining measure.<sup>674</sup>

11.130 A legal academic with expertise in health law and guardianship law also expressed the view that the limitation in section 36(2)(b) of the *Powers of Attorney Act 1998* (Qld) is inappropriate.<sup>675</sup>

There is no justification for treating this kind of life-sustaining measure differently from others. A competent adult should be able to make a binding directive notwithstanding that the directive is inconsistent with good medical practice. Again, there is no equivalent restriction under the common law.

11.131 The Christian Science Committee on Publication for Queensland expressed a similar view:<sup>676</sup>

We do not believe the stated conditions for withholding or withdrawing a life-sustaining measure under an advance health directive are appropriate, and have the potential to grossly contravene an individual's express declarations for their care.

11.132 The parents of an adult with an intellectual disability commented generally that quality of life should be a consideration.<sup>677</sup>

### ***The Commission's view***

11.133 Section 36(2)(b) of the *Powers of Attorney Act 1998* (Qld) imposes a limitation on the operation of a direction to withhold or withdraw artificial nutrition or artificial hydration. The direction cannot operate unless the commencement or continuation of the measure would be inconsistent with good medical practice.

11.134 The Commission recognises the importance of ensuring that the *Powers of Attorney Act 1998* (Qld) properly addresses the concerns that have been raised about the use of advance health directives in relation to the withholding and withdrawal of life-sustaining measures. However, as explained earlier, the Commission considers that those risks are satisfactorily addressed by.<sup>678</sup>

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674 Submission 164.

675 Submission 144.

676 Submission 151.

677 Submission 54A.

678 See [11.119]–[11.120] above.

- the provisions of the Act that deal with capacity to make an advance health directive and the execution requirements for making an advance health directive; and
- the Commission's recommendations about capacity to make an advance health directive and the execution requirements for making an advance health directive, as well as its recommendations about the mandatory use of the approved form, the content of the approved form, the recommended general limitations on the operation of a direction, and the power of the Supreme Court and the Tribunal to make declarations about the operation of a direction in an advance health directive.

11.135 In the Commission's view, there is no justification for singling out one particular form of life-sustaining measure, as section 36(2)(b) does, and subjecting a direction to withhold or withdraw that measure to the requirement that the commencement or continuation of the measure would be inconsistent with good medical practice. Accordingly, section 36(2)(b) of the *Powers of Attorney Act 1998* (Qld) should be omitted.

### **The requirement that the adult has no reasonable prospect of regaining capacity for health matters**

#### ***Issue for consideration***

11.136 The third issue for consideration is whether the operation of a direction in an advance health directive to withhold or withdraw a life-sustaining measure should require, as is presently the case under section 36(2)(c) of the *Powers of Attorney Act 1998* (Qld), that the adult has no reasonable prospect of regaining capacity for health matters.<sup>679</sup>

11.137 It has been suggested that the requirement in section 36(2)(c) may lead to confusion about when a direction in an advance health directive in relation to the withholding or withdrawal of a life-sustaining measure can operate.<sup>680</sup> The issue is whether the prospect of the adult regaining capacity should be determined with or without regard to the effect that the particular life-sustaining measure would have if provided to the adult.<sup>681</sup>

This issue ... has significant implications where a person executes an AHD refusing CPR. If CPR provides a reasonable prospect of regaining capacity, then the legislative requirement 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.

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679 *Powers of Attorney Act 1998* (Qld) s 36(2) is set out at [11.87] above.

680 B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 32.

681 *Ibid.*

11.138 In South Australia, the legislation provides a clearer resolution of this issue, although the relevant provision applies to a decision by a substitute decision-maker (rather than to a direction in an advance health directive). The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides that a medical power of attorney does not authorise the agent to refuse 'medical treatment that would result in the grantor regaining the capacity to make decisions about his or her own medical treatment *unless the grantor is in the terminal phase of a terminal illness*'.<sup>682</sup>

11.139 The South Australian provision therefore makes it clear that a medical agent appointed under a medical power of attorney may refuse medical treatment that, if provided, would result in the adult regaining capacity, but only if the adult is in the terminal phase of a terminal illness.

### **Discussion Paper**

11.140 In the Discussion Paper, the Commission sought submissions on whether, if an adult's advance health directive includes a direction to refuse a particular life-sustaining measure, in determining whether the condition in section 36(2)(c) of the *Powers of Attorney Act 1998* (Qld) has been satisfied (namely, that the adult has no reasonable prospect of regaining capacity for health matters):<sup>683</sup>

- the effect that the life-sustaining measure could have, if provided, should be disregarded; or
- the effect that the life-sustaining measure could have, if provided, should be taken into account.

11.141 The Commission also sought submissions on whether, if the effect that the life-sustaining measure could have, if provided, is to be disregarded, the determination of whether the condition in section 36(2)(c) of the *Powers of Attorney Act 1998* (Qld) has been satisfied should be made on that basis:

- in all cases; or
- only if the adult is in the terminal phase of a terminal illness (or some similar limitation).

### **Submissions**

11.142 Several respondents commented on the limitation imposed by section 36(2)(c) of the *Powers of Attorney Act 1998* (Qld).

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682 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8(7)(b)(iii) (emphasis added).

683 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 303–4.

11.143 Family Voice Australia commented generally that the legislation contains ‘appropriate provisions to ensure that advance health directives ... that could result in the unnecessary or untimely death of the adult are not acted upon recklessly’.<sup>684</sup>

11.144 However, a legal academic with expertise in health law and guardianship law commented that there ‘is no justification for limiting the application of an advance directive in this fashion’.<sup>685</sup>

11.145 The Christian Science Committee on Publication for Queensland expressed a similar view:<sup>686</sup>

We do not believe the stated conditions for withholding or withdrawing a life-sustaining measure under an advance health directive are appropriate, and have the potential to grossly contravene an individual’s express declarations for their care.

11.146 A respondent whose daughter sustained a brain injury in a car accident was of the view that section 36(2)(c) should provide that the effect that the life-sustaining measure could have should be disregarded, but only if the adult was in the terminal phase of a terminal illness.<sup>687</sup>

11.147 The Adult Guardian commented:<sup>688</sup>

The practice within this office does not inform a particular view about this issue. My personal inclination is to prefer patient choice; that is that the patient should be able to elect whether provision of [a life-sustaining measure] should occur or not and that the presumption of capacity is not determinative. The [advance health directive] includes a certificate by a medical practitioner that the patient has received advice about its conditions and application. Shouldn’t their informed consent in the form of the [advance health directive] be sufficient for this purpose?

### ***The Commission’s view***

11.148 Section 36(2)(c) of the *Powers of Attorney Act 1998* (Qld) provides that a direction in an advance health directive to withhold or withdraw a life-sustaining measure cannot operate unless, in addition to satisfying the other requirements of section 36(2), the principal has no reasonable prospect of regaining capacity for health matters.

11.149 In some cases, the provision of a life-sustaining measure could result in the adult regaining capacity for health matters. This could be the case, for example, if cardiopulmonary resuscitation was successfully administered to an

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684 Submission 157.

685 Submission 144.

686 Submission 151.

687 Submission 161.

688 Submission 164.

adult who did not otherwise have impaired capacity.<sup>689</sup> As explained above, where the provision of a particular life-sustaining measure could cause the adult to regain capacity for health matters, it is unclear whether the prospect of the adult regaining capacity should be determined with or without regard to the effect that the life-sustaining measure would have if provided.

11.150 While it is important to address the concerns that have been raised about the use of advance health directives in relation to the withholding and withdrawal of life-sustaining measures, as explained earlier, the Commission considers that those risks are satisfactorily addressed by provisions of the *Powers of Attorney Act 1998* (Qld) other than section 36(2)(c) and by the Commission's recommendations in relation to the making and operation of advance health directives.<sup>690</sup> Those provisions, in conjunction with the Commission's recommendations, provide appropriate safeguards without conflicting with an adult's autonomy. In view of those safeguards, section 36(2)(c) is an unjustified limitation on an adult's autonomy and should be omitted.

### **The requirement that the commencement or continuation of the life-sustaining measure would be inconsistent with good medical practice**

#### ***Issue for consideration***

11.151 As explained above, it appears that section 5(2) of the definition of 'health care' in schedule 2 of the *Powers of Attorney Act 1998* (Qld) has the effect that, even apart from the specific limitation in section 36(2)(b) of that Act in relation to a direction in an advance health directive to withhold or withdraw artificial nutrition or artificial hydration, a direction to withhold or withdraw a life-sustaining measure can be given only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>691</sup> Some commentators have queried whether this was the intention of the legislation.<sup>692</sup>

11.152 When the *Powers of Attorney Act 1998* (Qld) was enacted in 1998, the 'withholding or withdrawal of life-sustaining measures' was a category of special health care.<sup>693</sup> An adult could, by an advance health directive, give directions about health matters and special health matters for his or her future health care,<sup>694</sup>

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Note, however, that the success rate of cardiopulmonary resuscitation ('CPR') is relatively low. It has been suggested that (R Cavell, 'Not-for-resuscitation orders: The medical, legal and ethical rationale behind letting patients die' (2008) 16 *Journal of Law and Medicine* 305, 309):

of all-comers who receive CPR in a hospital only about 5 to 15% of them are discharged from the hospital alive, and the success rate is far more dismal than that for patients with chronic illnesses such as AIDS, kidney failure, pneumonia or cancer. Of those patients who are discharged alive, rarely will they walk out of the hospital under their own steam. They are more likely to have severe and permanent disability and, for those who are lucky (perhaps unlucky) enough to remain sentient, poor enjoyment of life.

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See [11.119]–[11.120] above.

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See [11.57]–[11.61] above. The concept of 'good medical practice' is considered at [11.181]–[11.182] below.

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B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 73–6.

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*Powers of Attorney Act 1998* (Qld) sch 2 s 7(f) (Act as passed).

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

including a direction requiring, in the circumstances specified, that particular life-sustaining measures be withheld or withdrawn.<sup>695</sup> Although section 36(2) of the Act was in substantially the same terms as the current form of that provision, the definition of 'health care' in schedule 2 of the Act when originally enacted did not include what currently appears as section 5(2) of the schedule. Accordingly, the Act did not generally restrict the power to give a direction about the withholding or withdrawal of a life-sustaining measure to circumstances where the commencement or continuation of the measure would be inconsistent with good medical practice.

11.153 When the *Guardianship and Administration Act 2000* (Qld) was enacted in 2000, it provided that the 'withholding or withdrawal of special life-sustaining measures'<sup>696</sup> was a category of special health care.<sup>697</sup> The Act established the Guardianship and Administration Tribunal and provided that consent to special health care could generally be given by the Tribunal but only if the adult had not made an advance health directive giving a direction about the matter.<sup>698</sup> Because each Act provided that the withholding or withdrawal of a special life-sustaining measure was a type of special health care, consent for the withholding or withdrawal of such a measure could not be given by a guardian appointed under the *Guardianship and Administration Act 2000* (Qld) or by an attorney for personal or health matters or a statutory health attorney under the *Powers of Attorney Act 1998* (Qld).

11.154 That changed in 2002 when the *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld) commenced. That Act omitted 'special life-sustaining measures' from the definition of special health care, and inserted what now appears as section 5(2) of the definition of health care in schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld).<sup>699</sup> The amendments to the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) had the effect that the withholding or withdrawal of a life-sustaining measure became a health matter, and that a decision to withhold or withdraw a life-sustaining measure could therefore be made by an adult's guardian, attorney or statutory health attorney.

11.155 The insertion of what is now section 5(2) of the definition of health care was no doubt intended as a safeguard for the adult for whom the decision was being made by a substitute decision-maker.<sup>700</sup> However, the 2001 amendment of

695 *Powers of Attorney Act 1998* (Qld) s 35(2)(b) (Act as passed).

696 The *Guardianship and Administration Act 2000* (Qld) sch 3 item 6 (Act as passed) amended ss 35(2)(b) and 36(2) of the *Powers of Attorney Act 1998* (Qld) to substitute 'special life-sustaining measures' and 'special life-sustaining measure' for 'life-sustaining measures' and 'life-sustaining measure' respectively.

697 *Guardianship and Administration Act 2000* (Qld) sch 2 s 7(f) (Act as passed).

698 *Guardianship and Administration Act 2000* (Qld) ss 65, 68.

699 *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld) ss 17, 29.

700 To the extent that the limitation in the definition of health care may be an appropriate safeguard in relation to substitute decision-making, the limitation is, in practical terms, duplicated in s 66A of the *Guardianship and Administration Act 2000* (Qld), which applies where consent is given to withhold or withdraw a life-sustaining measure. Section 66A is set out at [11.179] below.

the definition of 'health care' in the *Powers of Attorney Act 1998* (Qld) now operates as a restriction on the directions that an adult may effectively give by way of an advance health directive under that Act. Before that amendment, the only type of direction to which the concept of good medical practice was relevant was a direction to withhold or withdraw artificial nutrition or artificial hydration.<sup>701</sup>

11.156 Earlier in this chapter, the Commission has recommended that the limitation in section 5(2) of the definition of 'health care' is not appropriate for inclusion in a definition. It suggested that, if the limitation was considered appropriate, it could be included in section 36(2) of the *Powers of Attorney Act 1998* (Qld).<sup>702</sup>

11.157 Obviously, if the limitation currently found in section 5(2) of the definition of health care in the *Powers of Attorney Act 1998* (Qld) were considered appropriate for inclusion in section 36(2) of that Act, that would be a further reason not to retain section 36(2)(b) of that Act.

### ***The law in other jurisdictions***

11.158 Although the legislation in the Northern Territory and South Australia limits the operation of a direction to where the adult is in the terminal phase of a terminal condition,<sup>703</sup> no jurisdiction provides that a direction for the withholding or withdrawal of a life-sustaining measure may be made only if the commencement or continuation of the measure would be inconsistent with good medical practice.

11.159 Although the definition of 'health care' in the *Powers of Attorney Act 2006* (ACT) includes a paragraph in similar terms to section 5(2) of the definition of health care in the *Powers of Attorney Act 1998* (Qld), that definition serves to limit the circumstances in which an attorney under an enduring power of attorney may make a decision to withhold or withdraw a life-sustaining measure for the principal.<sup>704</sup> The *Medical Treatment (Health Directions) Act 2006* (ACT), which enables an adult to make a health direction refusing, or requiring the withdrawal of, medical treatment, does not include a similar limitation.

### ***Discussion Paper***

11.160 In the Discussion Paper, the Commission sought submissions on whether it is appropriate for a direction in an advance health directive to withhold or withdraw a life-sustaining measure that does not involve artificial nutrition or artificial hydration to be effective only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>705</sup>

<sup>701</sup> See s 36(2)(b) of the *Powers of Attorney Act 1998* (Qld) in relation to the operation of a direction to withhold or withdraw artificial nutrition or artificial hydration.

<sup>702</sup> See [11.62], [11.64]–[11.68] above.

<sup>703</sup> These limitations are discussed at [11.95]–[11.96] above.

<sup>704</sup> *Powers of Attorney Act 2006* (ACT) ss 12, 13(2). See [11.190]–[11.191] below.

<sup>705</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 318.

## Submissions

11.161 One respondent was of the view that it is appropriate that a direction to withhold or withdraw a life-sustaining measure that does not involve artificial nutrition or artificial hydration is effective only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>706</sup>

11.162 Family Voice Australia also appeared to support the current limitations in the *Powers of Attorney Act 1998* (Qld), suggesting that the Act contains ‘appropriate provisions to ensure that advanced health directives ... that could result in the unnecessary or untimely death of the adult are not acted upon recklessly’.<sup>707</sup>

11.163 However, several other respondents were critical of the provisions in the *Powers of Attorney Act 1998* (Qld) that limit the directions that can effectively be made in an advance health directive about the withholding or withdrawal of a life-sustaining measure.

11.164 The Christian Science Committee on Publication for Queensland generally supported measures in the legislation that support individual choice, but disagreed with the provisions in the *Powers of Attorney Act 1998* (Qld) that limit the operation of a direction to withhold or withdraw a life-sustaining measure:<sup>708</sup>

We support measures which recognise and support a person’s right to define their preferred type of health care. While, for many people this may involve medical care, others have found alternative health care methods to be both effective and religiously or culturally preferable. Those who practice spiritual care through Christian Science do so because they have found prayer to be the most effective health care method within their lives, and prefer to rely upon the health care means which they have found to be most effective.

We do not believe the stated conditions for withholding or withdrawing a life-sustaining measure under an advance health directive are appropriate, and have the potential to grossly contravene an individual’s express declarations for their care.

Any legislation relating to decisions on the use of medical care should continue to include due respect for the wishes and beliefs of the person. A decision to decline medical care does not necessarily mean the person is not participating in other effective health care activities, including prayer, and it is important for any legislation in this area to clearly support individual choice and promote awareness among health professionals of spiritual treatment through prayer as the preference of some decision makers.

11.165 A legal academic with expertise in health law and guardianship law commented that the legislation does not strike an appropriate balance.<sup>709</sup>

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706 Submission 165.

707 Submission 157.

708 Submission 151.

709 Submission 144.

The guardianship legislation does not currently strike the appropriate balance between recognising personal autonomy and safeguarding the adult's interests. This is particularly the case in relation to advance directives where an adult has expressly refused treatment, yet there is no obligation on health professionals to respect this decision given the excuses that are available to them.

11.166 She considered that there are clearly problems with the definition of health care that need to be addressed.

11.167 Right to Life Australia did not address the specific limitations in section 36(2) of the *Powers of Attorney Act 1998* (Qld), but referred more generally to its opposition to the inclusion in the legislation of provisions enabling the withholding and withdrawal of life-sustaining measures:<sup>710</sup>

We do not accept that the removal of life-sustaining measures can be in the adult's best interests. In particular, permitting any person, or persons, to deem that another person can be better off dead is a line that should not be allowed to be crossed. It was the acceptance in Germany during the 1920s and '30s of the notion that there is such a thing as 'a life not worthy to be lived' that finally culminated in the forced euthanasia of tens of thousands of disabled people. We should learn the lessons of history and not make any start down that track.

These matters are being made extremely complex as the dense nature of the contents of this chapter clearly affirm. We would attribute the level of complexity to efforts to try and accommodate the immoral notion that people should be allowed to decide that others can be better off dead and to then have this end brought about by ceasing to provide the basic necessities of water and food. It is not good medical practice to either, do an act, or omit to do an act, with the intention of hastening or bringing about a person's death.

11.168 Right to Life Australia considered that advance health directives may intentionally or unintentionally have the effect of pressuring the old, the sick and the disabled into thinking that they are a burden, and therefore suggested that advance health directives should not be legally binding. These concerns were considered to be of particular significance in the context of the withholding and withdrawal of life-sustaining measures because the consequences of the decision are irreversible.

### ***The Commission's view***

11.169 At present, the effect of section 5(2) of the definition of health care in schedule 2 of the *Powers of Attorney Act 1998* (Qld) is that a direction to withhold or withdraw a life-sustaining measure is a direction about a 'health matter', and therefore able to be given by an advance health directive, only if the commencement or continuation of the measure would be inconsistent with good medical practice. As explained above, this limitation did not apply when the *Powers of Attorney Act 1998* (Qld) was originally enacted and it is not clear that the imposition of this restriction in relation to advance health directives was intended. The limitation appears to have been enacted to regulate end-of-life decision-making by an adult's *substitute decision-maker*, although it now limits the directions that an adult with capacity may give about his or her *own* future health care. As the Commission has earlier recommended that this limitation should be omitted from

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Submission 149.

the definition of 'health care',<sup>711</sup> the issue is whether it would be an appropriate limitation to include in section 36(2) of the Act.

11.170 It is inevitable that some adults may wish to refuse a life-sustaining measure in circumstances where their decision might not meet the requirement that the commencement or continuation of the life-sustaining measure would be inconsistent with good medical practice. The refusal of a blood transfusion where the adult is likely to die without the transfusion but could be restored to good health with the transfusion is arguably such a case. At present, the Act avoids this issue by adopting an artificial definition of 'life-sustaining measure'. However, earlier in this chapter, the Commission has recommended that section 5A(3) of the definition of 'life-sustaining measure' should be omitted so that the definition does not exclude a blood transfusion.<sup>712</sup>

11.171 As explained earlier, the *Powers of Attorney Act 1998* (Qld) already contains important safeguards in relation to the required test of capacity to make an advance health directive and the execution requirements for an advance health directive. In addition, the Commission has made a number of recommendations to strengthen those safeguards.<sup>713</sup> In particular, the Commission has recommended that section 36 of the Act be amended to provide that a direction in an advance health directive does not operate if:<sup>714</sup>

- the direction is uncertain; or
- circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

11.172 This requirement would apply to a direction in an advance health directive to withhold or withdraw a life-sustaining measure.

11.173 In view of the existing and proposed additional safeguards, the Commission considers that it would not be appropriate for section 36(2) of the *Powers of Attorney Act 1998* (Qld) to impose, as an additional and general limitation on the operation of a direction to withhold or withdraw a life-sustaining measure, that the commencement or continuation of the measure would be inconsistent with good medical practice. In its view, such a requirement would be an unjustified restriction of an adult's right to refuse health care that he or she does not want.

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711 See [11.64]–[11.67] above and Recommendation 11-1 below.

712 See [11.83]–[11.84] above.

713 See [11.119] above.

714 See Recommendation 9-3(b)(i) of this Report.

## CONSENT TO THE WITHHOLDING OR WITHDRAWAL OF A LIFE-SUSTAINING MEASURE BY AN ADULT'S SUBSTITUTE DECISION-MAKER

### The law in Queensland

11.174 As mentioned earlier, section 66 of the *Guardianship and Administration Act 2000* (Qld) establishes an order of priority for decision-making in relation to health matters (which includes decisions about the withholding and withdrawal of life-sustaining measures).<sup>715</sup> An adult's substitute decision-maker (that is, in order of priority, the adult's guardian, attorney or statutory health attorney) may exercise power in relation to a health matter only if the adult has not made an advance health directive that contains a relevant direction about the matter.<sup>716</sup>

11.175 In making a decision about the withholding or withdrawal of a life-sustaining measure, a substitute decision-maker must apply the General Principles and the Health Care Principle.<sup>717</sup> The Health Care Principle provides that power for a health matter should be exercised:<sup>718</sup>

- (a) in the way least restrictive of the adult's rights; and
- (b) only if the exercise of power—
  - (i) is necessary and appropriate to maintain or promote the adult's health or wellbeing; or
  - (ii) is, in all the circumstances, in the adult's best interests.

11.176 Paragraph (b)(ii) of the Health Care Principle was inserted in 2001 when the withholding or withdrawal of a life-sustaining measure became a health matter,<sup>719</sup> and it became possible for a decision to withhold or withdraw a life-sustaining measure to be made by an adult's substitute decision-maker.<sup>720</sup> Its insertion recognised that 'it may be in the adult's interests for the natural processes of dying not to be interfered with by the futile administration of artificial measures'.<sup>721</sup>

<sup>715</sup> *Guardianship and Administration Act 2000* (Qld) s 66 is set out at [11.48] above.

<sup>716</sup> *Guardianship and Administration Act 2000* (Qld) s 66(3)–(5).

<sup>717</sup> *Guardianship and Administration Act 2000* (Qld) s 11 (for a guardian); *Powers of Attorney Act 1998* (Qld) s 76 (for an attorney under an enduring document and a statutory health attorney).

<sup>718</sup> *Guardianship and Administration Act 2000* (Qld) sch 1 s 12; *Powers of Attorney Act 1998* (Qld) sch 1 s 12. See now the redrafted Health Care Principle recommended in Chapter 5 of this Report.

<sup>719</sup> *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld) ss 19, 31. The 2001 amendments to the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) are considered at [11.153]–[11.155] above and [11.377]–[11.379] below.

<sup>720</sup> *Guardianship and Administration Act 2000* (Qld) s 33(1), sch 2 (definitions of 'personal matter', 'health matter'); *Powers of Attorney Act 1998* (Qld) ss 32(1)(a), 62, sch 2 (definitions of 'personal matter', 'health matter').

<sup>721</sup> Explanatory Notes, *Guardianship and Administration and Other Acts Amendment Bill 2001* (Qld) 6.

### ***Limitation on the operation of a consent by a substitute decision-maker or the Tribunal***

11.177 Clearly, a decision to withhold or withdraw a life-sustaining measure is a very significant decision. For that reason, the *Guardianship and Administration Act 2000* (Qld) includes two provisions (of similar, but not identical, effect) that limit the decisions that may be made by a substitute decision-maker.

11.178 First, the scope of a substitute decision-maker's, or the Tribunal's, power in relation to the withholding or withdrawal of a life-sustaining measure is limited by the definition of 'health care'. Both the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) define 'health care' to include the withholding or withdrawal of a life-sustaining measure for the adult 'if the commencement or continuation of the measure' for the adult 'would be inconsistent with good medical practice'.<sup>722</sup> The effect of the qualification that appears in the definition of 'health care' is that a decision to withhold or withdraw a life-sustaining measure is a decision about a health matter only if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.<sup>723</sup>

11.179 Secondly, section 66A of the *Guardianship and Administration Act 2000* (Qld) limits the circumstances in which a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure will operate. Section 66A provides:

**66A When consent to withholding or withdrawal of life-sustaining measure may operate**

- (1) This section applies if a matter concerning the withholding or withdrawal of a life-sustaining measure is to be dealt with under section 66(3), (4) or (5).

*Editor's note—*

If a matter concerning the withholding or withdrawal of a life-sustaining measure is to be dealt with under section 66(2), see the *Powers of Attorney Act 1998*, section 36(2) (Operation of advance health directive) as to when a direction to withhold or withdraw a life-sustaining measure can operate.

- (2) A consent to the withholding or withdrawal of a life-sustaining measure for the adult can not 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.

11.180 The effect of section 66A(2) is that a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure will not operate unless the adult's health provider 'reasonably considers the commencement or

<sup>722</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(2); *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2). These definitions are set out at [11.38], and considered at [11.91] above.

<sup>723</sup> Note, however, that the Commission has recommended that this limitation be omitted from the definition of 'health care': see [11.64]–[11.67] above and Recommendation 11-1 below.

continuation of the measure for the adult would be inconsistent with good medical practice’.

### **Good medical practice**

11.181 The guardianship legislation defines ‘good medical practice’ in the following terms:<sup>724</sup>

**Good medical practice** is good medical practice for the medical profession in Australia 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.

11.182 Only recognised medical standards, practices and procedures and recognised medical ethical standards fall within the definition of ‘good medical practice’. If particular views or practices are held by a minority within the medical profession and cannot be said to be the recognised medical standards, practices and procedures and the recognised ethical standards of the medical profession in Australia, those views or practices will not represent ‘good medical practice’ within the meaning of the guardianship legislation.

11.183 For a consent to the withholding or withdrawal of a life-sustaining measure to be effective, section 66A of the *Guardianship and Administration Act 2000* (Qld) requires that the adult’s health provider must reasonably consider that the commencement or continuation of the measure would be *inconsistent* with good medical practice. This is a higher test than merely requiring that the withholding or withdrawal of the measure be *consistent* with good medical practice.<sup>725</sup> In *Re HG*,<sup>726</sup> the Tribunal explained what is required by the test:<sup>727</sup>

Before a decision to withhold or withdraw a life-sustaining measure will be a ‘health matter’ for which consent can be given, the commencement or continuation of the measure must be inconsistent with good medical practice. This test will not be satisfied just because the withholding or withdrawal of the measure is consistent with good medical practice. More must be demonstrated. There must be evidence that the provision of the measure is inconsistent with good medical practice. Therefore, if there was evidence that there were two medically and ethically acceptable treatment options, one being the provision of the measure, the test in the legislation is not satisfied and consent could not be given to the withholding or withdrawal of the measure.

11.184 Because the definition of ‘good medical practice’ refers to the standards of the medical profession within Australia, the requirement under the guardianship legislation that the commencement or continuation of the life-sustaining measure

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<sup>724</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 5B; *Powers of Attorney Act 1998* (Qld) sch 2 s 5B.

<sup>725</sup> B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 59–60.

<sup>726</sup> [2006] QGAAT 26.

<sup>727</sup> *Ibid* [64]–[65].

would be 'inconsistent with good medical practice' arguably has the effect of delegating to the medical profession one aspect of the legal test for the lawful withholding or withdrawal of life-sustaining measures.

11.185 Although this aspect of the legislation may in some cases offer an additional safeguard against inappropriate decision-making, Parliament has no control over 'the recognised medical standards, practices and procedures of the medical profession in Australia' or 'the recognised ethical standards of the medical profession in Australia'. If professional standards and ethics change over time, this may lead to a different practice in relation to the withholding or withdrawal of life-sustaining measures, but one that nevertheless complies with the law.

11.186 It has also been suggested that difficulties may arise in determining what constitutes 'good medical practice' owing to the lack of comprehensive recognised medical and ethical standards in relation to the withholding and withdrawal of life-sustaining measures in Australia.<sup>728</sup> This can be contrasted with the position in other countries, for example the United Kingdom, where there are national guidelines dealing with this issue.<sup>729</sup>

11.187 On the other hand, it would be virtually impossible for legislation to prescribe the circumstances when the withholding or withdrawal of different types of life-sustaining measures would be appropriate. The Adult Guardian considered that the current reference to 'good medical practice' provides flexibility.<sup>730</sup>

One of the benefits of the current arrangement which sets the standard for the test as being 'good medical practice' is that the clinical opinion changes as scientific knowledge is accrued and is integrated into practice. Opinion is ever evolving and the legal response is not straight jacketed.

### The law in other jurisdictions

11.188 In all other Australian jurisdictions, the legislation makes provision for a range of substitute decision-makers to make health care decisions for an adult with impaired capacity. There are differences between the jurisdictions as to whether this power may be exercised by the equivalents in those jurisdictions of a guardian or attorney only, or also by a statutory health attorney.<sup>731</sup>

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See eg Australian Medical Association, Position Statement, *The Role of the Medical Provider in End of Life Care* (2007) <<http://ama.com.au/node/2803>> at 19 August 2010; Australian Medical Council, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (July 2009) [3.12] <<http://goodmedicalpractice.org.au/wp-content/downloads/Final%20Code.pdf>> at 19 August 2010; NSW Department of Health, *Guideline for end-of-life care and decision-making* (2006). See also the limited specific guidance available for the withholding or withdrawal of life-sustaining measures for those in a vegetative or minimally responsive state: National Health and Medical Research Council, *Ethical Guidelines for the care of people in post-coma unresponsiveness (vegetative state) or a minimally responsive state* (2008) [6.2.2]–[6.2.4].

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See British Medical Association, *Withholding and withdrawing life-prolonging medical treatment: guidance for decision making* (3rd ed, 2007); General Medical Council, *Treatment and Care towards the end of life: Good practice in decision-making* (2010) <[http://www.gmc-uk.org/guidance/ethical\\_guidance/6858.asp](http://www.gmc-uk.org/guidance/ethical_guidance/6858.asp)> at 19 August 2010.

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Submission 164.

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See Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, [12.53]–[12.62].

11.189 In some of these jurisdictions, the legislation imposes limitations on the decisions that may be made by a particular type of substitute decision-maker in relation to the withholding or withdrawal of a life-sustaining measure.

### **Australian Capital Territory**

11.190 The *Powers of Attorney Act 2006* (ACT) provides that an adult ('the principal') may, by an enduring power of attorney, appoint an attorney to exercise power in relation to health care matters.<sup>732</sup> 'Health care matter' is defined to mean 'a matter, other than a special health care matter, relating to the principal's health care', and gives, as an example, 'withholding or withdrawal of medical treatment for the principal'.<sup>733</sup> The Act further provides that:<sup>734</sup>

**health care**, for a person who is a principal for a power of attorney—

- (a) includes withholding or withdrawal of a life-sustaining measure for the principal if starting or continuing the measure for the principal would be inconsistent with good medical practice; ...

11.191 This definition, like the similar provision in the *Powers of Attorney Act 1998* (Qld), limits the decisions that may be made by an attorney under an enduring power of attorney. However, the *Guardianship and Management of Property Act 1991* (ACT) does not impose a similar limitation on a guardian.

11.192 Section 85 of the *Powers of Attorney Act 2006* (ACT) deals with the situation where a 'relevant person', which is defined to include an adult's health provider, reasonably believes that an adult's attorney has made a health care decision that is not in the best interests of the adult. It provides that the relevant person may tell the Public Advocate about the attorney's decision. Section 85 provides:

#### **85 Attorney's health care decision not in principal's interest**

- (1) In this section:

**relevant person**, in relation to a person who is a principal for a power of attorney, means—

- (a) a health professional who is treating, or has at any time treated, the principal; or
- (b) a person in charge of a health care facility where the principal is being, or has at any time been, treated.

- (2) This section applies if—

- (a) an attorney makes a decision in relation to the health care of the principal; and

<sup>732</sup> *Powers of Attorney Act 2006* (ACT) s 13(2).

<sup>733</sup> *Powers of Attorney Act 2006* (ACT) s 12.

<sup>734</sup> *Powers of Attorney Act 2006* (ACT) Dictionary.

- (b) a relevant person believes, on reasonable grounds, that the decision is not in the best interests of the principal.
- (3) The relevant person may tell the public advocate about the decision and explain why the relevant person believes the decision is not in the best interests of the principal.

*Note* Giving information to the public advocate honestly and without recklessness is protected (see *Public Advocate Act 2005*, s 15).

### South Australia

11.193 In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides that an adult may, by a medical power of attorney, appoint an agent to make decisions on his or her behalf about medical treatment.<sup>735</sup> The appointment of an agent under a medical power of attorney authorises the agent, subject to any conditions contained in the power of attorney, to make decisions about medical treatment of the person who granted the power if that person is incapable of making decisions on his or her own behalf.<sup>736</sup> However, a medical power of attorney does not authorise the agent to refuse:<sup>737</sup>

- (i) the natural provision or natural administration of food and water; or
- (ii) the administration of drugs to relieve pain or distress; or
- (iii) medical treatment that would result in the grantor regaining the capacity to make decisions about his or her own medical treatment unless the grantor is in the terminal phase of a terminal illness.

11.194 The South Australian Advance Directives Review Committee recommended two changes to the authority of an agent.

11.195 First, it recommended that agents should not be able to refuse non-invasive treatment for the relief of pain or distress, although it would be appropriate 'to permit agents to refuse invasive forms of palliative care on behalf of a person who is dying and interventions that are likely to prolong the dying process'.<sup>738</sup> The Committee observed:<sup>739</sup>

Prior to the mid 1990s palliative care focussed on non-invasive interventions to relieve pain and other symptoms. It has progressed to include more invasive procedures, such as stents (eg biliary, urinary or intestinal catheters) to maintain organ function, and a wider range of palliative chemotherapy, radiotherapy and surgical options. This is contrary to public perceptions and

<sup>735</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8(1).

<sup>736</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8(7)(a).

<sup>737</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8(7)(b).

<sup>738</sup> Advance Directives Review Committee (SA), *Advance Directives Review — Planning ahead: your health, your money, your life: First Report of the Review of South Australia's Advance Directives, Proposed Changes to Law and Policy* <[http://www.agd.sa.gov.au/news/pdfs/2009/AG\\_Report\\_1\\_final\\_300808.pdf](http://www.agd.sa.gov.au/news/pdfs/2009/AG_Report_1_final_300808.pdf)> 37 at 19 August 2010.

<sup>739</sup> *Ibid.*

expectations that an instruction for 'palliative care only' limits treatment to non-invasive pain and symptom management.

11.196 Secondly, the Review Committee recommended that agents 'not be authorised to refuse the natural provision or administration of food and water unless the person directly indicates that it is unwelcome, which can be the case late in the dying process or when there is difficulty swallowing'.<sup>740</sup> However, the Review Committee emphasised that 'agents must be able to refuse the artificial provision of nutrition and hydration'. It noted that:<sup>741</sup>

This accords with the current Consent Act and the 2003 decision in the Victorian *BWV* case<sup>742</sup> that artificial nutrition and hydration provided through a tube directly into the stomach of a woman in a persistent vegetative state was a medical procedure, and that it was a procedure to sustain life rather than a palliative measure to manage the dying process. (note added)

11.197 The *Guardianship and Administration Act 1993* (SA) does not impose similar limitations on an adult's enduring guardian. Such a person may, subject to the Act and the conditions, limitations or exclusions (if any) stated in the instrument of appointment, exercise the powers 'at law or in equity of a guardian' if the person becomes mentally incapacitated and may 'consent or refuse consent to the medical or dental treatment of the person, except where the person has a medical agent available and willing to act in the matter'.<sup>743</sup>

## Victoria

11.198 In Victoria, the *Medical Treatment Act 1988* (Vic) provides that a decision about an adult's medical treatment may be made in accordance with that Act by an agent appointed by the person under that Act, an alternate agent appointed by the person, or a guardian appointed under the *Guardianship and Administration Act 1986* (Vic) who is authorised to make decisions about medical treatment for the adult.<sup>744</sup>

11.199 However, an adult's agent or guardian may refuse medical treatment on behalf of an adult only if:<sup>745</sup>

- (a) the medical treatment would cause unreasonable distress to the patient; or
- (b) there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.

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740 Ibid.

741 Ibid.

742 *Re BWV; Ex parte Gardner* (2003) 7 VR 487. See [11.124] above.

743 *Guardianship and Administration Act 1993* (SA) s 25(5).

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

745 *Medical Treatment Act 1988* (Vic) s 5B(2).

11.200 Section 42L of the *Guardianship and Administration Act 1986* (Vic) provides a mechanism to resolve the situation where a substitute decision-maker does not consent to treatment but the health provider believes on reasonable grounds that the proposed treatment is in the best interests of the patient. The section is of general application and applies to any 'medical or dental treatment' as defined in the Act.<sup>746</sup> Accordingly, it would be relevant if a substitute decision-maker did not consent to the provision of a life-sustaining measure that the adult's health provider considered to be in the adult's best interests.

11.201 Section 42L provides that, if the person responsible does not consent to the proposed medical treatment and a registered practitioner considers that treatment should be given, the registered practitioner may, within three days after the person responsible has communicated to the practitioner that he or she does not consent, give the person responsible and the Public Advocate a written statement to the effect that:<sup>747</sup>

- the person responsible for the adult has been informed about the nature of the patient's condition to an extent that would be sufficient to enable the adult, if he or she were able to consent, to decide whether or not to consent to the proposed treatment generally or to treatment of a particular kind for that condition;
- the person responsible has not consented to the proposed treatment;
- the registered practitioner believes on reasonable grounds that the proposed treatment is in the best interests of the adult; and
- unless the person responsible applies to the Tribunal and the Tribunal otherwise orders, the practitioner will, not earlier than seven days after giving the statement to the person responsible, carry out the proposed treatment.

11.202 If the person responsible does not make such an application, the registered practitioner may carry out the treatment, but not earlier than seven days after giving the person responsible the statement.<sup>748</sup> However, if the registered practitioner does not disagree with the person responsible's decision not to consent to the provision of a life-sustaining measure, the decision will be effective to withhold the provision of the treatment.

11.203 The effect of these provisions is that a disagreement between a substitute decision-maker and a health provider about whether the withholding or withdrawal of a life-sustaining measure is in the adult's best interests will trigger a review by the Tribunal. In this way, the health provider acts as a 'gatekeeper', rather than as

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<sup>746</sup> See *Guardianship and Administration Act 1986* (Vic) s 3(1).

<sup>747</sup> *Guardianship and Administration Act 1986* (Vic) s 42L(1), (2)(a).

<sup>748</sup> *Guardianship and Administration Act 1986* (Vic) s 42L(2)(a).

a de facto decision-maker.<sup>749</sup> This type of model has found favour with commentators:<sup>750</sup>

[in] the comparatively rare situation in which physicians contest a surrogate's decision and disagreements persist, physicians should seek help from an independent source of review, such as a hospital ethics committee or the judicial system.

11.204 However, given the urgency of some decisions about the provision of life-sustaining measures, it is recognised that the Victorian model may not always be appropriate.

### Issue for consideration

11.205 A consent for the withholding or withdrawal of a life-sustaining measure is a decision about a health matter only if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>751</sup> Further, a consent for the withholding or withdrawal of a life-sustaining measure operates only if the adult's health provider reasonably considers that the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>752</sup> As a result, health providers play a critical role in determining whether a life-sustaining measure may be withheld or withdrawn.

11.206 These limitations were presumably intended to provide a safeguard against inappropriate decision-making about the adult's end-of-life health care, given the serious nature of a decision to withhold or withdraw a life-sustaining measure.<sup>753</sup> However, the effect of the provisions is that a stalemate can arise if the substitute decision-maker is of the view that a life-sustaining measure should be withheld or withdrawn but the adult's health provider does not reasonably consider that the commencement or continuation of the measure would be inconsistent with good medical practice.

11.207 Some commentators have referred to this condition on the effectiveness of a consent as giving the health provider a 'right of veto', and have queried the appropriateness of the current limitation.<sup>754</sup>

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749 L Willmott and B White, 'A Lawful Death at the End of Life: Reflections and Suggestions' (Paper presented at the 15th World Congress on Medical Law, Sydney, 2004) 9.

750 T Beauchamp and J Childress, *Principles of Biomedical Ethics* (6th ed, 2009) 189.

751 *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(2); *Powers of Attorney Act 1998* (Qld) sch 2 s 5(2). See *Re HG* [2006] QGAAT 26, [28] in relation to the application of this condition when the Tribunal's consent is sought for the withholding or withdrawal of a life-sustaining measure.

752 *Guardianship and Administration Act 2000* (Qld) s 66A.

753 See *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 570–1, where the Court found that antibiotics and artificial nutrition had been withheld prematurely, and ordered that the adult be provided with necessary and appropriate medical treatment directed towards the preserving of his life and the promoting of his good health and welfare and that no 'not for resuscitation' order be made in respect of the adult without prior leave of the Court.

754 B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 61–4.

## Discussion Paper

11.208 In the Discussion Paper, the Commission sought submissions on whether section 66A of the *Guardianship and Administration Act 2000* (Qld) should continue to provide that a consent to the withholding or withdrawal of a life-sustaining measure does not operate unless the adult's health provider reasonably considers that the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>755</sup>

11.209 Alternatively, the Commission sought submissions on whether the legislation should include a different mechanism for protecting an adult from inappropriate decision-making by a substitute decision-maker — for example, that the adult's health provider must refer the matter for independent review and that the independent reviewer may apply to the Tribunal in an appropriate case.<sup>756</sup> A range of possible independent reviewers were suggested for consideration:<sup>757</sup>

- a health provider who is not treating the adult;
- the Adult Guardian;
- the Public Advocate;<sup>758</sup>
- a clinical ethics committee; or
- another person.

## Submissions

11.210 The Department of Communities was of the view that the limitation in section 66A of the *Guardianship and Administration Act 2000* (Qld) on the operation of a consent to the withholding or withdrawal of a life-sustaining measure is appropriate.<sup>759</sup>

11.211 Family Voice Australia also appeared to support the current limitation in section 66A, commenting that the Act contains 'appropriate provisions to ensure that decisions by substitute decision-makers ... that could result in the unnecessary or untimely death of the adult are not acted upon recklessly'.<sup>760</sup>

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755 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 316.

756 Ibid.

757 Ibid.

758 As explained in Chapter 24 of this Report, the functions of the Public Advocate are to be transferred to the Adult Guardian.

759 Submission 169.

760 Submission 157.

11.212 A doctor at one of the Commission's health forums also considered that section 66A provides an appropriate safeguard for adults with impaired capacity.<sup>761</sup>

11.213 However, a legal academic with expertise in health law and guardianship law considered that a health professional 'should not have the power *not* to act on the consent if that consent is reached in accordance with the principles of the legislation'.<sup>762</sup> In her view:

The existing legislative model that allows a health professional to take the matter to the Adult Guardian or to the Tribunal would seem sufficient to address the situation if the health professional has concerns about the decision to withhold or withdraw.

11.214 Although this respondent was of the view that 'the threshold of good medical practice should not be relevant in many of the contexts in which it is currently used', she nevertheless suggested that:

if the standard continues to be used, it should be rephrased. The reference instead should be to consistency with good medical practice. There is no justification for having the bar higher than that. Provided conduct can be justified on the basis that it is good medical practice, that should be sufficient.

11.215 That view was also expressed by a doctor at one of the Commission's health forums.<sup>763</sup>

11.216 A respondent who was a long-term member of the Guardianship and Administration Tribunal commented on the suggestion made in the Discussion Paper about referring the matter for independent review. In his view, where the substitute decision-maker is the Adult Guardian, the matter should be referred to the Tribunal.<sup>764</sup>

11.217 The parents of an adult with an intellectual disability commented generally that quality of life should be a consideration. They were also of the view that referral to the Tribunal should be a last resort. The first option in situations of conflict should be review by an independent health provider.<sup>765</sup>

11.218 The Queensland Centre for Intellectual and Development Disability ('QCIDD'), which is part of the University of Queensland's School of Medicine, commented generally that:<sup>766</sup>

Decision-making around life-sustaining treatments for people with intellectual disability is fraught with prejudice and subsequently the debate becomes polarised. There is substantial evidence that the quality of healthcare given to

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761 Health forum 6.

762 Submission 144.

763 Health forum 6.

764 Submission 179.

765 Submission 54A.

766 Submission 153.

people with intellectual disability is poor. Omission of healthcare services which are afforded the general community is rife for people with intellectual disability and part of the bigger picture of their devaluing by our society. Their 'dispensability' leads to skewed end-of-life decision-making and/or withdrawal/non-supply of medical measures which would assist the person to live a healthier existence. The paucity of adequate support for daily living contributes to the way society perceives the person with intellectual disability. The argument holds firm that if a person with intellectual disability were appropriately supported to live their life, then the perceived 'burden' would decrease dramatically and their contribution to society would increase to match. Such a current climate produces unwritten and unspoken policies about withdrawing life-sustaining procedures for people with intellectual disability which continue to perpetrate the eugenics of WWII.

#### 11.219 The QCIDD suggested that:

Responses to the discriminatory assumptions about value and quality of life for people with disability include stringent legislative safeguards, development of policy guidelines about 'good medical practice' which encourage medical practitioners and others to be conscious of the potential for false assumptions to dominate and ongoing training and development to increase disability awareness.

11.220 The Adult Guardian considered that there was merit in omitting section 66A of the *Guardianship and Administration Act 2000* (Qld). However, she commented that 'any mechanism that then applied should be external to the medical system (such as another health provider or clinical ethics committee)'.<sup>767</sup>

### The Commission's view

#### ***The limitation in section 5(2) of the definition of 'health care'***

11.221 At present, the effect of section 5(2) of the definition of 'health care' in schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) is that a decision to withhold or withdraw a life-sustaining measure will be a decision about a health matter only if the commencement or continuation of the measure would be inconsistent with good medical practice. This will be the case whether the decision is to be made by a substitute decision-maker or by the Tribunal.

11.222 Earlier in this chapter, the Commission has recommended that this limitation should be omitted from section 5(2) of the definition of 'health care'. It suggested that, if the limitation was considered to be appropriate, it could be included in the *Guardianship and Administration Act 2000* (Qld) as a substantive limitation on the operation of a consent to the withholding or withdrawal of a life-sustaining measure.<sup>768</sup>

11.223 It is important that the guardianship legislation includes safeguards in relation to decision-making about the withholding or withdrawal of life-sustaining

<sup>767</sup> Submission 164.

<sup>768</sup> See [11.62], [11.64]–[11.68] above.

measures. As part of the decision-making framework, if a substitute decision-maker or the Tribunal is deciding whether to consent to the withholding or withdrawal of such a measure, the substitute decision-maker or the Tribunal, as the case may be, must apply the General Principles and the Health Care Principle. While the fact that the commencement or continuation of the measure would be inconsistent with good medical practice may be relevant to whether the withholding or withdrawal of the measure would, in all the circumstances, be in the adult's best interests,<sup>769</sup> it is not formally part of the Health Care Principle. This requirement could limit the extent to which a substitute decision-maker or the Tribunal could give effect to the principle of substituted judgment when making a decision about withholding or withdrawing a life-sustaining measure.

11.224 Accordingly, the legislation should not be amended to include a requirement that a substitute decision-maker or the Tribunal may consent to the withholding or withdrawal of a life-sustaining measure only if the commencement or continuation of the measure would be inconsistent with good medical practice.

***The limitation in section 66A of the Guardianship and Administration Act 2000 (Qld)***

11.225 A similar, although not identical, limitation is found in section 66A of the *Guardianship and Administration Act 2000* (Qld). Section 66A applies if a matter concerning the withholding or withdrawal of a life-sustaining measure is to be dealt with under section 66(3), (4) or (5) of the Act — that is, by an adult's guardian or under a Tribunal order,<sup>770</sup> by an attorney, or by a statutory health attorney. The effect of the section is that a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure does not operate unless the adult's health provider reasonably considers that the commencement or continuation of the measure would be inconsistent with good medical practice. Obviously, if an adult's substitute decision-maker and health provider are in agreement about the withholding or withdrawal of the life-sustaining measure, section 66A does not prevent the substitute decision-maker's consent to the withholding or withdrawal of the measure from operating. Section 66A will be relevant where there is a dispute between the substitute decision-maker and the health provider — the substitute decision-maker wanting to withhold or withdraw a life-sustaining measure and the health provider wanting to commence or continue a life-sustaining measure.

11.226 The Commission considers that the approach currently reflected in section 66A of the *Guardianship and Administration Act 2000* (Qld) is unsatisfactory for a number of reasons.

11.227 First, it effectively reposes in an adult's health provider the decision about whether a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure for the adult may operate. Although it might be suggested

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See *Guardianship and Administration Act 2000* (Qld) sch 1 s 12(1)(b)(i); *Powers of Attorney Act 1998* (Qld) sch 1 s 12(1)(b)(i). See now the redrafted Health Care Principle recommended in Chapter 5 of this Report, in particular new Health Care Principle 12.

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*Guardianship and Administration Act 2000* (Qld) s 66A(1). Although s 66(3) refers to the situation where the Tribunal 'has appointed 1 or more guardians for the matter or made an order about the matter', it is not clear that this is a reference to a consent given by the Tribunal or to a different type of order, such as a direction to a substitute decision-maker about the matter. This issue is discussed at [11.382] below.

that, if there is a disagreement between an adult's substitute decision-maker and the adult's health provider, the solution is to find a new health provider, in many cases that will not be possible. In those cases, this means that the health provider's assessment of what would be inconsistent with good medical practice will effectively determine the matter. A substitute decision-maker's only option in these circumstances would be to apply to the Tribunal for its consent to the withholding or withdrawal of the life-sustaining measure.<sup>771</sup>

11.228 Secondly, as it is not a requirement of the Health Care Principle or of the redrafted Health Care Principle recommended in Chapter 5, in its application to the withholding or withdrawal of a life-sustaining measure, that the commencement or continuation of the measure would be inconsistent with good medical practice, the Commission does not consider it appropriate that this limitation should be the overriding factor in determining whether a substitute decision-maker's consent can operate.

11.229 By giving the adult's health provider a 'power of veto' in relation to a substitute decision-maker's consent, section 66A(2) appears to be based on an assumption (which may not in fact be correct) that the reason for the disagreement between the substitute decision-maker and the health provider is an unjustified request by the substitute decision-maker for a life-sustaining measure to be withheld or withdrawn.

11.230 Where a dispute arises between an adult's substitute decision-maker (who wants to withhold or withdraw a life-sustaining measure) and the adult's health provider (who wants to commence or continue the measure), it is important that the guardianship legislation is capable of ensuring that:

- the adult is not deprived of life-sustaining measures because of poor decision-making on the part of the adult's substitute decision-maker (whether or not as a result of particular views held by the substitute decision-maker or perhaps even a decision made in bad faith); and
- the adult is not subjected to life-sustaining measures in circumstances that would be inconsistent with the application of the General Principles or the Health Care Principle (whether as a result of particular views held by the adult's health provider or perhaps even the health provider's own self-interest in continuing to treat the adult).

11.231 The issue is how best to achieve these two goals.

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Later in this chapter, the Commission has recommended that, to support the Tribunal's current function of consenting to the withholding or withdrawal of a life-sustaining measure, the *Guardianship and Administration Act 2000* (Qld) should be amended to include a specific power to consent to the withholding or withdrawal of a life-sustaining measure. It has further recommended that s 66 of the Act be amended to ensure that s 66(1), (3)–(5) does not limit the Tribunal's power to consent to the withholding or withdrawal of a life-sustaining measure: see [11.390]–[11.392] and Recommendations 11-11, 11-12 below. The creation of that specific power and the proposed amendment of s 66 will clarify that the limitation in s 66A does not apply where it is the Tribunal, rather than an adult's substitute decision-maker, that consents to the withholding or withdrawal of the life-sustaining measure.

*Majority view*

11.232 As explained earlier in this chapter, section 43 of the *Guardianship and Administration Act 2000* (Qld) enables the Adult Guardian to exercise power for a health matter for an adult if the adult's substitute decision-maker refuses to make, or makes, a decision about the health matter that is contrary to the Health Care Principle.<sup>772</sup> That provision is a key feature of the Act in safeguarding an adult against the risk of poor or improper decision-making about a health matter by the adult's substitute decision-maker.

11.233 Section 43 of the Act is not limited to decisions about the withholding or withdrawal of life-sustaining measures, but applies generally in relation to decisions about health matters. This is important because decisions about life-sustaining measures, while undoubtedly significant, are not the only decisions that may have life and death consequences for an adult. For example, a substitute decision-maker might refuse coronary by-pass surgery for an adult who is a good candidate for the surgery and who has a poor prognosis without the surgery. The substitute decision-maker's decision could be inconsistent with good medical practice, although it may well be in accordance with the General Principles and the Health Care Principle, depending on a range of factors, including the adult's views and wishes. What is significant is that the substitute decision-maker's decision to refuse the surgery is not specifically regulated by the legislation in the way that a decision to withhold or withdraw a life-sustaining measure is. The adult's protection against poor or improper decision-making on the part of his or her substitute decision-maker lies in the ability of the adult's health provider to refer the matter to the Adult Guardian who may, if it is justified, exercise power for the health matter under section 43.

11.234 In view of the power conferred on the Adult Guardian by section 43 of the Act, a majority of the Commission is of the view that section 66A of the Act should be omitted. It is not appropriate that section 66A effectively gives the adult's health provider the power to determine whether a life-sustaining measure may be withheld or withdrawn from an adult. The effect of the section, in preventing the substitute decision-maker's consent from operating, is too absolute and, given the Adult Guardian's power under section 43 of the Act, cannot be justified in terms of the need to safeguard the adult's interests. It is noted, in this regard, that the Adult Guardian operates a 24 hour consent service for health professionals.<sup>773</sup>

11.235 These members gave serious consideration to the alternative proposal suggested below by a minority of the Commission to ameliorate the effect of section 66A(2) by:

- requiring the health provider, in the relevant circumstances, to refer the matter to the Adult Guardian; and

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In Chapter 23, the Commission has recommended that s 43 of the *Guardianship and Administration Act 2000* (Qld) be amended to refer to a refusal, or a decision, that is contrary to the *General Principles* or the Health Care Principle: see Recommendation 23-4 of this Report.

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Adult Guardian, *Annual Report 2008–09* (2009) 53.

- providing that, if the health provider does not refer the matter to the Adult Guardian within two days of forming the view that the substitute decision-maker's decision to withhold or withdraw the life-sustaining measure is inconsistent with good medical practice, the substitute decision-maker's consent will become operative.

11.236 However, in the majority's view, the additional complexity that would result from these amendments is not justified in terms of providing any greater safeguard for the adult than is already available under the legislation. Under both the majority and minority views, the real protection for the adult is that the adult's health provider correctly identifies that the substitute decision-maker's decision does not comply with the Act and is sufficiently concerned about the decision to refer it to the Adult Guardian. If a health provider would, despite his or her concerns, be willing to act on the substitute decision-maker's consent to withhold or withdraw a life-sustaining measure, such a health provider could, under the minority proposal (which does not impose a sanction for non-referral), simply wait the two days, and then act in accordance with the substitute decision-maker's consent which would by then have become operative.

11.237 A majority of the Commission also notes that the alternative proposal of the minority necessitates the amendment of the *Guardianship and Administration Act 2000* (Qld) to include a new provision that, to a large extent, duplicates the Adult Guardian's existing power under section 43.<sup>774</sup>

11.238 For these reasons, a majority of the Commission is of the view that the best way to address the problems raised by section 66A of the *Guardianship and Administration Act 2000* (Qld) is to omit that section. As a consequence of that amendment, section 66B(2)(b) of the Act should be amended by omitting the words 'and section 66A'.<sup>775</sup>

11.239 Although these members are of the view that the Adult Guardian's existing power under section 43 of the *Guardianship and Administration Act 2000* (Qld) provides a sufficient safeguard for an adult against the risk that the adult's substitute decision-maker will make a decision to withhold or withdraw a life-sustaining measure that does not comply with the Act, they are nevertheless of the view that it is desirable for the Act to be amended to include a specific provision to draw the Adult Guardian's power to the attention of health providers.

11.240 In their view, the *Guardianship and Administration Act 2000* (Qld) should be amended to include a provision that refers to the circumstances in which a decision about a health matter may be referred to the Adult Guardian. The new provision should be based broadly on section 85 of the *Powers of Attorney Act 2006* (ACT),<sup>776</sup> but should include the following modifications. First, in addition to the persons who may refer a matter under the ACT provision, the new provision should enable an 'interested person' to refer a decision about a health matter to the

<sup>774</sup> See [11.255]–[11.258] below.

<sup>775</sup> *Guardianship and Administration Act 2000* (Qld) s 66B(2) is discussed at [11.52] above.

<sup>776</sup> *Powers of Attorney Act 2006* (ACT) s 85 is set out at [11.192] above.

adult. Secondly, the new provision should apply to a decision made by a guardian, attorney or statutory health attorney, and should not be limited, as is the ACT provision, to a decision made by an attorney. Thirdly, the new provision should apply where the relevant person believes on reasonable grounds that the decision is not in accordance with the General Principles and the Health Care Principle.<sup>777</sup> A majority of the Commission considers that this test is to be preferred to the current test in section 66A(2) as it reflects a substitute decision-maker's duty under the Act when making a health care decision, as well as that of the Adult Guardian, when making a decision about a health matter under section 42 or 43 of the *Guardianship and Administration Act 2000* (Qld).

11.241 The new provision should be generally in the following terms:

**Referral of health care decision to the adult guardian**

(1) In this section:

**relevant person**, in relation to an adult with impaired capacity for a health matter, means—

- (a) a health provider who is treating, or has at any time treated, the adult;
- (b) a person in charge of a health care facility where the adult is being, or has at any time been, treated or
- (c) an interested person.

(2) This section applies if—

- (a) a guardian or attorney for a health matter for an adult—
  - (i) refuses to make a decision about the health matter for the adult; or
  - (ii) makes a decision about the health matter for the adult; and
- (b) a relevant person believes, on reasonable grounds, that the decision is not in accordance with the general principles and the health care principle.

(3) The relevant person may tell the adult guardian about the decision and explain why the relevant person believes the decision is not in accordance with the general principles and the health care principle.

*Editor's notes*

- 1 Under section 43(1), the adult guardian may exercise power for the health matter if the requirements of paragraph (a) or (b) are satisfied.

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See n 772 above.

2 Under section 247(1)(c), a person is not liable civilly, criminally or under an administrative process, for disclosing to the adult guardian information in accordance with this section.<sup>778</sup>

(4) In this section—

**attorney** means an attorney acting under an enduring document or a statutory health attorney.

11.242 An advantage of this provision is that it applies generally to decisions about health matters. As a result, it will serve as a reminder to health providers that the Adult Guardian's power under section 43 of the Act is not limited to decisions about the withholding or withdrawal of life-sustaining measures. This is important because, as explained above, there are many health care decisions that have serious consequences for the adult.

#### *Minority view*

11.243 One member of the Commission, Mr Bond SC, does not agree that section 66A of the *Guardianship and Administration Act 2000* (Qld) should be omitted. If section 66A of the *Guardianship and Administration Act 2000* (Qld) is simply omitted, that will enable the substitute decision-maker's consent to be operative. While a health provider who was concerned about the substitute decision-maker's decision could refer the matter to the Adult Guardian, who could, in an appropriate case, make the decision whether to withhold or withdraw the measure,<sup>779</sup> there would be no requirement on the health provider to do so. Further, because the consent to withhold or withdraw the measure would operate immediately, until the Adult Guardian gave his or her consent for the commencement or continuation of the life-sustaining measure, the health provider would not have authority to commence or continue the measure.

11.244 Mr Bond considers that, where there is a dispute of the kind contemplated by section 66A, it needs to be resolved. It is not appropriate that the health provider's view should automatically prevail (as is presently the case) or that the substitute decision-maker's decision should automatically prevail.

11.245 Although section 66A of the *Guardianship and Administration Act 2000* (Qld) should generally be retained, Mr Bond is of the view that the Act should be amended to include new provisions to the effect that if, under section 66A(2), a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure for the adult does not operate:

- the adult's health provider (if the adult's substitute decision-maker is not the Adult Guardian); or
- the Adult Guardian (if the Adult Guardian is the adult's substitute decision-maker)

<sup>778</sup> In Chapter 27 of this Report, the Commission has recommended that the protection given by s 247(1) of the *Guardianship and Administration Act 2000* (Qld) be extended to a person who discloses information to the Adult Guardian in accordance with this section: see Recommendation 27-1 of this Report.

<sup>779</sup> See *Guardianship and Administration Act 2000* (Qld) s 43.

must take the steps specified in [11.246] or [11.249], as the case may be, to resolve the disagreement about the withholding or withdrawal of the life-sustaining measure.

11.246 The *Guardianship and Administration Act 2000* (Qld) should provide that, if the adult's substitute decision-maker is not the Adult Guardian:

- the adult's health provider must, within two days of forming the relevant view under section 66A(2) about the substitute decision-maker's consent, refer to the Adult Guardian the decision whether to withhold or withdraw the life-sustaining measure for the adult;<sup>780</sup> and
- despite section 66A(2), if the adult's health provider does not refer the decision to the Adult Guardian within that time, the substitute decision-maker's consent to the withholding or withdrawal of the life-sustaining measure for the adult becomes operative.

11.247 This recommendation does not require the Adult Guardian to make the decision within two days. It only requires the adult's health provider to refer the decision to the Adult Guardian within two days. While that is a short period of time, a telephone call to the Adult Guardian will be sufficient to comply with this requirement.

11.248 Under this proposal, the onus of taking steps to resolve the disagreement is placed on the adult's health provider rather than on the adult's substitute decision-maker. This is generally consistent with the approach adopted by the court in *Re B*.<sup>781</sup> In addition, an adult's health provider (or more usually the hospital where the adult is a patient) is better placed than an individual substitute decision-maker to take these steps.

11.249 The *Guardianship and Administration Act 2000* (Qld) should include a different mechanism to resolve the disagreement where the Adult Guardian is the adult's substitute decision-maker. The Act should provide that, if the Adult Guardian is the adult's substitute decision-maker:

- the Adult Guardian must apply to the Tribunal for a declaration that the withholding or withdrawal of the life-sustaining measure for the adult is a valid exercise of the Adult Guardian's power; and
- despite section 66A(2), if the Tribunal makes such a declaration, the Adult Guardian's consent to the withholding or withdrawal of the life-sustaining measure becomes operative.

11.250 Mr Bond considered whether section 66A(2) should continue to use the expression 'inconsistent with good medical practice' or whether that subsection should refer instead to the health provider having reasonable grounds to consider that the substitute decision-maker's decision is inconsistent with the General

<sup>780</sup> For a similar power in the ACT, see *Guardianship and Management of Property Act 1991* (ACT) s 32H.

<sup>781</sup> [2002] 2 All ER 449, 473–4 (Butler-Sloss P), quoted at [11.31] above.

Principles or the Health Care Principle (those being the principles that must be applied by the substitute decision-maker).

11.251 In his view, as the fact that the substitute decision-maker's consent is operative under section 66A(2) will only be the trigger for the health provider's referral of the decision to the Adult Guardian, and will not regulate the Adult Guardian's decision-making, it is better to use the term that is familiar to health providers. Further, unless a health provider is familiar with an adult's personal circumstances and, in particular, an adult's views and wishes, it may be difficult for a health provider to form a view about whether the decision to withhold or withdraw the life-sustaining measure is in accordance with the General Principles and the Health Care Principle. A test that may require a health provider to consider factors that, in the circumstances, are unknown to the health provider does not provide a realistic safeguard for the adult.

11.252 Mr Bond acknowledges that it is possible for a decision that is inconsistent with good medical practice nevertheless to be consistent with the General Principles and the Health Care Principle (for example, where the adult had previously expressed the view that he or she did not wish to receive life-sustaining measures in particular circumstances). However, he considers that, to the extent that there is a difference between these tests, the continued use of the expression 'inconsistent with good medical practice' will operate as an additional safeguard for the adult.

11.253 Mr Bond is also of the view that section 66A(2) of the *Guardianship and Administration Act 2000* (Qld) should be redrafted to make that subsection less complex. In his view, the complexity of section 66A(2) arises in part because the effectiveness of a consent to the *withholding or withdrawal* of a life-sustaining measure is expressed in terms of a test that applies to the *commencement or continuation* of the measure (that is, to the opposite of that to which consent has been given). Accordingly, while Mr Bond favours the continued use of the expression 'inconsistent with good medical practice' in section 66A(2), section 66A(2) should be replaced with a provision to the following effect:

- (2) A consent to the withholding or withdrawal of a life-sustaining measure for the adult does not operate if the adult's health provider reasonably considers the withholding or withdrawal of the measure for the adult would be inconsistent with good medical practice.

11.254 Finally, Mr Bond is of the view that the section heading for section 66A should be amended so that it better reflects the effect of that section. The current section heading for section 66A is 'When consent to withholding or withdrawal of life-sustaining measure may operate'. However, section 66A specifies the circumstances in which a substitute decision-maker's consent does *not* operate. A section heading to the effect of 'When consent to withholding or withdrawal of life-sustaining measure does not operate' would be more accurate.

11.255 Mr Bond is further of the view that the *Guardianship and Administration Act 2000* (Qld) should be amended to include a new provision to the effect that, if a health provider refers a decision about the withholding or withdrawal of a life-

sustaining measure to the Adult Guardian under the provision proposed at [11.246] above, the Adult Guardian must exercise power for the matter.

11.256 The new section should also include provisions to the general effect of section 43(2)(a)–(b), (d) and (3) of the *Guardianship and Administration Act 2000* (Qld) so that the Adult Guardian must advise the Tribunal in writing of the following details:

- the name of the adult;
- the name of the guardian or attorney; and
- the decision made by the Adult Guardian.

11.257 It is not necessary for the section to require the Adult Guardian to give the Tribunal a statement as to why the refusal or decision is contrary to the Health Care Principle, as required by section 43(2)(c) of the Act, as that is not a condition for the exercise of the Adult Guardian's power and the Adult Guardian may, in fact, make the same decision as the substitute decision-maker.

11.258 The provision recommended at [11.246] above, which will require a health provider, in specified circumstances, to refer the substitute decision-maker's decision to the Adult Guardian, should include a note referring to the new provision that will require the Adult Guardian to exercise power for the matter.

11.259 Finally, although Mr Bond does not agree with the view of the majority regarding the omission of section 66A of the *Guardianship and Administration Act 2000* (Qld), he nevertheless supports the inclusion of the provision recommended by the majority at [11.240]–[11.241] above.

## **THE EFFECT OF THE CONSENT REQUIREMENTS WHERE THE LIFE-SUSTAINING MEASURE IS 'MEDICALLY FUTILE'**

### **Background**

11.260 Section 79(1) of the *Guardianship and Administration Act 2000* (Qld) makes it an offence for a person to carry out health care of an adult with impaired capacity unless:

- the *Guardianship and Administration Act 2000* (Qld) or another Act provides that the health care may be carried out without consent;
- consent to the health care is given under the *Guardianship and Administration Act 2000* (Qld) or another Act; or
- the health care is authorised by the Supreme Court by an order made in its *parens patriae* jurisdiction.

11.261 Because the *Guardianship and Administration Act 2000* (Qld) defines 'health care' to include the withholding or withdrawal of a life-sustaining

measure,<sup>782</sup> it appears that, unless the withholding or withdrawal of a life-sustaining measure is authorised to be carried out without consent under section 63A of the Act or is authorised by the Supreme Court, section 79 requires consent for the withholding or withdrawal of a life-sustaining measure<sup>783</sup> — whether from the adult's advance health directive, if he or she has one, from a substitute decision-maker, or from the Tribunal.<sup>784</sup>

11.262 The situation may sometimes arise where an adult's substitute decision-maker is not willing to consent to the withholding or withdrawal of a life-sustaining measure that is, or has become, 'futile'.<sup>785</sup> Because the withholding or withdrawal of a life-sustaining measure generally requires consent,<sup>786</sup> it seems that a substitute decision-maker, by not giving his or her consent, may effectively be able to insist that a life-sustaining measure be commenced or continued, even though the measure may be medically futile. In that situation, the adult's health provider may withhold or withdraw the measure only if:

- the Adult Guardian consents to the withholding or withdrawal of the measure under section 43 of the *Guardianship and Administration Act 2000* (Qld);<sup>787</sup>
- the Tribunal consents to the withholding or withdrawal of the measure,<sup>788</sup> or
- the Supreme Court authorises the withholding or withdrawal of the measure.

11.263 A similar situation may arise in relation to a direction in an advance health directive requiring that an adult be given a particular life-sustaining measure. Under section 66 of the *Guardianship and Administration Act 2000* (Qld), if the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.

<sup>782</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(2), which is set out at [11.57] above.

<sup>783</sup> Until that consent is obtained, there may also be uncertainty as to whether the health provider is under a legal obligation to provide such treatment. However, unless the requirements of s 63 of the *Guardianship and Administration Act 2000* (Qld) are satisfied, consent is required in order to *provide* a life-sustaining measure. Arguably, if a health provider is endeavouring to obtain consent from a substitute decision-maker to provide a life-sustaining measure to an adult, the health provider cannot be said to be 'withholding' the measure.

<sup>784</sup> In Chapter 9 of this Report, the Commission has recommended the amendment of s 79(1) of the *Guardianship and Administration Act 2000* (Qld) to clarify that, in addition to the circumstances currently mentioned in s 79(1), it is not an offence to carry out health care of an adult with impaired capacity for the health matter concerned if the adult consented to the health care at a time when he or she had capacity to make decisions about the matter: see Recommendation 9-28 of this Report.

<sup>785</sup> See the discussion of the concept of 'futility' at [11.273]–[11.286] below.

<sup>786</sup> *Guardianship and Administration Act 2000* (Qld) s 63A provides that, in specified circumstances, a life-sustaining measure (other than artificial nutrition and hydration) may be withheld or withdrawn without consent.

<sup>787</sup> See [11.56] above. *Guardianship and Administration Act 2000* (Qld) s 43 applies where an adult's substitute decision-maker is acting contrary to the Health Care Principle. See, however, n 777 above in relation to the Commission's recommendation that s 43 be amended.

<sup>788</sup> Note, however, that the Commission has recommended that the *Guardianship and Administration Act 2000* (Qld) should be amended to ensure that s 66(1), (3)–(5) does not limit the Tribunal's power to consent to the withholding or withdrawal of a life-sustaining measure: see [11.391]–[11.392] below.

11.264 There is a tension between the consent requirements in the guardianship legislation, as they apply in relation to the provision of futile life-sustaining measures, and the position at common law. As explained in Chapter 9 of this Report, at common law, a competent patient is not generally entitled to insist on the provision of a treatment that is not offered. In *R (Burke) v General Medical Council*,<sup>789</sup> the English Court of Appeal observed:<sup>790</sup>

If ... [a patient] refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (ie he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.

11.265 The Court of Appeal concluded that:<sup>791</sup>

ultimately, however, a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs.

11.266 The common law position in relation to the provision of medically futile treatment is also reflected in the Australian Medical Association's statement on the role of the medical practitioner in end-of-life care:<sup>792</sup>

Medical practitioners are not obliged to give, nor patients to accept, futile or burdensome treatments or those treatments that will not offer a reasonable hope of benefit or enhance quality of life.

11.267 In the emergency context, where little may be known about an adult's medical history and prognosis, it is not uncommon for life-sustaining measures to be administered until such time as more is known about the adult's condition and prognosis:<sup>793</sup>

One common example is the post-cardiac arrest patient who appears to have sustained anoxic encephalopathy and does not respond to any stimulus. Although an endotracheal tube has been inserted and ventilation is being assisted with a bag-valve apparatus, should she be supported with a ventilator? The normal course is to start ventilation and continue it until her course becomes clearer. Such action is called a 'time-limited trial'. If the patient does not respond to treatment in a limited period of time, the ventilator can be discontinued ... If, however, the patient begins to show neurologic improvement, ventilation can be continued. A decision to withhold care may be fraught with error when it is made in haste or without adequate information.

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789 [2006] QB 273. This decision is considered in more detail at [9.28]–[9.31] above.

790 Ibid 301.

791 Ibid 302.

792 Australian Medical Association, Position Statement, *The Role of the Medical Practitioner in End of Life Care* (2007) [10.2] <<http://ama.com.au/node/2803>> at 20 August 2010.

793 KV Iserson, 'Withholding and Withdrawing Medical Treatment: An Emergency Medicine Perspective' (1996) 28(1) *Annals of Emergency Medicine* 51, 53.

11.268 It has been suggested that, in practical terms, it may be easier for a health provider not to obtain consent for the withholding of medical treatment:<sup>794</sup>

In withholding care, doctors typically withhold information about interventions judged too futile to offer. They thus retain greater decision-making burden (and power) and face weaker obligations to secure consent from patients or proxies. In withdrawing care, there is a clearer imperative for the doctor to include patients (or proxies) in decisions, share information and secure consent, even when continued life support is deemed futile.

11.269 It has also been suggested that the decision to withdraw a life-sustaining measure may be a more difficult decision for a substitute decision-maker to make.<sup>795</sup>

In the normal course of medical treatment, medical practitioners often find it emotionally easier to withhold rather than to withdraw treatment. In the [Intensive Care Unit], where such decisions are made regularly, physicians fail to start new antibiotics, do not offer dialysis, or avoid surgical interventions without much emotion or deliberation. These remain quiet decisions, often unvoiced, and usually unquestioned.

Withdrawal of ongoing treatment, however, often involves emotional discussions with the family, other surrogate decision-makers, nursing staff, and, frequently, the hospital bioethics committee. Even after such discussion, clinicians usually avoid taking the most dramatic and emotionally laden actions, such as stopping a ventilator. This demonstrates that, at least from a level of personal discomfort, withdrawal and withholding of treatment do differ, with withholding being the easier course of action. Likewise, families and other surrogate decision-makers find that not instituting a new treatment rests easier on the conscience than does withdrawing an ongoing intervention. (note omitted)

11.270 In this Report, the Commission has made several recommendations to clarify that a direction requiring the provision of health care (whether given by an advance health directive or an adult's substitute decision-maker) is as effective as, *but no more effective than*, if:<sup>796</sup>

- the adult gave the direction when decisions about the matter needed to be made; and
- the adult then had capacity for the matter.

11.271 The purpose of these recommendations is to emphasise the common law limitations that apply to the effectiveness of a demand for treatment made by a competent adult, and to clarify that a direction in an adult's advance health directive or a decision made by an adult's substitute decision-maker cannot be more

794 E Gedge, M Giacomini and D Cook, 'Withholding and withdrawing life support in critical care settings: ethical issues concerning consent' (2007) 33 *Journal of Medical Ethics* 215, 215.

795 KV Iserson, 'Withholding and Withdrawing Medical Treatment: An Emergency Medicine Perspective' (1996) 28(1) *Annals of Emergency Medicine* 51, 52.

796 See Recommendations 9-3(a), 10-6, 15-5, 16-9 of this Report.

effective than a decision made by the adult would have been in these circumstances.

11.272 The issue to be decided is whether the current consent requirements for the withholding or withdrawal of life-sustaining measures are appropriate or whether the guardianship legislation should be amended so that a health provider does not need consent to withhold or withdraw a futile life-sustaining measure if, at common law, the health provider would not have a duty to provide, or to continue to provide, the measure.

### ***The meaning of 'futile'***

11.273 In considering whether futile life-sustaining measures should be exempted from the consent requirements that apply generally to the withholding and withdrawal of life-sustaining measures under the *Guardianship and Administration Act 2000* (Qld),<sup>797</sup> it is important to have regard to the different meanings that may be attributed to the concept of 'futility', and their implications for this issue.

11.274 Some commentators have referred to a distinction that is sometimes made between 'quantitative futility', where, for example, a treatment has not been successful in the last 100 cases, and 'qualitative futility', where the treatment does not achieve its desired goals and is said to be inconsistent with the 'ends' of medicine.<sup>798</sup> In their view, there are difficulties with both concepts of futility.

11.275 In relation to the concept of 'quantitative futility', they have raised two problems. The first is said to arise 'from the nature of clinical uncertainty and the language of probability'.<sup>799</sup> In their view:

Most medical situations are characterised by uncertainty and seldom is there room for absolutes such as *never* or *always*. Indeed, most judgments are a matter of probability rather than certainty, where *futile* treatment may represent one end of a spectrum of therapies of variable efficacy and where benefit becomes infinitely small before it becomes negative. Clinical uncertainty is the norm rather than the exception.

11.276 They also consider that, clinically, 'it may not be possible to define futile treatment on the basis of a statistical threshold as there may be insufficient data to make accurate prognostications'.<sup>800</sup> A further complication is that expressions of probability may mean different things to different physicians or patients:<sup>801</sup>

some may invoke futility if the success rate is 0 per cent whereas others may invoke futility for treatment with a success rate as high as 10 per cent.

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<sup>797</sup> See *Guardianship and Administration Act 2000* (Qld) s 79.

<sup>798</sup> 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, 236–7.

<sup>799</sup> *Ibid* 237.

<sup>800</sup> *Ibid*.

<sup>801</sup> *Ibid*.

11.277 These commentators have also suggested that the problems associated with reaching agreement on the meaning of 'qualitative futility' are even 'more formidable' and include:<sup>802</sup>

- disagreements about the goals of therapy, and the ends of medicine;
- whose values should determine decision-making;
- the limits of patient autonomy; and
- professional integrity.

11.278 While they agree that 'statistical probability alone cannot be the sole determinant of futility', they consider that assessments of the goals of therapy that are undertaken in determining futility are 'intrinsically value-laden'.<sup>803</sup> For example:<sup>804</sup>

the minutest prospect of surviving for a few days, or even hours, may be valued by a patient with a terminal malignancy (who is perhaps awaiting a relative's arrival), even if continuing treatment is deemed futile by the physician. ...

Furthermore, even where it is difficult to quantify any form of outcome, as with for instance, continuing enteral nutrition for a patient in a persistent vegetative state, therapy may still be valued for its emotional, psychological or symbolic importance to patients' families or society.

11.279 In their view, the 'qualitative aspect of futility highlights the need to weigh and compare the expected *effects*, outcome *benefits* and *burdens* that might come from medical intervention'.<sup>805</sup> It also raises the issue of who it is who should decide whether such medical intervention is futile.<sup>806</sup> They have suggested, in this regard, that:<sup>807</sup>

The problem with making determinations of futility purely the prerogative of the physician is that assessments of outcomes, benefits and burdens incorporate and reflect the values, concerns and perspective of the individual making the assessment.

11.280 An analysis of the different concepts of medical futility has been undertaken by another commentator who has also considered the implications of that analysis in relation to who should be able to make decisions about whether a

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802 Ibid.

803 Ibid 237–8.

804 Ibid 238.

805 Ibid.

806 Ibid.

807 Ibid 239.

particular treatment is futile. In her view, there are really two different types of futility — ‘futile (will not work) treatment’ and ‘futile (not worth doing) treatment’.<sup>808</sup>

11.281 In her analysis, ‘futile (will not work) treatment’ is treatment that will be physiologically ineffective.<sup>809</sup>

To be precise, if a patient experiences respiratory failure and mechanical ventilation will not maintain adequate ventilation and oxygenation, then mechanical ventilation is futile (will not work) treatment. Similarly, if a patient experiences cardiorespiratory failure and CPR will not maintain adequate cardiac output and respiration (eg, in cases of cardiac rupture or severe outflow obstruction), then CPR is futile (will not work) treatment. In the literature, this type of futility is referred to by some as physiological futility. There is reason to avoid the use of this term, however, as the scope of its meaning is not consistent in the literature.

11.282 It has been suggested that the definition of ‘futile (will not work) treatment’ is ‘very narrow, and empirically verifiable’. The benefit of this understanding of futility is that it:<sup>810</sup>

is as close as possible to a value-free ‘objective’ understanding of the term, because the treatment goal with respect to which a specific intervention is deemed to be futile is not [a] matter of choice, but rather is a feature of the intervention. The limitation of this definition is that because of diagnostic and prognostic uncertainty it applies to very few cases; rarely (only in the most extreme cases) can it be asserted with confidence that there is *no* chance that the treatment will have its intended physiological effects on the body.

11.283 The significance of treatment being categorised as ‘futile (will not work) treatment’ is that this is an essentially medical issue:<sup>811</sup>

As regards the issue before the court about whether a physician may unilaterally decide that an intervention is ‘futile’ treatment and may be withheld on this ground, it is clear that a decision about whether an intervention is futile (will not work) can be made solely on the basis of medical considerations by persons with the relevant medical expertise.

11.284 In contrast, it is suggested that in relation to ‘futile (not worth doing) treatment’ the decision-making process is considerably more complex because ‘a decision about the futility of a treatment rests on a subjective (ie, personal, idiosyncratic) evaluation of anticipated benefits and harms, with particular attention to their magnitude and probability’.<sup>812</sup> It is further suggested that there are two aspects of ‘futile (not worth doing) treatment’:<sup>813</sup>

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808 F Baylis, ‘Expert Testimony by Persons Trained in Ethical Reasoning: The Case of Andrew Sawatzky’ (2000) 28(3) *Journal of Law, Medicine & Ethics* 224, 227–8.

809 Ibid 227.

810 Ibid 227–8.

811 Ibid 228.

812 Ibid.

813 Ibid.

i) *Low probability of medical benefit and good quality of life*

Some argue that 'futile' treatments include not only interventions where there is *no medical benefit*, but also interventions where *medical benefit is limited and unlikely to ensure good quality of life*. Essentially the claim is that the probability that an intervention will work (ie, have the intended physiological effects) need not be zero for the intervention to be considered futile. Interventions with a small probability of success (variously defined) should also be considered futile. In the literature, we find the following descriptions of this type of futility, 'little likelihood of success', 'no real expectation of success', 'negligible chance of success', and 'almost certain to fail'.

The benefit of this definition of futile (not worth doing) treatment is that it may have some practical impact on treatment decisions if all relevant parties agree to the use of this definition and understand the facts of the case in the same way. The obvious limitation of this definition is that it is clearly value-laden and thus legitimately open to challenge. ...

ii) *High probability of medical benefit and poor quality of life*

With this type of futility the concern is with interventions that are *likely to confer some medical benefit but not a good quality of life*. There is a reasonable expectation that the intervention will have the intended physiological effects, but the actual quality of life prior to treatment, or the anticipated quality of life after treatment is such that the treatment is deemed futile (not worth doing). In the literature, descriptions of this type of futility include the following, 'intervening is of no value to the patient', 'will not improve the patient's condition', 'will not heal the patient', 'will not benefit the patient', 'will only delay an unavoidable death', 'is not in the patient's best interests' and 'is to no avail'.

11.285 It is suggested that, although the 'definitional debate is not amenable to factual resolution', 'the real issue to be decided is not the futility debate, but who has the authority to make which kinds of decisions'.<sup>814</sup> A distinction is drawn depending on the type of futility.<sup>815</sup>

it is reasonable to hold that decisions about what treatments will or will not work are to be made by persons with the relevant medical and scientific expertise. It follows that some physicians can make unilateral decisions about access to futile (will not work) treatment. These decisions should be few and far between, however, because: i) this category of futile treatment only captures interventions with a zero probability of having the intended physiological effects on the body; and ii) if dealt with appropriately, these situations should not be contentious.

11.286 It is argued, however, that patients or their surrogate decision-makers (substitute decision-makers) must be involved in the determination of futile (not worth doing) treatment:<sup>816</sup>

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814 Ibid 229.

815 Ibid.

816 Ibid.

There is no objective standard that physicians can appeal to in determining and weighing the benefits and burdens of specific interventions for specific patients; ... Patients ([and/or their] legitimate surrogate decision-makers) must be involved in decision-making about life-sustaining treatment so that their religious beliefs, values, goals, hopes and expectations can be understood and inform discussions about the benefits and harms of life-sustaining treatment.

***Whether the withholding and withdrawal of a life-sustaining measure should be treated in an identical manner***

11.287 If the legislation were to be amended so that the current consent requirements did not apply to futile life-sustaining measures, the further issue that arises is whether that exception should apply to both the withholding and withdrawal of a futile life-sustaining measure or whether withholding and withdrawal should be treated differently.

11.288 It has been suggested by some commentators that there is a difference between a decision not to implement a life-sustaining measure and a decision to withdraw or stop a life-sustaining measure that is already in place.<sup>817</sup>

Many professionals and family members feel justified in withholding treatment they never started, but not in withdrawing treatment already initiated. They sense that decisions to stop treatments are more momentous and consequential than decisions not to start them.

11.289 However, bioethicists are of the view that no distinction should be drawn between the withholding and withdrawal of a life-sustaining measure.<sup>818</sup>

One line of reasoning for moral and legal equivalence for the two actions is that if a medical intervention will not result in a desired or beneficial result for the patient, it matters not whether clinicians withhold the intervention before they begin it or after it is in use.

11.290 It has also been suggested that it may be difficult to draw a distinction between acts of withholding and withdrawal:<sup>819</sup>

Feelings of reluctance about withdrawing treatments are understandable, but the distinction between withdrawing and withholding treatment is morally irrelevant and can be dangerous. The distinction is unclear, inasmuch as withdrawing can happen through an omission (withholding) such as not

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T Beauchamp and J Childress, *Principles of Biomedical Ethics* (6th ed, 2009) 157. See also General Medical Council, *Treatment and Care towards the end of life: Good practice in decision-making* (2010) [33] <[http://www.gmc-uk.org/guidance/ethical\\_guidance/6858.asp](http://www.gmc-uk.org/guidance/ethical_guidance/6858.asp)> at 19 August 2010; KV Iserson, 'Withholding and Withdrawing Medical Treatment: An Emergency Medicine Perspective' (1996) 28(1) *Annals of Emergency Medicine* 51, 52 (see [11.269] above); D Sulmasy and J Sugarman, 'Are withholding and withdrawing therapy always morally equivalent?' (2004) 20 *Journal of Medical Ethics* 218. Cf J Harris, 'Are withholding and withdrawing therapy always morally equivalent? A reply to Sulmasy and Sugarman' (1994) 20 *Journal of Medical Ethics* 223. For views of some health care professionals see: G Melltorp and T Nilstun, 'The difference between withholding and withdrawing life-sustaining treatment' (1997) 23 *Intensive Care Medicine* 1264.

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T Beauchamp and J Childress, *Principles of Biomedical Ethics* (6th ed, 2009) 157.

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Ibid 158. See also G Melltorp and T Nilstun, 'The difference between withholding and withdrawing life-sustaining treatment' (1997) 23 *Intensive Care Medicine* 1264, 1264 ref 1-11.

recharging batteries that power respirators or not putting the infusion into a feeding tube.

## Discussion Paper

11.291 In the Discussion Paper, the Commission sought submissions on whether the *Guardianship and Administration Act 2000* (Qld) should be changed so that a health provider is not required to obtain consent in order:<sup>820</sup>

- to withhold a medically futile life-sustaining measure; or
- to withdraw a medically futile life-sustaining measure.

11.292 The Commission also sought submissions on whether:<sup>821</sup>

- it is appropriate that the guardianship legislation treats the withholding and withdrawal of life-sustaining measures in an identical manner; and
- if the withholding and withdrawal of life-sustaining measures should not be treated in an identical manner, how they should be treated.

## Submissions

11.293 A number of respondents, including the Adult Guardian, a legal academic with expertise in health law and guardianship law and a respondent who was a long-term member of the Guardianship and Administration Tribunal, were of the view that the legislation should treat the withholding and withdrawal of life-sustaining measures in the same way.<sup>822</sup>

11.294 The legal academic with expertise in health law and guardianship law commented that the same medical and ethical issues arise in each of these situations.<sup>823</sup>

11.295 However, doctors at one of the Commission's health forums were divided on this issue.<sup>824</sup> One doctor was of the view that withholding and withdrawal should be treated in the same way under the legislation. Other doctors at the same forum commented that, although ethicists are of the view that there is no difference between the withholding and withdrawal of a life-sustaining measure, clinically, the two are quite different. They said that, while doctors do not, in practice, offer futile treatments, if a patient was actively being given a futile life-sustaining treatment, no doctor would withdraw the treatment without consent.

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820 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 309–10.

821 *Ibid* 297–8.

822 Submissions 144, 164, 165, 179.

823 Submission 144.

824 Health forum 6.

11.296 A respondent whose daughter sustained a brain injury in an accident was also of the view that the legislation should not treat the withholding and withdrawal of life-sustaining measures in an identical way.<sup>825</sup>

11.297 Parents of an adult with an intellectual disability suggested that the withholding and withdrawal of a life-sustaining measure were different. In their view, a life-sustaining measure should be given in the first instance 'until the matter can be better researched so the matter then becomes one of whether to withdraw the treatment'.<sup>826</sup>

11.298 The Commission received a submission, endorsed by 25 staff at the Princess Alexandra Hospital, that commented on the requirement under the *Guardianship and Administration Act 2000* (Qld) to obtain consent before withholding an ineffective life-sustaining measure. The submission commented that such a requirement raises practical and professional concerns for clinicians. The submission proposed that it should not be necessary to obtain consent in order to withhold ineffective treatments:<sup>827</sup>

From our clinical experience we have observed that judging care to be futile is an important medical process with significant implications for end-of-life care. Following such a diagnosis, subsequent end-of-life management should not mandate the seeking of consent to withhold ineffective treatments, including CPR, because:

1.1 In addition to preserving the autonomy of patients, we believe that the law also needs to protect patients from an undignified and prolonged death. This ruling may result in [statutory health attorneys] unnecessarily, and unintentionally, prolonging death.

1.2 Clinicians absolutely respect the patient and family's right to be fully informed of decisions regarding end-of-life care. However, when treatment has been deemed futile, it would be highly inappropriate to seek consent of the family or patients to withhold such futile treatments. The doctor's action of seeking such consent implies that a valid choice exists, when, in reality there is no successful alternative. Grieving relatives, including those in the anticipatory grief phase, may use denial as a method of coping — this may significantly impact their decision-making, and may preclude their ability to make a decision in the best interests of their relatives. The refusal of consent to withhold intervention may subsequently deny patients (and their families) dignity in the dying process.

1.3 Mandating the need to obtain consent for such decisions may place a heavy burden on an already distressed family, making them 'complicit' in ending the life of their relative.

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825 Submission 161.

826 Submission 54A.

827 Submission 154. The submission was endorsed by various doctors in the Emergency Department and Intensive Care Unit of the Princess Alexandra Hospital, as well as by nurses who are members of the hospital's Resuscitation Committee. It referred to the finding of the State Coroner in an inquest that the guardianship legislation requires a doctor to have the consent of the adult's substitute decision-maker before withholding life-sustaining measures such as CPR: see <[http://www.courts.qld.gov.au/Woo\\_findings.pdf](http://www.courts.qld.gov.au/Woo_findings.pdf)> at 20 August 2010.

1.4 The greater public are generally unaware of the poor outcomes and distressing nature of ineffective treatment at end of life. These negative outcomes affect patients and carers alike.

11.299 The submission commented that it is unsustainable for doctors to be compelled to seek consent *not* to do something that is:<sup>828</sup>

- not deemed ‘good medical practice’;
- not clinically indicated; and
- not in the patient’s interests.

11.300 The submission argued that such an approach would be unworkable in many medical specialties:<sup>829</sup>

For example, in the treatment of terminal cancer, permission is not sought to withhold therapies that will not benefit the patient. Thus, where chemotherapy is judged to be an ineffective treatment, permission for not offering that treatment is not required. Similarly surgeons are not compelled to obtain consent for not offering an operation that would be ineffective for a patient with a life-threatening illness.

11.301 The Brisbane South Palliative Care Collaborative, while acknowledging the importance of maintaining robust legal frameworks that promote patient autonomy and individual decision-making at end-of-life, raised a concern about the operation of advance health directives where the adult demands that a particular treatment be given:<sup>830</sup>

The Queensland Advance Health Directive differs from equivalent documents in most other Australian states and territories in that it gives provision for a person to request particular treatments at end-of-life. It is our understanding that most Australian states and territories (through various advance planning documents) give provision for refusal of treatment only.

From a clinical perspective this aspect of the Queensland [advance health directive] may be problematic. While it is a clinician’s duty to provide care, and it is illegal to withhold a life-sustaining measure, in the context of end-of-life care, certain treatments may justifiably not be offered. We feel that the current ability to ‘request’ certain interventions such as ventilation, resuscitation, artificial nutrition or antibiotics, communicates a false option to patients, as it is our understanding that patients cannot demand a treatment that is not being offered.

For example, the [advance health directive] theoretically creates a situation in which a person in a persistent vegetative (PCU) state can request that they be continually resuscitated. This situation could cause intense distress to health care staff.

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828 Ibid.

829 Ibid.

830 Submission 102.

If a treatment is medically warranted, the clinician has a legal duty to provide it and the patient need not specifically 'request' it. Therefore, if a treatment is not offered because it is medically futile, the clinician is not compelled to provide it simply because the patient asks for it. (emphasis in original)

11.302 Two other respondents were of the view that the legislation should be amended so that it is not necessary to obtain consent to withhold or withdraw a medically futile life-sustaining measure.<sup>831</sup> A legal academic with expertise in health law and guardianship law commented:<sup>832</sup>

The requirement to obtain consent to withhold or withdraw futile treatment has significant clinical implications. From the meetings that I have had with medical professionals over the years, it appears that this provision is generally not understood and, in rare cases where it is understood, is ignored. The intensive care unit is one context in which this concern is commonly raised. ICU beds are frequently at a premium. In many cases, medical professionals make an assessment that the provision of intensive care to a patient would be futile because of the person's medical conditions. This problem comes into sharp focus in the ICU context where there are limited ICU beds available. Intensivists argue that it is contrary to good medical practice, ignores medical reality and defies common sense to insist that intensive care be given to a patient where such care is futile in the circumstances. In my view, there is merit in this argument.

I note that the legislation in Queensland in this regard is at odds with the common law.

11.303 This respondent noted that there may, of course, be disagreement about whether treatment is futile and considered that it would be appropriate that there be a mechanism to resolve such a disagreement. However, in this respondent's view, the answer should not be to require consent to be obtained for futile treatment.

11.304 As noted earlier, some of the doctors at the Commission's health forums were of the view that it should not be necessary to obtain consent to withhold a life-sustaining measure. However, a doctor at one of the forums commented that a life-sustaining measure would not be withdrawn without consent.<sup>833</sup> A doctor at another forum also expressed reluctance about exercising a power to withdraw a futile life-sustaining measure without consent.<sup>834</sup>

11.305 The Adult Guardian, on the other hand, was opposed to amending the legislation to enable a health provider to withhold or withdraw a medically futile life-sustaining measure without consent.<sup>835</sup>

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831 Submissions 144, 165.

832 Submission 144.

833 Health forum 6.

834 Health forum 5.

835 Submission 164.

In an era where the risk is under treatment as opposed to over treatment, it is important that patients who do not have capacity to make their own decisions have the benefit of an external decision maker.

11.306 The Adult Guardian commented that, in her view, the current legislative provisions in sections 42 and 43 of the *Guardianship and Administration Act 2000* (Qld) seem to work well. She noted that during 2008–09, she overrode the decision of a substitute decision-maker on three occasions under section 43 of the Act. On one of those occasions, the family members applied to the Tribunal disputing the Adult Guardian’s decision to withdraw the life-sustaining measure.<sup>836</sup>

11.307 The Adult Guardian also advised that decisions under section 43 (and 42) of the Act are taken only when ‘other measures, such as mediation, provision of information, obtaining second opinions, family meetings etc fail’. The timeframe for the decision is based on the health care needs of the adult and sometimes the timeframe is relatively short.

### The Commission’s view

11.308 Occasionally, disputes arise between the family of an adult, who want a life-sustaining measure to be commenced or continued, and the adult’s health provider, who considers that the measure is futile and that it is in the adult’s interests for the measure to be withheld or withdrawn.<sup>837</sup> In this situation, it is important to ensure that the legislation provides adequate safeguards to ensure that:

- the adult is not deprived of life-sustaining measures because of a premature or incorrect assessment that the life-sustaining measure is, in the circumstances, futile; and
- the adult is not subjected to futile and possibly burdensome life-sustaining measures because the adult’s substitute decision-maker will not consent to the withholding or withdrawal of the measure or because the adult in an advance health directive has given a direction that, in particular circumstances, the measure is to be commenced or continued.

### *Withholding of a ‘futile’ life-sustaining measure*

11.309 Generally, the Commission is of the view that the withholding and withdrawal of life-sustaining measures should be treated in an identical manner under the legislation, and that consent should therefore be required in order to withhold or withdraw a life-sustaining measure from an adult. This provides a consistent legal framework and is also consistent with the approach taken in other Australian jurisdictions. It also avoids the need to define ‘withholding’ and ‘withdrawal’ in order to distinguish between the two.

<sup>836</sup> See *Re AAC* [2009] QGAAT 27, where the Tribunal declared that the continuation of life-sustaining measures for AAC was inconsistent with good medical practice.

<sup>837</sup> This is the opposite of the situation discussed earlier in relation to s 66A of the *Guardianship and Administration Act 2000* (Qld): see [11.206] and the discussion commencing at [11.225] above.

11.310 However, the Commission also recognises the difficulties that arise under the legislation by reason of the fact that consent is required for the withholding of a 'futile' life-sustaining measure. The issue is whether that difficulty should be addressed by creating an exception to the consent requirement where the life-sustaining measure is futile or whether the difficulty can be addressed in a better way.

11.311 It is apparent from the earlier discussion in this chapter that there is a lack of consensus in relation to the meaning of 'futile' medical treatment. Moreover, where the term is used to refer to 'qualitative futility' or treatment that is futile in the sense that it is 'not worth doing', it appears that the decision whether particular treatment is futile is not solely a medical decision. In the Commission's view, these factors make it undesirable to create an exception to the consent requirements of the guardianship legislation that is framed in terms of a 'futile' life-sustaining measure.

11.312 The Commission agrees with the point made in the submission from the staff of the Princess Alexandra Hospital that the act of seeking consent to withhold treatment that is futile suggests to a patient's family that there is a valid choice to be made when, in fact, no viable treatment is available.<sup>838</sup> There is also a practical difficulty in complying with the current requirement to obtain consent in that the range of futile life-sustaining measures could be quite large. Technically, compliance with the legislation would require that a health provider obtain consent to withhold each of these measures.

11.313 The Commission notes the suggestion made by the staff of the Princess Alexandra Hospital that consent should not be required in order not to do something that is 'not deemed good medical practice, not clinically indicated, and not in the patient's interests'.<sup>839</sup>

11.314 In the Commission's view, the guardianship legislation should be amended to provide that 'withholding a life-sustaining measure' does *not* include not commencing a life-sustaining measure if the adult's health provider reasonably considers that commencing the measure would not be consistent with good medical practice. The use of the expression 'not consistent with good medical practice', as distinct from the expression 'not clinically indicated', has the advantage that it is already defined in the legislation.<sup>840</sup> The effect of this recommendation is that, although ordinarily there will still be a requirement to obtain consent in order to withhold a life-sustaining measure, it will not be necessary to obtain consent in circumstances where the commencement of the measure would not be consistent with good medical practice.

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838 See [11.298] above.

839 See [11.299] above.

840 See *Guardianship and Administration Act 2000* (Qld) sch 2 s 5B (Good medical practice); *Powers of Attorney Act 1998* (Qld) sch 2 s 5B (Good medical practice).

### **Withdrawal of a 'futile' life-sustaining measure**

#### *Majority view*

11.315 A majority of the Commission is of the view that it should not be possible for a health provider to withdraw a futile life-sustaining measure without consent. In their view, this creates too great a risk that the health provider may incorrectly form the view that the life-sustaining measure is futile and withdraw the measure without an opportunity for that view to be tested.

11.316 If a health provider considers that a life-sustaining measure that is being provided to an adult has become futile and is no longer in the adult's interests and the adult's substitute decision-maker will not consent to the withdrawal of the measure, the appropriate course is for the health provider to approach the Adult Guardian for the Adult Guardian's consent to the withdrawal of the measure. Under the Commission's recommendation in relation to section 43 of the *Guardianship and Administration Act 2000* (Qld), the Adult Guardian may consent to the withdrawal of the measure if the substitute decision-maker, in declining to consent, is acting contrary to the General Principles or the Health Care Principle.<sup>841</sup>

11.317 If the Adult Guardian does not consider that the substitute decision-maker is acting contrary to the General Principles or Health Care Principle in not consenting to the withdrawal of the measure, or if the Adult Guardian is the adult's substitute decision-maker, the health provider may apply to the Tribunal for its consent to the withdrawal of the measure.

11.318 A majority of the Commission is concerned that, once the measure is in place, a change to the adult's treatment regime that will in all likelihood result in the adult's death should not occur without consent — whether from the adult's substitute decision-maker, the Adult Guardian or the Tribunal.

#### *Minority view*

11.319 One member of the Commission, Associate Professor White, is of the view that there is no justification for treating the withholding and withdrawal of futile life-sustaining measures differently. Accordingly, it should not be necessary to obtain consent to withdraw a futile life-sustaining measure. Any duty to provide health care should depend on the nature of the health care and the circumstances of the adult, not on whether the health care has initially been provided or not provided at all. Distinguishing between the withholding and withdrawal of life-sustaining measures is inconsistent with the way in which the criminal law would treat a failure to provide the necessities of life. Criminal responsibility does not depend on whether the necessities have been withheld, or provided initially and then withdrawn. Rather, liability depends on the nature of the treatment and whether it is a necessary of life in the circumstances of the case.

11.320 Further, if withholding and withdrawal are to be treated differently in this respect, it will be necessary for the distinction between the two to be clearly

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See Recommendation 23-4 of this Report and n 777 above.

defined. However, it has been suggested that the distinction between the withholding and withdrawal of life-sustaining measures is problematic.<sup>842</sup> For example, if a patient is being PEG-fed and pulls the tube out, it is unclear whether a decision not to reinsert the tube constitutes the withholding or withdrawal of artificial nutrition and hydration. It is undesirable and impractical for the legal duties of doctors to depend on distinctions that are not clearly defined.

11.321 Finally, distinguishing between the withholding and withdrawal of futile life-sustaining measures, and requiring consent for one but not the other, is inconsistent with the common law and the position in all other Australian jurisdictions.

11.322 Accordingly, Associate Professor White considers that the Commission's recommendation in relation to the withholding of futile life-sustaining measures should also be adopted in relation to the withdrawal of such measures. The guardianship legislation should therefore be amended to provide that 'the withdrawal of a life-sustaining measure' does *not* include the discontinuing of a life-sustaining measure if the adult's health provider reasonably considers that continuing the measure would not be consistent with good medical practice.

### **THE EFFECT OF AN ADULT'S OBJECTION TO THE COMMENCEMENT OR CONTINUATION, OR WITHHOLDING OR WITHDRAWAL, OF A LIFE-SUSTAINING MEASURE**

11.323 Under the guardianship legislation, 'health care' of an adult includes:<sup>843</sup>

- the care or treatment of, or a service or a procedure for, the adult:
  - to diagnose, maintain, or treat the adult's physical or mental condition; and
  - carried out by, or under the direction or supervision of, a health provider;
- the withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure would be inconsistent with good medical practice.<sup>844</sup>

11.324 As a result, an adult's objection to 'health care' could be an objection to the commencement or continuation of a life-sustaining measure or to the withholding or withdrawal of a life-sustaining measure.

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842 See [11.290] above.

843 *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(1)–(2); *Powers of Attorney Act 1998* (Qld) sch 2 s 5(1)–(2): see [11.57] above.

844 The Commission has recommended that the words 'if the commencement or continuation of the measure would be inconsistent with good medical practice' be omitted from s 5(2) of the definition of 'health care': see [11.64]–[11.67] above and Recommendation 11-1 of this Report.

11.325 In Chapter 12 of this Report, the Commission has generally considered the effect under the *Guardianship and Administration Act 2000* (Qld) of an adult's objection to health care. In this chapter, the Commission considers whether the general recommendations made in Chapter 12 are appropriate to deal with the more specific issue of the effect of an adult's objection to the commencement or continuation of a life-sustaining measure or to the withholding or withdrawal of a life-sustaining measure.

### ***Non-urgent health care***

11.326 In a non-emergency situation, the effect of an adult's objection to health care is governed by section 67 of the *Guardianship and Administration Act 2000* (Qld). Section 67 provides:

#### **67 Effect of adult's objection to health care**

- (1) Generally, the exercise of power for a health matter or special health matter is ineffective to give consent to health care of an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care.

*Editor's note—*

**Object** is defined in schedule 4 (Dictionary). Note also the *Powers of Attorney Act 1998*, section 35(2)(a) (Advance health directives) provides that 'by an advance health directive [a] principal may give a direction—

- (a) consenting, in the circumstances specified, to particular future health care of the principal when necessary and despite objection by the principal when the health care is provided'.
- (2) However, the exercise of power for a health matter or special health matter is effective to give consent to the health care despite an objection by the adult to the health care if—
- (a) the adult has minimal or no understanding of 1 of the following—
- (i) what the health care involves;
- (ii) why the health care is required; and
- (b) the health care is likely to cause the adult—
- (i) no distress; or
- (ii) temporary distress that is outweighed by the benefit to the adult of the proposed health care.
- (3) Subsection (2) does not apply to the following health care—
- (a) removal of tissue for donation;
- (b) participation in special medical research or experimental health care or approved clinical research.

11.327 The effect of section 67(1) is that, generally, an exercise of power for a health matter — in this case, a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure or to the commencement or continuation of a life-sustaining measure — is ineffective if the health provider knows, or ought reasonably to know, that the adult objects to the health care.

11.328 However, a substitute decision-maker's consent will be effective, and will therefore override an adult's objection to the commencement or continuation, or the withholding or withdrawal, of a life-sustaining measure if the requirements of section 67(2) are satisfied, namely that:

- the adult has minimal or no understanding of what the health care involves or why the health care is required; and
- the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

11.329 Where the health care in question consists of the commencement or continuation of a life-sustaining measure, section 67 deals with the effect of an adult's objection in the same way that it deals with the effect of an adult's objection to the provision of any other health care.

11.330 However, where the health care consists of the withholding or withdrawal of a life-sustaining measure (as distinct from the commencement or continuation of a life-sustaining measure), the requirements of section 67(2)(b) do not seem apposite. Given that death is the usual consequence of withholding or withdrawing a life-sustaining measure, the requirement in section 67(2)(b) that the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefits of the health care is arguably not an appropriate test for the withholding or withdrawal of a life-sustaining measure.

11.331 The term 'object' is defined in the Act in the following terms:<sup>845</sup>

**object**, by an adult, to health care means—

- (a) the adult indicates the adult does not wish to have the health care; or
- (b) the adult previously indicated, in similar circumstances, the adult did not then wish to have the health care and since then the adult has not indicated otherwise.

*Example—*

An indication may be given in an enduring power of attorney or advance health directive or in another way, including, for example, orally or by conduct.

11.332 This definition applies to a number of provisions of the *Guardianship and Administration Act 2000* (Qld).<sup>846</sup> In the context of section 67, the reference to 'object' necessarily means an objection that is made *other* than in an advance

<sup>845</sup> *Guardianship and Administration Act 2000* (Qld) sch 4.

<sup>846</sup> See eg *Guardianship and Administration Act 2000* (Qld) ss 63(3), 63A(2), 64(2), 69(2), 73(3)(a).

health directive. As explained earlier, if an adult has previously made an advance health directive that contains a relevant direction about the withholding or withdrawal of a life-sustaining measure, the matter may only be dealt with under that direction.<sup>847</sup> In those circumstances, there is no scope for the adult's substitute decision-maker to exercise power for the matter. As a result, section 67 does not apply to the situation where the adult has objected in an advance health directive to the commencement or continuation, or to the withholding or withdrawal, of a life-sustaining measure.

### ***Urgent health care***

11.333 Section 63(1) of the *Guardianship and Administration Act 2000* (Qld) provides that, in specified situations, a health provider is authorised to carry out, without consent:

- health care to meet imminent risk to an adult's life or health; and
- health care to prevent significant pain or distress to an adult.

11.334 These provisions are framed generally, and therefore capable of applying to the *provision* of a life-sustaining measure.

11.335 However, section 63(2) provides that a health provider is not authorised to carry out health care to meet imminent risk to an adult's life or health if the health provider knows that the adult objects to the health care in an advance health directive.<sup>848</sup>

11.336 Further, section 63(3) provides that a health provider is not authorised to carry out health care to prevent significant pain or distress if the health provider knows that the adult objects to the health care, unless:<sup>849</sup>

- the adult has minimal or no understanding of what the health care involves or why it is required; and
- the health care is likely to cause the adult either no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

11.337 Where the health care consists of the withholding or withdrawal of a life-sustaining measure, the effect of an adult's objection is governed by section 63A of the *Guardianship and Administration Act 2000* (Qld). That section authorises a health provider, in limited circumstances, to withhold or withdraw a life-sustaining measure without consent. However, section 63A(2) provides that a measure may not be withheld or withdrawn without consent if the health provider knows that the

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847 *Guardianship and Administration Act 2000* (Qld) s 66(2). Section 66 is set out at [11.48] above.

848 The Commission's recommendations in relation to s 63(2) are explained at [11.352], [11.355], [12.114]–[12.117] below.

849 *Guardianship and Administration Act 2000* (Qld) s 63(3). The Commission's recommendations in relation to s 63(3) are explained at [11.354]–[11.355], [12.118]–[12.121] below.

adult objects to the withholding or withdrawal. This provision does not depend on the adult's level of understanding or on whether the objection is made in an advance health directive.

## The law in other jurisdictions

### *Non-urgent health care*

11.338 The *Guardianship Act 1987* (NSW) includes provisions dealing with the effect, in a non-emergency situation, of an adult's objection to medical or dental treatment on a consent to treatment given by the adult's substitute decision-maker (the 'person responsible'). Because the definition of '*medical or dental treatment or treatment*' in section 33(1) of the Act does not include the withholding or withdrawal of treatment, the relevant provisions apply only where the adult objects to the provision of treatment.

11.339 Section 46 of the *Guardianship Act 1987* (NSW)<sup>850</sup> has a similar effect to section 67 of the *Guardianship and Administration Act 2000* (Qld). Generally, a consent given by a person responsible has no effect if:<sup>851</sup>

- the person carrying out or supervising the proposed treatment is aware, or ought reasonably to be aware, that the adult objects to the carrying out of the treatment; or
- the proposed treatment is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the adult.

11.340 However, an adult's objection is to be disregarded if:<sup>852</sup>

- the adult has minimal or no understanding of what the treatment entails; and
- the treatment will cause the adult no distress or, if it will cause the adult some distress, the distress is likely to be reasonably tolerable and only transitory.

11.341 Section 46A of the *Guardianship Act 1987* (NSW) further provides that the NSW Guardianship Tribunal may confer on a guardian the power to override an adult's objection to medical or dental treatment.<sup>853</sup>

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850 *Guardianship Act 1987* (NSW) s 46 is set out at [12.36] below.

851 *Guardianship Act 1987* (NSW) s 46(2).

852 *Guardianship Act 1987* (NSW) s 46(4).

853 *Guardianship Act 1987* (NSW) s 46A is set out at [12.40] below.

### ***Urgent health care***

11.342 The legislation in New South Wales,<sup>854</sup> Tasmania,<sup>855</sup> Victoria<sup>856</sup> and Western Australia<sup>857</sup> authorises urgent treatment to be carried out in specified circumstances without consent. The provisions in these jurisdictions do not include, as a specified circumstance, that the adult does not object to the proposed treatment.<sup>858</sup> Accordingly, the fact that the adult may object to the treatment does not affect the health provider's authority to carry out the treatment.

11.343 Because the definitions of 'medical or dental treatment' and 'treatment' do not include the withholding or withdrawal of treatment,<sup>859</sup> the relevant provisions apply to the urgent provision of a life-sustaining measure but would not appear to apply to the urgent withholding or withdrawal of a life-sustaining measure.

### **Discussion Paper**

11.344 In the Discussion Paper, the Commission considered whether the *Guardianship and Administration Act 2000* (Qld) should be amended so that generally, an adult's objection to health care must be taken into account, but would not necessarily determine the issue.<sup>860</sup> The Commission sought submissions on whether, if the Act were amended in that way, that would be an appropriate way to deal with the effect of an adult's objection to:

- the commencement or continuation of a life-sustaining measure; or
- the withholding or withdrawal of a life-sustaining measure.<sup>861</sup>

11.345 The Commission also sought submissions on whether, if the Act were generally amended in that way, section 67 should be retained at least to the extent of regulating the effect of an adult's objection to:

- the commencement or continuation of a life-sustaining measure; or

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854 *Guardianship Act 1987* (NSW) s 37(1).

855 *Guardianship and Administration Act 1995* (Tas) s 40.

856 *Guardianship and Administration Act 1986* (Vic) s 42A.

857 *Guardianship and Administration Act 1990* (WA) s 110ZI, which is set out at [12.106] below.

858 However, in Western Australia, one of the requirements for the treatment to be authorised in the absence of a 'treatment decision' is that 'it is not practicable for the health professional who proposes to provide the treatment to determine whether or not the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment': *Guardianship and Administration Act 1990* (WA) s 110ZI(1)(c).

859 See *Guardianship Act 1987* (NSW) s 33(1); *Guardianship and Administration Act 1995* (Tas) s 3(1); *Guardianship and Administration Act 1986* (Vic) s 3(1); *Guardianship and Administration Act 1990* (WA) s 3(1).

860 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, [14.68].

861 *Ibid* 312.

- the withholding or withdrawal of a life-sustaining measure.<sup>862</sup>

## Submissions

11.346 The Adult Guardian expressed the view that, if the *Guardianship and Administration Act 2000* (Qld) were amended so that, generally, an adult's objection is a factor to be taken into account but does not determine the issue, that would be an appropriate way to deal with the effect of an adult's objection to both the commencement or continuation of a life-sustaining measure and the withholding or withdrawal of a life-sustaining measure.<sup>863</sup>

11.347 A legal academic with expertise in health law and guardianship law commented that section 67 of the *Guardianship and Administration Act 2000* (Qld) needs to be amended to clarify its ambit and meaning.<sup>864</sup> This respondent also considered that:

It is difficult to imagine a situation where the withholding or withdrawal of life-sustaining medical treatment would be contemplated if the adult had an understanding of the issue, and did not want the treatment to be withheld or withdrawn.

## The Commission's view

### ***Objection to the commencement or continuation of a life-sustaining measure***

#### *Non-urgent health care*

11.348 In Chapter 12, the Commission has generally endorsed the approach reflected in section 67(2) of the *Guardianship and Administration Act 2000* (Qld), which has the effect that, for non-urgent health care, a substitute decision-maker's consent will prevail over an adult's objection to health care if:

- the adult has minimal or no understanding of what the health care involves or why it is required; and
- the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

11.349 However, the Commission recognises that in some cases it may be in an adult's interests to receive health care to which he or she objects, even if the adult has more than a minimal understanding of what the health care involves or why it is required. For that reason, the Commission has recommended that the *Guardianship and Administration Act 2000* (Qld) should include a new provision to

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862 Ibid.

863 Submission 164.

864 Submission 144.

enable the Tribunal to confer on a substitute decision-maker the power to override an adult's objection to health care.<sup>865</sup>

11.350 In the Commission's view, its general recommendations about the effect of an adult's objection to health care are appropriate in the context of an objection to the provision of a life-sustaining measure. The consent of an adult's substitute decision-maker to the commencement or continuation of a life-sustaining measure will be effective, despite the adult's objection, if the requirements of section 67(2) are satisfied. If the requirements of section 67(2) are not satisfied, the adult's objection will ordinarily be effective, in which case the health care cannot be given to the adult. However, the substitute decision-maker will be able to apply to the Tribunal for the power to override the adult's objection in order to consent to the commencement or continuation of the life-sustaining measure.

11.351 Where the adult's objection to the commencement or continuation of a life-sustaining measure is contained in an advance health directive, the adult's objection will not be able to be overridden by the adult's substitute decision-maker as the substitute decision-maker will not have any power in relation to the health matter.<sup>866</sup> The Commission does not recommend any change to this principle.

#### *Urgent health care*

11.352 Section 63(2) of the *Guardianship and Administration Act 2000* (Qld) currently provides that health care (including a life-sustaining measure) may not be provided urgently, without consent, to meet imminent risk to an adult's life or health if the health provider knows that the adult objects to the health care in an advance health directive.<sup>867</sup> In Chapter 12, the Commission has recommended that section 63(2) be amended to add, as a further limitation on carrying out the health care, that the health provider knows that, while the adult had capacity, he or she refused the health care.<sup>868</sup>

11.353 Further, section 63(3) provides that health care (including a life-sustaining measure) may not be provided urgently, without consent, to prevent significant pain or distress to the adult if the health provider knows that the adult objects to the health care, unless:<sup>869</sup>

- the adult has minimal or no understanding of what the health care involves or why it is required; and
- the health care is likely to cause the adult either no distress or temporary distress that is outweighed by the benefit to the adult of the health care.

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<sup>865</sup> See Recommendation 12-1 of this Report.

<sup>866</sup> *Guardianship and Administration Act 2000* (Qld) s 66(2).

<sup>867</sup> If the adult's objection is made in any other way, it will not affect the health provider's authority to carry out the health care without consent: *Guardianship and Administration Act 2000* (Qld) s 63(2).

<sup>868</sup> See Recommendation 12-7 of this Report.

<sup>869</sup> *Guardianship and Administration Act 2000* (Qld) s 63(3).

11.354 In Chapter 12, the Commission has recommended that, in addition to the limitation presently provided for by section 63(3), the health care should not be authorised to be carried out without consent if the health provider knows that the adult has objected to the health care in an advance health directive or that the adult refused the health care while he or she had capacity.<sup>870</sup> In its view, the fact that an adult currently has minimal or no understanding of what the health care involves or why it is required is no reason to discount an objection made by the adult in an advance health directive at a time when the adult had capacity or a refusal of the health care made by the adult while he or she had capacity.<sup>871</sup>

11.355 In the Commission's view, its general recommendations about the effect of an adult's objection to health care in an urgent situation are appropriate in the context of an objection to the provision of a life-sustaining measure. The Commission's recommendations about section 63(2) and (3) of the *Guardianship and Administration Act 2000* (Qld) are intended to give greater recognition to an adult's right to autonomy and, for that reason, an objection to a life-sustaining measure should have the same effect as an objection to other health care.

### **Objection to the withholding or withdrawal of a life-sustaining measure**

#### *Non-urgent health care*

11.356 If the issue of the withholding or withdrawal of the life-sustaining measure does not arise in circumstances where the decision to withhold or withdraw the measure must be taken immediately,<sup>872</sup> the effect of an adult's objection is governed by section 67 of the *Guardianship and Administration Act 2000* (Qld).

11.357 As explained earlier, the effect of section 67(1) is that, generally, a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure (or to the commencement or continuation of a life-sustaining measure) is ineffective if the health provider knows, or ought reasonably to know, that the adult objects to the health care.<sup>873</sup> However, a substitute decision-maker's consent to the withholding or withdrawal of a life-sustaining measure will be effective, and will therefore override an adult's objection to the withholding or withdrawal of the measure, if the requirements of section 67(2) are satisfied, namely that:

- (a) the adult has minimal or no understanding of 1 of the following—
  - (i) what the health care involves;
  - (ii) why the health care is required; and

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870 See Recommendation 12-8 of this Report.

871 See [12.119] below.

872 See *Guardianship and Administration Act 2000* (Qld) s 63A.

873 See [11.327] above.

- (b) the health care is likely to cause the adult—
- (i) no distress; or
  - (ii) temporary distress that is outweighed by the benefit to the adult of the proposed health care.

11.358 As a result, the adult's objection will be effective only if:

- the adult has more than a minimal understanding of what the health care involves *and* why it is required;<sup>874</sup> and
- the health care is *not* likely to cause the adult either no distress or temporary distress that is outweighed by the benefit to the adult of the health care.

11.359 When the *Guardianship and Administration Act 2000* (Qld) was originally enacted, section 67 did not apply to the withholding or withdrawal of a life-sustaining measure.<sup>875</sup> Its application to the withholding or withdrawal of such a measure came about in 2002 as a result of the insertion of what now appears as section 5(2) of the definition of 'health care' in schedule 2 of the Act:<sup>876</sup>

**5 Health care**

(1) ...

(2) Health care, of an adult, includes withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.

...

11.360 In the Commission's view, section 67 of the *Guardianship and Administration Act 2000* (Qld) does not provide an appropriate mechanism for determining the effectiveness of an adult's objection to the withholding or withdrawal of a life-sustaining measure.

11.361 The requirement in section 67(2)(a) in relation to the adult's level of understanding of 'what the health care involves' and 'why the health care is required' provides a meaningful test where the issue is whether the adult's objection should prevent a substitute decision-maker from consenting to the *provision* of medical treatment; in that context, it is relevant in determining the

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Note, if an adult has more than a minimal understanding of only one of the matters mentioned in s 67(2)(a), the condition in s 67(2)(a) for overriding an adult's objection to health care will have been satisfied.

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Further, although s 67 of the *Guardianship and Administration Act 2000* (Qld) is based on the provision included in the draft Bill contained in the Commission's original 1996 Report, the Commission's original scheme did not apply to a substitute decision about the withholding or withdrawal of life-sustaining measures. Such a decision was specifically excluded from the definition of 'health care decision': see Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 2, Draft Assisted and Substituted Decision Making Bill 1996 cl 163 (Effect of objection to health care by adult), sch 1 s 8 (Health care decision).

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See *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld) s 29.

extent to which the adult should be able to control his or her bodily integrity (and not be subjected to treatment to which he or she objects). However, if an adult objects to the withholding or withdrawal of a life-sustaining measure and the requirements of section 67(2)(a) are not satisfied, section 67(1) has the effect that the objection is effective and the measure cannot be withheld or withdrawn. As explained in Chapter 9, even where an adult is competent, the common law recognises that there are limits on the extent to which the adult may insist on receiving particular medical treatment.

11.362 Moreover, the Commission is concerned that the requirements of section 67(2)(b) are simply not apposite to the withholding and withdrawal of a life-sustaining measure. Given that the adult's death is the likely result of withholding or withdrawing the measure, it is not appropriate to frame a test based on whether the 'health care' — in this case, the withholding or withdrawal of the life-sustaining measure — is likely to cause the adult 'no distress' or 'temporary distress that is outweighed by the benefit to the adult of the proposed health care'.

11.363 Section 67 should therefore be amended by inserting a new subsection to the effect that, for the purpose of that section, 'health care' does not include the withholding or withdrawal of a life-sustaining measure. This amendment will restore section 67 to its original purpose.

11.364 The Commission has considered whether, in light of this amendment of section 67, the *Guardianship and Administration Act 2000* (Qld) should be amended to include a new provision that deals specifically with the effect of an adult's objection to the withholding or withdrawal of a life-sustaining measure. Given the diverse range of medical scenarios in which this situation could arise, the Commission does not consider it feasible to articulate the precise circumstances in which an adult's objection to the withholding or withdrawal of a life-sustaining measure should be able to be overridden. However, the Commission is of the view that a decision to withhold or withdraw a life-sustaining measure from an adult in circumstances where the adult objects to the withholding or withdrawal of the measure is a very serious matter, which requires a high degree of oversight to ensure that the decision is not made inappropriately.

11.365 For that reason, the Commission is of the view that the *Guardianship and Administration Act 2000* (Qld) should provide (adopting the structure of section 67(1) of the Act) that an adult's guardian or attorney should not generally be able to give an effective consent to the withholding or withdrawal of a life-sustaining measure if the adult's health provider knows, or ought reasonably to know, that the adult objects. To ensure that an independent decision is made in those circumstances, the Act should enable the Adult Guardian to give an effective consent, despite the adult's objection.

11.366 The Commission considered whether, where the Adult Guardian is an adult's guardian, attorney or statutory health attorney, the Adult Guardian should be able to override the adult's objection or whether, in that situation, only the Tribunal should have the power to override the adult's objection. Ultimately, the Commission has decided that it is appropriate, given the Adult Guardian's statutory

function of protecting adults from neglect, exploitation or abuse,<sup>877</sup> for this power to be exercisable by the Adult Guardian even where the Adult Guardian is the adult's guardian, attorney or statutory health attorney.

11.367 However, if the Adult Guardian's decision to withhold or withdraw the life-sustaining measure is disputed by another person or if the Adult Guardian is concerned about the proposed decision in a particular case, it would be appropriate for the Adult Guardian to apply to the Tribunal either for the Tribunal's consent to the withholding or withdrawal of the measure<sup>878</sup> or for the Tribunal's advice, directions and recommendations about the Adult Guardian's proposed decision.<sup>879</sup> The Commission notes that, in *Re HG*,<sup>880</sup> the Adult Guardian made such an application to the Tribunal after the adult's carers requested that the Adult Guardian review her decision to consent to the withdrawal of artificial hydration and the withholding of artificial nutrition for the adult.<sup>881</sup>

11.368 The new provision that is to deal with the effect of an adult's objection to the withholding or withdrawal of a life-sustaining measure should also include a definition of 'object' that is specific to the context of that provision. Although the specific definition should be based on the definition of 'object' contained in schedule 4 of the *Guardianship and Administration Act 2000* (Qld),<sup>882</sup> it should refer to the adult's wish not to have the life-sustaining measure withheld or withdrawn, rather than to the adult's wish not to have the 'health care'. In addition, the specific definition should not include the expression 'in similar circumstances', which appears in paragraph (b) of the definition of 'object' in schedule 4. That limitation is relevant in relation to the giving of medical treatment, where an adult may have had a history of refusing or objecting to the provision of a particular treatment in similar circumstances. However, in the context of the withholding or withdrawal of a life-sustaining measure, if the adult has not previously been in similar circumstances, the adult will not have had an opportunity to indicate a wish that would meet the requirements of paragraph (b) of the current definition, despite the fact that the adult may nevertheless have expressed a relevant view about the withholding or withdrawal of the measure.

11.369 The *Guardianship and Administration Act 2000* (Qld) should therefore be amended to include a provision to the following general effect:

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877 See *Guardianship and Administration Act 2000* (Qld) s 174(2)(a).

878 The Tribunal has the function, under s 81(1)(f) of the *Guardianship and Administration Act 2000* (Qld), of consenting to the withholding or withdrawal of a life-sustaining measure. The Commission has recommended in this chapter that this function be supported by an express power: see [11.390] and Recommendation 11-11 below.

879 See *Guardianship and Administration Act 2000* (Qld) s 138.

880 [2006] QGAAT 26.

881 Ibid [6]–[7].

882 The definition of 'object' is set out at [11.331] above.

**67A Effect of an adult's objection to the withholding or withdrawal of a life-sustaining measure**

- (1) Generally, the consent of an adult's guardian or attorney to the withholding or withdrawal of a life-sustaining measure for the adult does not operate if the health provider knows, or ought reasonably to know, the adult objects to the withholding or withdrawal of the measure.
- (2) If an adult objects to the withholding or withdrawal of a life-sustaining measure—
  - (a) the Adult Guardian may consent to the withholding or withdrawal of a life-sustaining measure for the adult; and
  - (b) the Adult Guardian's consent is effective despite the adult's objection.
- (3) The Adult Guardian may exercise power under subsection (2) whether or not the Adult Guardian is the adult's guardian or attorney.
- (4) In this section—

**attorney** means an attorney under an enduring document or a statutory health attorney.

**object**, by an adult, to the withholding or withdrawal of a life-sustaining measure means—

- (a) the adult indicates the adult does not wish to have the life-sustaining measure withheld or withdrawn; or
- (b) the adult previously indicated the adult did not wish to have the life-sustaining measure withheld or withdrawn and since then the adult has not indicated otherwise.

11.370 Earlier in this chapter, the Commission has recommended that the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be amended to provide that 'withholding a life-sustaining measure for an adult' does not include not commencing a life-sustaining measure if the adult's health provider reasonably considers that commencing the measure would not be consistent with good medical practice.<sup>883</sup> Because that definition will apply for the purpose of the new section 67A, if an adult objects to the 'withholding' of a life-sustaining measure, but the commencement of the measure would not be consistent with good medical practice, it will not be necessary to obtain the Adult Guardian's consent in order not to provide the measure.

11.371 It should also be noted that, because the proposed section 67A affects the operation of a consent given by an adult's guardian, attorney or statutory health attorney, it does not affect the Tribunal's power to give an effective consent to the

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See [11.309]–[11.314] above. Associate Professor White has also recommended that the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be amended to provide that 'the withdrawal of a life-sustaining measure' does not include the discontinuing of a life-sustaining measure if the adult's health provider reasonably considers that continuing the measure would not be consistent with good medical practice: see [11.319]–[11.322] above.

withholding or withdrawal of a life-sustaining measure for an adult despite the adult's objection to the withholding or withdrawal of the measure.

#### *Urgent health care*

11.372 As explained earlier, if an adult's health provider reasonably considers that the decision to withhold or withdraw a life-sustaining measure must be taken immediately, section 63A of the *Guardianship and Administration Act 2000* (Qld) provides that, in specified circumstances, the life-sustaining measure may be withheld or withdrawn without consent.<sup>884</sup> However, the measure may not be withheld or withdrawn without consent if the health provider knows that the adult objects to the withholding or withdrawal of the measure. In the Commission's view, it is appropriate that, under section 63A, an adult's objection to the withholding or withdrawal of a life-sustaining measure has the effect that the measure may not be withheld or withdrawn without consent.

## THE TRIBUNAL'S POWERS IN RELATION TO THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING MEASURES

### Background

11.373 As explained earlier, when the *Guardianship and Administration Act 2000* (Qld) was originally enacted, the withholding or withdrawal of 'special life-sustaining measures' was a category of special health care. Accordingly, only the Tribunal could consent to the withholding or withdrawal of such measures.<sup>885</sup>

11.374 The Tribunal's power to withhold or withdraw a special life-sustaining measure was originally found in section 68 of the *Guardianship and Administration Act 2000* (Qld), which provided (in virtually identical terms to the current provision):

#### **Special health care**

- 68.(1) The tribunal may consent to special health care, other than electroconvulsive therapy or psychosurgery, for an adult.
- (2) To the extent another entity is authorised by an Act to make a decision for an adult about prescribed special health care, the tribunal does not have power to make the decision.<sup>31</sup>

31 For the application of the general principles and the health care principle to the tribunal and to an entity authorised by an Act to make a decision for an adult about prescribed special health care, see section 11 (Principles for adults with impaired capacity).

11.375 The Tribunal's power to consent to special health care (including the withholding or withdrawal of a special life-sustaining measure) was reflected in section 82(1)(f) of the *Guardianship and Administration Act 2000* (Qld), which listed the Tribunal's functions:

884 See [11.337] above.

885 See [11.153] above.

### Functions

82.(1) The tribunal has the functions given to it by this Act, including the following functions—

...

- (f) subject to section 68, consenting to special health care for adults with impaired capacity for the special health matter concerned; ...

11.376 The priority for making decisions about the withholding or withdrawal of a special life-sustaining measure was determined by section 65 of the Act, which was in virtually the same terms as the current form of that provision. At the time of enactment, section 65 provided:

#### **Adult with impaired capacity—order of priority in dealing with special health matter**

65.(1) If an adult has impaired capacity for a special health matter, the matter may only be dealt with under the first of the following subsections to apply.

- (2) If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.
- (3) If subsection (2) does not apply and an entity other than the tribunal is authorised to deal with the matter, the matter may only be dealt with by the entity.
- (4) If subsections (2) and (3) do not apply and the tribunal has made an order about the matter, the matter may only be dealt with under the order.<sup>28</sup>

28 However, the tribunal may not consent to electroconvulsive therapy or psychosurgery—section 68(1).

### The current provisions

11.377 As explained earlier, in 2002 the *Guardianship and Administration Act 2000* (Qld) was amended to make the withholding or withdrawal of a life-sustaining measure a health matter.<sup>886</sup> The reference to the withholding or withdrawal of a special life-sustaining measure was omitted from the definition of special health care<sup>887</sup> and section 82(1) of the Act, which then set out the Tribunal's functions, was also amended to insert a new paragraph (f).<sup>888</sup> When the QCAT Amendment

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886 See [11.154] above.

887 *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld) s 19(1).

888 *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld) s 13(3).

Act commenced on 1 December 2009, section 82 was repealed and replaced by a new section 81 in similar terms.<sup>889</sup> Section 81(1)(f) currently provides:

**81 Functions**

(1) The tribunal has the functions given to it by this Act, including the following functions—

...

(f) consenting to the withholding or withdrawal of a life-sustaining measure for adults with impaired capacity for the health matter concerned; ...

11.378 However, no specific power was included to confer on the Tribunal the power to consent to the withholding or withdrawal of a life-sustaining measure. Whereas previously consent was given under section 68 of the Act, the Tribunal's power to consent to the withholding and withdrawal of a life-sustaining measure now depends entirely on the function mentioned in section 81.

11.379 The lack of a specific power appears to have been a drafting oversight. The Explanatory Notes for the Guardianship and Administration and Other Acts Amendment Bill 2001 (Qld) stated in relation to the insertion of the new section 82(1)(f) of the *Guardianship and Administration Act 2000* (Qld) that it was inserted 'to ensure that the Tribunal retains the capacity to consent to the withholding or withdrawing of life-sustaining measures for an adult with impaired capacity'.<sup>890</sup>

11.380 However, a further ambiguity in relation to the Tribunal's power to consent to the withholding or withdrawal of a life-sustaining measure arises as a result of the terms of section 66 of the *Guardianship and Administration Act 2000* (Qld). As mentioned above, section 66 sets out the priority for dealing with health matters for an adult. When the withholding or withdrawal of a life-sustaining measure became a health matter, section 66 was not amended to address how a decision made by the Tribunal about the withholding or withdrawal of a life-sustaining measure should affect the priority that otherwise applies under that section.<sup>891</sup>

11.381 Section 66 provides that, for a health matter, the matter may only be dealt with in the following order:

- If the adult has an advance health directive that includes a direction about the matter, the matter may only be dealt with under the direction (section 66(2)).
- If the adult does not have a relevant advance health directive and the Tribunal has appointed a guardian or made an order about the matter, the

<sup>889</sup> *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 1445.

<sup>890</sup> Explanatory Notes, Guardianship and Administration and Other Acts Amendment Bill 2001 (Qld) 9.

<sup>891</sup> *Guardianship and Administration Act 2000* (Qld) s 66 is set out at [11.48] above.

matter may only be dealt with by the guardian or under the order (section 66(3)).

- If the adult does not have a relevant advance health directive and the Tribunal has not appointed a guardian or made an order about the matter, the matter may only be dealt with by the attorney for the matter appointed by the most recent enduring document (section 66(4)).
- If none of the above applies, the matter may only be dealt with by the adult's statutory health attorney (section 66(5)).

11.382 Although section 66(3) refers to a Tribunal order about the matter, it is not clear that that subsection is intended to refer to consent given by the Tribunal (as distinct from a direction made by the Tribunal). The reference to a Tribunal 'order' appeared in section 66(3) of the *Guardianship and Administration Act 2000* (Qld) when it was originally enacted, at which time the Tribunal did not have a power to consent to any health matters.

11.383 In addition, the relationship between the Tribunal's function of consenting to the withholding or withdrawal of a life-sustaining measure and the Adult Guardian's powers under sections 42 and 43 of the *Guardianship and Administration Act 2000* (Qld) is unclear.<sup>892</sup> As explained earlier, the Adult Guardian has the power under these provisions to exercise power for a health matter (which would include the withholding or withdrawal of a life-sustaining measure) if the adult's substitute decision-makers disagree about the matter or if the adult's substitute decision-maker is acting contrary to the Health Care Principle.

11.384 When the withholding or withdrawal of special life-sustaining measures was a type of special health care, there was no issue about the relationship between sections 42 and 43 and the Tribunal's power to consent to the withholding or withdrawal of the measure. This was because sections 42 and 43 apply only to decisions about health matters and do not apply to decisions about special health matters.

## Discussion Paper

11.385 In the Discussion Paper, the Commission sought submissions on whether:<sup>893</sup>

- the *Guardianship and Administration Act 2000* (Qld) should be amended to include a provision conferring on the Tribunal the specific power to consent to the withholding or withdrawal of life-sustaining measures;
- if the *Guardianship and Administration Act 2000* (Qld) is amended to include a new provision giving the Tribunal the specific power to consent to the withholding or withdrawal of a life-sustaining measure:

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*Guardianship and Administration Act 2000* (Qld) ss 42–43 are considered at [11.54]–[11.56] above.

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Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 323, 325.

- the Act should provide that that section applies despite section 66 of the *Guardianship and Administration Act 2000* (Qld) or, alternatively, section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to incorporate into the priority for decisions about health matters the circumstance where the Tribunal consents to the withholding or withdrawal of a life-sustaining measure;
- the Act should also be amended to clarify the relationship between that provision and the Adult Guardian's powers under sections 42 and 43 of the Act.<sup>894</sup>

## Submissions

11.386 One respondent was of the view that the *Guardianship and Administration Act 2000* (Qld) should be amended to include a provision conferring on the Tribunal the specific power to consent to the withholding and withdrawal of life-sustaining measures.<sup>895</sup>

11.387 A legal academic with expertise in health law and guardianship law commented that the question about a specific power 'does not raise issues of principle, but of legal drafting ... that is best left to the drafting experts'.<sup>896</sup>

11.388 One respondent was of the view that, if the *Guardianship and Administration Act 2000* (Qld) is amended to include a new provision giving the Tribunal the specific power to consent to the withholding or withdrawal of a life-sustaining measure, the Act should provide that the new provision applies despite section 66 of the Act.<sup>897</sup> That respondent was also of the view that the Act should clarify the relationship between the Tribunal's power to consent to the withholding and withdrawal of a life-sustaining measure and the Adult Guardian's powers under sections 42 and 43 of the Act.

11.389 A legal academic with expertise in health law and guardianship law commented generally that these issues should be clarified.<sup>898</sup>

## The Commission's view

11.390 The omission of a specific power to support the Tribunal's function under section 81(1)(f) of the *Guardianship and Administration Act 2000* (Qld) of consenting to the withholding or withdrawal of a life-sustaining measure appears to have been a drafting oversight. Clearly, it was intended that the Tribunal should

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894 Ibid.

895 Submission 165.

896 Submission 144.

897 Submission 165.

898 Submission 144.

have that power.<sup>899</sup> To avoid any doubt about the extent of the Tribunal's jurisdiction in this regard, the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that the Tribunal may consent to the withholding or withdrawal of a life-sustaining measure.

11.391 It is also important for the legislation to clarify the relationship between the Tribunal's power to consent to the withholding or withdrawal of a life-sustaining measure and the priority for health matters established under section 66 of the *Guardianship and Administration Act 2000* (Qld). The purpose of giving the Tribunal the power to consent is to enable it to consent where a dispute arises in relation to the exercise of power by a substitute decision-maker or by the Adult Guardian under section 42 or 43 of the Act. Accordingly, it would not be appropriate to incorporate the Tribunal into the hierarchy established by section 66, whether before or after subsections (3) to (5).

11.392 Instead, section 66 should be amended to ensure that subsections (1) and (3) to (5) do not limit the operation of the new provision that is to confer on the Tribunal the power to consent to the withholding or withdrawal of a life-sustaining measure. However, section 66(2) is not to be affected by the new provision. If an adult has a relevant direction in an advance health directive, it should still be the case that the health care may only be carried out in accordance with the direction.

11.393 Sections 42 and 43 of the *Guardianship and Administration Act 2000* (Qld) should also be amended by inserting a new subsection in each provision to the effect that the section does not limit the operation of the new provision that is to confer on the Tribunal the power to consent to the withholding or withdrawal of a life-sustaining measure.

11.394 In exercising the power to consent to the withholding or withdrawal of a life-sustaining measure the Tribunal will be required to apply the General Principles and the Health Care Principle.<sup>900</sup>

## **The need for the Tribunal's function of consenting to the withholding or withdrawal of life-sustaining measures**

### ***Issue for consideration***

11.395 The *Guardianship and Administration Act 2000* (Qld) provides that an application may be made to the Tribunal for a declaration, order, direction, recommendation or advice in relation to an adult about something in, or related to, the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act*

<sup>899</sup> The Explanatory Notes for the Guardianship and Administration and Other Acts Amendment Bill 2001 state (at 9):

*Clause 13 amends section 82 (Functions). ...*

*The section is also amended to insert a new section 82(1)(f) to ensure that the Tribunal retains the capacity to consent to the withholding or withdrawing of life-sustaining measures for an adult with impaired capacity. (emphasis added)*

<sup>900</sup> *Guardianship and Administration Act 2000* (Qld) s 11.

1998 (Qld).<sup>901</sup> The Act also provides that a guardian, administrator or attorney who acts under the Tribunal's advice is taken to have complied with the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld) unless the person knowingly gave false or misleading information relevant to the Tribunal's advice, directions or recommendations.<sup>902</sup>

11.396 The Tribunal has used its power to make a declaration where issues have arisen about whether a substitute decision-maker's decision to withhold or withdraw a life-sustaining measure was in accordance with the legislation. In *Re MHE*,<sup>903</sup> the Tribunal made a declaration to the effect that the adult's attorney under an enduring power of attorney was empowered under sections 66 and 66A of the *Guardianship and Administration Act 2000* (Qld) to make decisions about health care for the adult, including the withholding or withdrawal of a life-sustaining measure. In *Re SAJ*,<sup>904</sup> where the Adult Guardian had been appointed as the adult's guardian for a number of decisions including health care, the Tribunal made a declaration to the effect that the continuation of artificial hydration to the adult was inconsistent with good medical practice.

11.397 The Tribunal's power to give directions would also enable the Tribunal to direct a guardian, attorney or statutory health attorney as to how a decision in relation to the withholding or withdrawal of a life-sustaining measure should be made.<sup>905</sup>

11.398 It is important for the legislation to ensure that the Tribunal has all necessary powers to supervise decisions of this kind so that only decisions that comply with the legislation are made.

### **Discussion Paper**

11.399 In the Discussion Paper, the Commission raised the issue of whether, given the Tribunal's existing powers, it needs the function of consenting to the withholding or withdrawal of life-sustaining measures. The Commission observed that, in relation to other health matters,<sup>906</sup> the Tribunal does not have a function of giving consent.<sup>907</sup>

11.400 The Commission sought submissions on whether the Tribunal should retain the function of consenting to the withholding or withdrawal of life-sustaining measures, or whether the Tribunal's current powers are sufficient to enable the

901 *Guardianship and Administration Act 2000* (Qld) s 115(1).

902 *Guardianship and Administration Act 2000* (Qld) s 138(4).

903 [2006] QGAAT 9.

904 [2007] QGAAT 62.

905 See *Re WFM* [2006] QGAAT 54. That decision and the power to give directions are considered in Chapter 20 of this Report.

906 The *Guardianship and Administration Act 2000* (Qld) defines 'health matter' for an adult as 'a matter relating to health care, other than special health care, of the adult': sch 2 s 4.

907 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 326.

Tribunal to supervise decisions made by substitute decision-makers in relation to the withholding or withdrawal of life-sustaining measures.<sup>908</sup>

### **Submissions**

11.401 The Adult Guardian considered the Tribunal's primary role should be the appointment of decision-makers rather than itself exercising a decision-making function. It was suggested that decisions about the withholding or withdrawal of life-sustaining measures should generally be made by family members with the Tribunal exercising a review function:<sup>909</sup>

To maintain consistency with the integrity of the guardianship regime, the role of the tribunal should primarily be to appoint decision makers as opposed to making decisions. Decisions about withholding and withdrawing [life-sustaining measures] should primarily be made by family members and appointed decision makers who have a more intimate and ongoing involvement in the adult's life. Safeguards should be put in place to ensure that in the case of either inaction or inappropriate decisions, action can be taken or decisions reviewed. The role of the tribunal is most appropriately the latter. It is appropriate for example and the practice within this office that if a decision taken by the Adult Guardian pursuant to s 42 and s 43 is disputed, that the tribunal ought to review that decision.

11.402 The Adult Guardian considered that the Tribunal's current powers are sufficient to enable the Tribunal to supervise decisions made by substitute decision-makers in relation to the withholding or withdrawal of life-sustaining measures.

11.403 However, a respondent who is a long-term Tribunal member was of the view that, although the Tribunal has the power to direct a substitute decision-maker how to make a particular decision, including a decision to withhold or withdraw a life-sustaining measure, it could be difficult for the Tribunal to require a substitute decision-maker who was opposed to that course to make that decision. In that situation, it would be easier and more appropriate for the Tribunal to make the decision.<sup>910</sup>

### **The Commission's view**

11.404 In the Commission's view, it is appropriate for the Tribunal to have the power to consent to the withholding or withdrawal of a life-sustaining measure, and not to be restricted to giving directions about withholding and withdrawal. The Commission agrees with the respondent who suggested that, where an adult's substitute decision-maker is opposed to the withholding or withdrawal of a life-sustaining measure, the appropriate course is for the Tribunal to exercise the power. In that situation, it could be distressing for the substitute decision-maker to be directed to withhold or withdraw the life-sustaining measure. In the absence of a power to consent to the withholding or withdrawal of the measure, the only other alternatives would be for the Tribunal to remove the substitute decision-maker (if he

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908 Ibid 327.

909 Submission 164.

910 Submission 179.

or she was a guardian or attorney) and appoint another guardian who would consent to the withholding or withdrawal of the measure or, if the substitute decision-maker was a statutory health attorney, appoint a guardian who would be willing to consent.

## POTENTIAL CRIMINAL RESPONSIBILITY FOR WITHHOLDING OR WITHDRAWING A LIFE-SUSTAINING MEASURE

### Introduction

11.405 In *Re HG*,<sup>911</sup> the Tribunal raised the possibility that a health provider who withholds or withdraws a life-sustaining measure under the guardianship legislation could nevertheless be criminally responsible for the adult's death. It suggested that this issue should be clarified by the legislature:<sup>912</sup>

The tensions between the consent provisions of the guardianship legislation relating to withholding and withdrawing of life-sustaining measures and the obligations that exist under the criminal law to provide necessities of life<sup>913</sup> has been examined in academic literature. This literature notes that these tensions are highlighted by the fact that the guardianship legislation expressly provides that nothing in the *Guardianship and Administration Act 2000* authorises, justifies or excuses the killing of a person, or affects section 284 of the Criminal Code which provides that the consent by a person to their own death does not affect criminal responsibility of a person causing the death.

The Tribunal has provided relief in this matter by consenting to the withholding and withdrawal of treatment from HG. It has also given declaratory relief about the provision of such treatment being inconsistent with good medical practice on the facts of this case. The Tribunal does not consider it necessary to further explore provisions of the Criminal Code ... that deal with the criminal responsibility of health professionals who withdraw or withhold treatment on the basis of consent provided under the *Guardianship and Administration Act 2000*. However, it notes that the intersection of the Criminal Code ... with the *Guardianship and Administration Act 2000* in the context of consent to withholding and withdrawing life-sustaining measures is a matter that should be clarified by the legislature. (note added)

### The law in Queensland

#### *Guardianship legislation*

11.406 The *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) contain several provisions that are relevant to whether a health provider can be criminally responsible for the death of an adult that occurs following the withholding or withdrawal of a life-sustaining measure.

911 [2006] QGAAT 26. In this case, the Tribunal consented to the withdrawal of artificial hydration currently being provided to HG and to the withholding of artificial nutrition: at [100].

912 Ibid [56].

913 See Criminal Code (Qld) s 285, which is set out at [11.417] below.

11.407 Section 80 of the *Guardianship and Administration Act 2000* (Qld) and section 101 of the *Powers of Attorney Act 1998* (Qld), which are in similar terms, provide:

**80 No less protection than if adult gave health consent**

A person carrying out health care of an adult that is authorised by this or another Act is not liable for an act or omission to any greater extent than if the act or omission happened with the adult's consent and the adult had capacity to consent.

**101 No less protection than if adult gave health consent**

A person, other than an attorney, acting in accordance with a direction in an advance health directive, or a decision of an attorney for a health matter, is not liable for an act or omission to any greater extent than if the act or omission happened with the principal's consent and the principal had capacity to consent.

11.408 However, the operation of these provisions is limited by section 238 of the *Guardianship and Administration Act 2000* (Qld) and section 37 of the *Powers of Attorney Act 1998* (Qld), which deal with the effect of those Acts on a person's criminal responsibility for the death of another person.

11.409 Section 238 of the *Guardianship and Administration Act 2000* (Qld) provides:

**238 Act does not authorise euthanasia or affect particular provisions of Criminal Code**

To remove doubt it is declared that nothing in this Act—

- (a) authorises, justifies or excuses killing a person; or
- (b) affects the Criminal Code, section 284 or chapter 28.

11.410 Section 37 of the *Powers of Attorney Act 1998* (Qld) is in virtually identical terms, except that section 37(b) includes a footnote that sets out three provisions of the Criminal Code (Qld): sections 284 (Consent to death immaterial),<sup>914</sup> 296 (Acceleration of death)<sup>915</sup> and 311 (Aiding suicide).<sup>916</sup>

***Criminal Code (Qld)***

11.411 Section 291 of the Criminal Code (Qld) sets out the circumstances in which it is unlawful to kill a person:

<sup>914</sup> Criminal Code (Qld) s 284 appears in ch 27 of the Code. It provides:

**284 Consent to death immaterial**

Consent by a person to the causing of the person's own death does not affect the criminal responsibility of any person by whom such death is caused.

<sup>915</sup> Criminal Code (Qld) s 296 is set out at [11.436] below.

<sup>916</sup> Criminal Code (Qld) s 311 is set out at [11.442] below.

### 291 Killing of a human being unlawful

It is unlawful to kill any person unless such killing is authorised<sup>917</sup> or justified or excused by law. (note added)

11.412 Section 293 of the Code defines 'killing' in the following terms:

### 293 Definition of killing

Except as hereinafter set forth, any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person.

11.413 It has been held that a person 'causes' the death of another 'if his act or conduct is a substantial or significant cause of death, or substantially contributed to the death'.<sup>918</sup>

11.414 A person who unlawfully kills another person is guilty of a crime, 'which is called murder, or manslaughter, according to the circumstances of the case'.<sup>919</sup>

11.415 Although a health provider may have withheld or withdrawn a life-sustaining measure in accordance with the provisions of the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld), the potential for criminal responsibility arises because, as explained above, both section 238 of the *Guardianship and Administration Act 2000* (Qld) and section 37 of the *Powers of Attorney Act 1998* (Qld) provide that nothing in those Acts:

- authorises, justifies or excuses killing a person; or
- affects section 284 of the Code or Chapter 28 of the Code.

11.416 Whether a health provider will be criminally responsible for a death that follows the withholding or withdrawal of a life-sustaining measure will depend on whether:

- having regard to the relevant provisions of the Code, there is a killing; and
- if so, the killing is authorised, justified or excused by law.

### *Section 285: Duty to provide necessities*

11.417 Section 285 of the Code provides:

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In *R v Stott and Van Embden* [2002] 2 Qd R 313, McPherson JA observed (at 318) that, 'since the abolition of capital punishment in Queensland in 1921, there can now be no lawful authority for killing a person'.

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*R v Sherrington* [2001] QCA 105, [4] (McPherson JA).

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Criminal Code (Qld) s 300. See Criminal Code (Qld) ss 302 (Definition of *murder*), 303 (Definition of *manslaughter*).

## 285 Duty to provide necessities

It is the duty of every person having charge of another who is unable by reason of age, sickness, unsoundness of mind, detention, or any other cause, to withdraw himself or herself from such charge, and who is unable to provide himself or herself with the necessities of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessities of life; and the person is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.

11.418 Section 285 does not create an offence.<sup>920</sup> Instead, it creates a duty and provides that a person who omits to perform that duty 'is held to have caused any consequences which result to the life or health of the other person by reasons of any omission to perform that duty'. If the consequence of the omission is the death of the other person, the person who omitted to perform the duty is held to have caused the death of the other person. The effect of section 293 of the Code is that the person is then deemed to have killed the other person.<sup>921</sup>

11.419 In considering the operation of section 285 of the Code, it is important to note that this section is found in Chapter 27 of the Code (rather than Chapter 28). Accordingly, the effect of section 80 of the *Guardianship and Administration Act 2000* (Qld) and section 101 of the *Powers of Attorney Act 1998* (Qld) are not excluded by either section 238(b) of the *Guardianship and Administration Act 2000* (Qld) or section 37(b) of the *Powers of Attorney Act 1998* (Qld).

11.420 Where the relevant act or omission is the withholding or withdrawal of a life-sustaining measure, section 80 of the *Guardianship and Administration Act 2000* (Qld) and section 101 of the *Powers of Attorney Act 1998* (Qld) both raise the issue of what a health provider's criminal responsibility would be for withholding or withdrawing a life-sustaining measure with the consent of an adult with capacity.

11.421 That issue was recently considered by the Supreme Court of Western Australia in *Brightwater Care Group (Inc) v Rossiter*<sup>922</sup> in relation to the Western Australian equivalent of section 285 of the Criminal Code (Qld). Mr Rossiter was a quadriplegic who was unable to take nutrition or hydration orally. Accordingly, nutrition and hydration were provided by way of a percutaneous endoscopic gastrostomy tube ('PEG'), which had been inserted directly into his stomach by way of surgical intervention. Mr Rossiter was mentally competent and indicated to the staff of Brightwater, the residential care facility where he resided, that he wished to discontinue the provision of nutrition and general hydration through the PEG.<sup>923</sup> Brightwater sought a declaration as to whether it was legally obliged to comply with Mr Rossiter's direction or, alternatively, legally obliged to continue the provision of the services that would maintain his life. This raised the issue of whether section

920 This is in contrast to s 311 of the Criminal Code (Qld) (Aiding suicide), which creates a specific offence.

921 See *R v MacDonald* [1904] St R Qd 151, 174 (Real J).

922 [2009] WASC 229.

923 Ibid [5], [8], [11] (Martin CJ).

262 of the Criminal Code (WA), which is in virtually identical terms to section 285 of the Criminal Code (Qld), required Brightwater to provide Mr Rossiter with artificial nutrition and hydration against his express instructions.

11.422 Martin CJ noted that, if section 262 was construed as imposing on Brightwater a legal duty to continue to provide Mr Rossiter with the necessaries of life even though he had directed them not to, other provisions of the Code would come into operation. For example, it may be arguable that a breach of that duty would lead to the conclusion that Brightwater had caused the death of Mr Rossiter within the meaning of section 270 (Term used: kill)<sup>924</sup> or 273 (Acceleration of death)<sup>925</sup> of the Criminal Code (WA).

11.423 Martin CJ observed that such a construction of section 262 would be a drastic alteration of the common law position, and that the section should not be construed to impose duties that would be unlawful at common law:<sup>926</sup>

if s 262 of the Criminal Code is to be construed as imposing a legal duty to provide medical treatment against the wishes of a mentally competent patient, it would represent a drastic alteration of the common law position. That is because it would require a medical service provider who is under a common law duty to not provide services against the wishes of a patient, to provide services against the patient's wishes or face criminal prosecution for not doing so. Given the strength of the principle of self-determination to which I have referred, it seems inherently unlikely that the Parliament intended such a drastic change when enacting s 262 in its current form, and I would only conclude that it was Parliament's intention to make such a drastic change if compelled to that conclusion by the clear and unequivocal language of the section. It seems to me that there is no such clear and unequivocal language in that section and that therefore the first answer to the proposition that s 262 might apply to the circumstances of this case is that the section should not be read as extending to the imposition of duties which would be unlawful at common law.

11.424 In addition, Martin CJ held that Mr Rossiter was not in 'the charge' of Brightwater within the meaning of that term in section 262 of the Criminal Code (WA):<sup>927</sup>

On a superficial reading of s 262, it might be thought to apply to this case and to impose a duty on Brightwater to provide Mr Rossiter with the necessaries of life, irrespective of Mr Rossiter's wishes. That is because the section appears

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924 Criminal Code (WA) s 270, which is in similar terms to s 293 of the Criminal Code (Qld), provides:

**270 Term used: kill**

Any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person.

925 Criminal Code (WA) s 273, which is in similar terms to s 296 of the Criminal Code (Qld), provides:

**273 Acceleration of death**

A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person.

926 *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [38] (Martin CJ).

927 *Ibid* [39]–[40].

to apply in circumstances where a person has charge of another who is by reason of sickness unable to withdraw himself from such charge and who is unable to provide himself with the necessaries of life. However, upon a more considered reading, it is clear that the section is aimed at a wide variety of circumstances in which, by reason of age, sickness, mental impairment, detention or any other cause, a person lacks the capacity to control or direct their own destiny and to provide themselves with the necessaries of life. Put another way, it seems to me that in s 262 the reference to a person 'having charge of another' is a reference to a person who, by reason of one or more of the various disabilities identified in the section, lacks the capacity to direct or control their own destiny and is therefore dependent upon the person 'having charge' of them.

Mr Rossiter lacks the physical capacity to control his own destiny, but enjoys the mental capacity to make informed and insightful decisions in respect of his future treatment. In that latter respect he is not relevantly within 'the charge' of Brightwater. Rather, Brightwater is, in that respect, consistent with the well-established common law position to which I have referred, subject to Mr Rossiter's direction.

11.425 Martin CJ also considered that there was a third reason why section 262 might have no application to Mr Rossiter, although his Honour lacked the evidence to arrive at any final conclusion on this point. It was observed that Mr Rossiter had the capacity to give directions about his future care and it seemed he may have had the financial capacity to implement those directions. There was nothing to prevent him from discharging himself from Brightwater into the care of another service provider. If that were the case, he would not be a person who is 'unable to withdraw himself' from the charge of Brightwater.

11.426 In light of these considerations, Martin CJ made a declaration in the following terms:<sup>928</sup>

If after Mr Rossiter has been given advice by an appropriately qualified medical practitioner as to the consequences which would flow from the cessation of the administration of nutrition and hydration,<sup>929</sup> other than hydration associated with the provision of medication, Mr Rossiter requests that Brightwater cease administering such nutrition and hydration, then Brightwater may not lawfully continue administering nutrition and hydration unless Mr Rossiter revokes that direction, and Brightwater would not be criminally responsible for any consequences to the life or health of Mr Rossiter caused by ceasing to administer such nutrition and hydration to him. (note added)

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Ibid [58].

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Martin CJ noted that, in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, McDougall J rejected the notion that a refusal of treatment in an advance directive had to be informed in order to be effective at a time when the person lacked the capacity to receive further information. In his Honour's view, the circumstances of Mr Rossiter's case were different, as he 'has the capacity to receive and consider information he is given, and to make informed decisions after weighing that information'. Further, as it was 'perfectly feasible to ensure that Mr Rossiter is given full information as to the consequences of any decision to discontinue treatment before he makes that decision', Martin CJ held that Mr Rossiter's medical service providers should be under a similar obligation to the duty of medical service providers generally to 'inform patients of all aspects and risks associated with any medical procedure before seeking their consent to that procedure': *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [28]–[30].

11.427 However, commentators have suggested that *Brightwater Care Group (Inc) v Rossiter* does not provide a comprehensive solution to concerns about criminal responsibility in this area, and that there is still considerable uncertainty for health providers who act in accordance with the guardianship legislation (or a competent adult's refusal) in withholding or withdrawing a life-sustaining measure.<sup>930</sup>

11.428 First, they contend that 'it is possible for an adult to have capacity and still be in the charge of another' for the purposes of section 285 of the Criminal Code (Qld).<sup>931</sup> In their view:<sup>932</sup>

To argue that once a person has capacity, they can no longer be in charge of a treating doctor or others fails to recognise the reality of almost absolute control that *potentially* can be exercised over a person with profound physical disabilities.

11.429 Accordingly, although Martin CJ held that, because Mr Rossiter had mental capacity, he was not relevantly within the care of Brightwater, they consider that this proposition cannot be applied universally.<sup>933</sup>

11.430 Secondly, they note that not all competent adults will have the financial resources needed to withdraw themselves from the charge of another. Further, a competent adult may be unable to withdraw from the charge of another because the adult has profound physical disabilities and has no contact with people other than his or her service providers.<sup>934</sup>

11.431 Thirdly, in relation to Martin CJ's conclusion that the Code should not be construed to require Brightwater to provide artificial nutrition and hydration where they had been refused by Mr Rossiter, they consider that, while that construction leads to a desirable and sensible outcome, there is some doubt about whether, as a matter of statutory interpretation, the plain words of the Criminal Code (WA) may be limited by reference to the common law.<sup>935</sup>

11.432 Commentators have also suggested that, despite the apparent *prima facie* criminal responsibility of health providers who act on a decision to withhold or withdraw a life-sustaining measure, there are two bases on which it may be argued that a person who carries out health care in accordance with the guardianship legislation will not be liable for a breach of the Criminal Code (Qld).<sup>936</sup>

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930 B White, L Willmott and J Allen, 'Withholding and withdrawing life-sustaining treatment: Criminal responsibility for established medical practice?' (2010) 17 *Journal of Law and Medicine* 849, 859, 864–5.

931 *Ibid* 859.

932 *Ibid* 858–9.

933 *Ibid* 859.

934 *Ibid*.

935 *Ibid* 860.

936 L Willmott and B White, 'Charting a course through difficult legislative waters: Tribunal decisions on life-sustaining measures' (2005) 12 *Journal of Law and Medicine* 441, 451–3.

11.433 The first basis depends on the effect of section 80 of the *Guardianship and Administration Act 2000* (Qld). The argument is based on the fact that a person with capacity can refuse treatment, even if that refusal will result in the person's death, and a health provider is not criminally responsible for acting in accordance with the person's wishes; in fact, if the health provider did otherwise, he or she would be guilty of assault. As a result, section 80 arguably has the effect that a person who acts on an adult's advance health directive or on the consent of an adult's substitute decision-maker to withhold or withdraw a life-sustaining measure is not liable for that act or omission as the person would not be liable if he or she had withheld or withdrawn the life-sustaining measure with the adult's consent.<sup>937</sup>

11.434 The second basis upon which it is argued that the withholding or withdrawal of a life-sustaining measure in accordance with the guardianship legislation does not result in criminal responsibility relates specifically to the duty to provide necessities in accordance with section 285 of the Criminal Code (Qld). The argument is that, if a life-sustaining measure is not a 'necessary of life', a health provider will not be under a duty to provide it.<sup>938</sup> In *Auckland Area Health Board v Attorney General*,<sup>939</sup> Thomas J considered that whether the provision of a particular life-sustaining measure amounted to the provision of a necessary of life would depend on the facts of the individual case:<sup>940</sup>

To my mind, however, there is no absolute answer; the answer in each case must depend on the facts. Thus, the provision of artificial respiration may be regarded as a necessary of life where it is required to prevent, cure or alleviate a disease that endangers the health or life of the patient. If, however, the patient is surviving only by virtue of the mechanical means which induces heartbeat and breathing and is beyond recovery, I do not consider that the provision of a ventilator can properly be construed as a necessary of life.

11.435 On this view, it is arguable that, depending on the life-sustaining measure in question and the circumstances of the adult, a life-sustaining measure may not be a necessary of life, in which case the withholding or withdrawal of the measure would not amount to a breach of section 285 of the Criminal Code (Qld).<sup>941</sup> If a health provider does not breach the duty imposed by section 285, the question of criminal responsibility for the adult's death will not arise.

937 Ibid. Although this argument is not made specifically in relation to s 285 of the Criminal Code (Qld), it is most relevant to the issue of criminal responsibility arising from a breach of the duty imposed by that section for the reason that s 285 is not referred to by s 238(b) of the *Guardianship and Administration Act 2000* (Qld) or s 37(b) of the *Powers of Attorney Act 1998* (Qld).

938 *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 249–50, discussed in L Willmott and B White, 'Charting a course through difficult legislative waters: Tribunal decisions on life-sustaining measures' (2005) 12 *Journal of Law and Medicine* 441, 452–3.

939 [1993] 1 NZLR 235.

940 Ibid 249–50.

941 Cf R Cavell, 'Not-for-resuscitation orders: The medical, legal and ethical rationale behind letting patients die' (2008) 16 *Journal of Law and Medicine* 305, 331: 'There is no clarity as to whether Queensland's "necessaries of life" ... include therapies that would prolong life without benefiting it'.

*Section 296: Acceleration of death*

11.436 Section 296 of the Criminal Code (Qld) provides:

**296 Acceleration of death**

A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person.<sup>942</sup> (note added)

11.437 Section 296 does not create an offence. Instead, it provides that, in the relevant circumstances, a person who does any act or makes any omission that hastens the death of another person 'is deemed to have killed that other person'. It has been held that:<sup>943</sup>

on the present state of authority, it is enough to satisfy the requirement of causation for the purpose of attributing criminal responsibility if the act of the accused makes a significant contribution to the death of the victim, whether by accelerating the victim's death or otherwise, and that it is for the jury to decide whether or not the connection is sufficiently substantial.

11.438 If the requirement for causation is satisfied, section 291 of the Code has the effect that the killing will be unlawful unless it is authorised, justified or excused by law.

11.439 As mentioned earlier, nothing in the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld) authorises, justifies or excuses the killing of a person. Further, because section 296 is located in Chapter 28 of the Code, its operation is not affected by anything in the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld).<sup>944</sup>

11.440 It may be arguable that section 282 of the Code could protect a health provider from criminal responsibility for withholding or withdrawing a life-sustaining measure. That section provides, relevantly:

**282 Surgical operations and medical treatment**

- (1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—
- (a) a person or an unborn child for the patient's benefit; or
  - (b) a person or an unborn child to preserve the mother's life;

<sup>942</sup> Note, however, s 282A(1)–(2) of the Criminal Code (Qld), which provides that, in specified circumstances, a person is not criminally responsible for providing palliative care to another person even if an incidental effect of providing the palliative care is to hasten the other person's death. However, nothing in s 282A authorises, justifies or excuses an act done or omission made with intent to kill another person or aiding another person to kill himself or herself: s 282A(3).

<sup>943</sup> *Krakouer v Western Australia* (2006) 161 A Crim R 347, 359 (Steytler P).

<sup>944</sup> *Guardianship and Administration Act 2000* (Qld) s 238(b); *Powers of Attorney Act 1998* (Qld) s 37(b).

if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

- (2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.
- (3) It is lawful for a person acting under the lawful direction or advice, or in the reasonable belief that the advice or direction was lawful, to administer the substance, or supply or procure the substance, in accordance with the direction or advice.
- (4) In this section—

**health professional** has the same meaning as in the *Health Services Act 1991*, section 60.

**medical treatment**, for subsection (1)(a), does not include medical treatment intended to adversely affect an unborn child.

**patient** means the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided.

**surgical operation**, for subsection (1)(a), does not include a surgical operation intended to adversely affect an unborn child.

11.441 However, because section 282(1) applies where a person has provided, in good faith and with reasonable care and skill, 'medical treatment' to another person, the section will protect a health provider from criminal responsibility only if the provision of medical treatment is taken to include the withholding or withdrawal of a life-sustaining measure. If medical treatment is construed to mean the active provision of medical treatment, as distinct from the withholding or withdrawal of medical treatment, the section will not apply where a life-sustaining measure is withheld or withdrawn.

#### *Section 311: Aiding suicide*

11.442 Section 311 of the Criminal Code (Qld) provides:

#### **311 Aiding suicide**

Any person who—

- (a) procures another to kill himself or herself; or
- (b) counsels another to kill himself or herself and thereby induces the other person to do so; or
- (c) aids another in killing himself or herself;

is guilty of a crime, and is liable to imprisonment for life.

11.443 Section 311 is one of the provisions set out in the footnote to section 37(b) of the *Powers of Attorney Act 1998* (Qld). It is an essential ingredient of the offence created by section 311(c) that the accused ‘should have been aware of the existence of an intention on the part of [the deceased] to take his own life’.<sup>945</sup>

11.444 That requirement would seem to make the section inapplicable to the situation where a health provider withholds or withdraws a life-sustaining measure on the basis of consent given by the adult’s substitute decision-maker or under the authority of section 63A of the *Guardianship and Administration Act 2000* (Qld).

11.445 It is not clear whether section 311(c) would apply where a health provider withheld or withdrew a life-sustaining measure from an adult in compliance with a direction contained in an advance health directive made under the *Powers of Attorney Act 1998* (Qld). In *Airedale NHS Trust v Bland*,<sup>946</sup> Lord Goff stated that there was no suggestion that a competent patient who refused treatment that was required to sustain the patient’s life had committed suicide or that the treating doctor had aided or abetted the patient in doing so.<sup>947</sup> Because of section 37(b) of the *Powers of Attorney Act 1998* (Qld), nothing in that Act can affect the operation of section 311 of the Code. However, given that it is essential for a conviction under section 311(c) that the defendant should have been aware of the deceased’s intention to take his or her own life, the direction in the advance health directive would have to be construed as being capable of expressing such an intention. That would seem inconsistent with the view expressed by Lord Goff in *Airedale NHS Trust v Bland*.

11.446 It is apparent from the preceding discussion that, while there are certainly sound arguments that a health provider who withholds or withdraws a life-sustaining measure in accordance with the guardianship legislation will not be criminally responsible for the adult’s death, it still remains an area of uncertainty.

### The law in other jurisdictions

11.447 Most of the other Australian jurisdictions have a legislative provision that gives some form of protection from criminal and civil liability to a health provider who withholds or withdraws medical treatment in accordance with the relevant legislation.

#### *Australian Capital Territory*

11.448 In the ACT, the *Medical Treatment (Health Directions) Act 2006* (ACT) makes provision for an adult to make a health direction refusing, or requiring the withdrawal of, medical treatment generally or of a particular kind.<sup>948</sup> Section 16 of

945 *R v Stott and Van Embden* [2002] 2 Qd R 313, 317 (McPherson JA).

946 [1993] AC 789.

947 See [11.24] above.

948 *Medical Treatment (Health Directions) Act 2006* (ACT) s 7(1).

the Act deals with the liability of a health professional who withholds or withdraws treatment in accordance with the Act. It provides:

**16 Protection of health professionals relying on decisions**

- (1) This section applies to a health professional, or a person acting under the direction of a health professional, if—
  - (a) the health professional makes a decision that the health professional believes, on reasonable grounds, complies with this Act; and
  - (b) the health professional, or other person, honestly and in reliance on the decision, withholds or withdraws medical treatment from a person.
- (2) The withholding or withdrawing of treatment is not—
  - (a) a breach of professional etiquette or ethics; or
  - (b) a breach of a rule of professional conduct.
- (3) Civil or criminal liability is not incurred only because of the withholding or withdrawing of treatment.

11.449 In addition, the *Guardianship and Management of Property Act 1991* (ACT) includes provisions dealing with the liability of a protected person's health attorney and health provider:

**32K Protection of health attorney from liability**

No action or proceeding, civil or criminal, lies against a health attorney for a protected person in relation to consent given, or not given, in good faith as a health attorney for the protected person.

**32L Protection of health professional from liability**

No action or proceeding, civil or criminal, lies against a health professional in relation to reliance by the health professional, in good faith, on consent given by—

- (a) a health attorney for a protected person; or
- (b) a person the health professional believes on reasonable grounds is a health attorney for a protected person.

**32M Preservation of liability**

Nothing in this part relieves a health professional from liability in relation to the provision of medical treatment if the health professional would have been subject to the liability—

- (a) had the protected person not had impaired decision-making ability; and
- (b) had the treatment been carried out with the protected person's consent.

### **Northern Territory**

11.450 In the Northern Territory, the *Natural Death Act* (NT) enables an adult to make a direction that, in the event that he or she is suffering from a terminal illness, he or she is not be subjected to extraordinary measures.<sup>949</sup> Section 6 of the Act addresses the issue of causation of the adult's death. It provides:

#### **6 Certain aspects of causation of death**

- (1) For the purposes of the law of the Territory, the non-application of extraordinary measures to, or the withdrawal of extraordinary measures from, a person suffering from a terminal illness does not constitute a cause of death where the non-application or withdrawal was as a result of and in accordance with a direction made under section 4(1) by the person.
- (2) This section does not relieve a medical practitioner from the consequences of a negligent decision as to whether or not a patient is suffering from a terminal illness.

### **South Australia**

11.451 In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) enables an adult to make anticipatory directions about medical treatment that are to apply if, in the future, the person is in the terminal phase of a terminal illness or is in a persistent vegetative state.<sup>950</sup> The Act also enables an adult, by a medical power of attorney, to appoint an agent to make decisions about the person's medical treatment.<sup>951</sup> Section 16 of the Act gives the following protection from criminal and civil liability to a medical practitioner:

#### **16 Protection for medical practitioners etc**

A medical practitioner responsible for the treatment or care of a patient, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability for an act or omission done or made—

- (a) with the consent of the patient or the patient's representative or without consent but in accordance with an authority conferred by this Act or any other Act; and
- (b) in good faith and without negligence; and
- (c) in accordance with proper professional standards of medical practice; and
- (d) in order to preserve or improve the quality of life.

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949 *Natural Death Act* (NT) s 4(1).

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

951 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8(1).

**Victoria**

11.452 In Victoria, the *Medical Treatment Act 1988* (Vic) enables an adult to make a refusal of treatment certificate.<sup>952</sup> It also enables a refusal of treatment certificate to be made by an agent appointed by the adult under an enduring power of attorney (medical treatment) or the adult's guardian.<sup>953</sup> Section 9 of the Act protects a registered medical practitioner who, in good faith and in reliance on a refusal of treatment certificate, does not provide medical treatment that he or she believes on reasonable grounds has been refused. Section 9 provides:

**9 Protection of registered medical practitioners**

- (1) A registered medical practitioner or a person acting under the direction of a registered medical practitioner who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or continue medical treatment which he or she believes on reasonable grounds has been refused in accordance with this Act is not—
- (a) guilty of misconduct or infamous misconduct in a professional respect; or
  - (b) guilty of an offence; or
  - (c) liable in any civil proceedings—
- because of the failure to perform or continue that treatment.
- (2) For the purposes of this section a person who acts in good faith in reliance on a refusal of treatment certificate but who is not aware that the certificate has been cancelled, is to be treated as having acted in good faith in reliance on a refusal of treatment certificate.

11.453 Finally, section 259(2) of the Criminal Code (WA) provides:

**259 Surgical and medical treatment**

- (1) ...
- (2) A person is not criminally responsible for not administering or ceasing to administer, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) if not administering or ceasing to administer the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

11.454 Section 259(2) was inserted by the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA), which also amended the *Guardianship and Administration Act 1990* (WA) to make provision for advance health directives and the appointment of an enduring guardian by an adult.

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<sup>952</sup> *Medical Treatment Act 1988* (Vic) s 5.

<sup>953</sup> *Medical Treatment Act 1988* (Vic) s 5B.

## Discussion Paper

11.455 In the Discussion Paper, the Commission sought submissions on whether the law should be changed to clarify the criminal responsibility of a person who acts on the basis of a consent provided in accordance with the guardianship legislation for the withholding or withdrawal of life-sustaining measures from an adult.<sup>954</sup>

11.456 The Commission also sought submissions on whether any such change should be made in the guardianship legislation or in the Criminal Code (Qld).

## Submissions

11.457 Three respondents, including the Adult Guardian, were of the view that the issue of potential criminal responsibility for withholding or withdrawing a life-sustaining measure should be clarified.<sup>955</sup>

11.458 One of these respondents favoured amending the Criminal Code (Qld) rather than the *Guardianship and Administration Act 2000* (Qld).<sup>956</sup>

11.459 A legal academic with expertise in health law and guardianship law, was of the view that the location of the provision was 'best left to the drafter', although other considerations probably favoured amending the Code.<sup>957</sup>

Whether that should be in the guardianship legislation or the Criminal Code is best left to the drafter. (There may also be difficulties in relation to the criminal liability of health professionals who withhold or withdraw life-sustaining treatment from a person with capacity. If this is the case, it is perhaps more logical to amend the Criminal Code so both issues can be addressed.)

## The Commission's view

### *Amendment of the Criminal Code (Qld)*

11.460 The issues that arise as a result of the provisions of the Criminal Code (Qld) and their relationship to the guardianship legislation are not peculiar to Queensland. In the early 1980s, the Law Reform Commission of Canada examined the effect of the Canadian Criminal Code on the cessation and refusal of treatment and commented:<sup>958</sup>

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954 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 331.

955 Submissions 144, 164, 165.

956 Submission 165.

957 Submission 144.

958 Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Report No 20 (1983) 9.

Certain provisions ... of the *Criminal Code* were drafted at a time when the specific problems confronted in this paper had not then arisen. For example, modern medical technology was not yet available to the medical profession. Sophisticated and scientific palliative care was either unknown or at best in its infancy. Indeed, the very practice of medicine and hospital management was radically different from what it is now.

Those provisions, drafted in general language, were adequate to meet the problems of the era for which they were conceived. However, they were never supplemented, as they perhaps should have been, by amendments adapting them to changed realities. The Commission believes that these *Criminal Code* sections now need to be re-examined and revised in the light of current conditions and problems.

... the *Criminal Code* provisions which are the object of the Commission's reform proposals<sup>959</sup> have never really been subjected to a sophisticated and clear judicial interpretation in the context of these life-and-death issues. It is possible to undertake a lengthy theoretical discussion to determine the interpretation which the courts might apply to a given word or section of the *Criminal Code*. However, in real life and perhaps to an even greater extent in criminal law, rules should have a certain degree of predictability, especially in matters as crucial as the life or death of an individual. (note added)

11.461 It is apparent from the preceding discussion of the criminal law in Queensland that it is uncertain whether a health provider who withholds or withdraws a life-sustaining measure from an adult could be criminally responsible for the adult's death.

11.462 One of the purposes of the guardianship legislation is to provide a scheme for advance and substitute decision-making in relation to health care, including the withholding and withdrawal of life-sustaining measures. While there may legitimately be different views about what the scope and content of that scheme should be, it is unsatisfactory that a health provider who, in good faith, complies with the legislation in withholding or withdrawing a life-sustaining measure for an adult should be at any risk of criminal responsibility for the adult's death.

11.463 While section 80 of the *Guardianship and Administration Act 2000* (Qld) and section 101 of the *Powers of Attorney Act 1998* (Qld) were no doubt intended to ensure that this would not be the case, health providers are presently in an uncertain situation because of the way in which section 238 of the *Guardianship and Administration Act 2000* (Qld) and section 37 of the *Powers of Attorney Act 1998* (Qld) are framed.

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The Law Reform Commission of Canada recommended that a new provision be inserted into the *Criminal Code* to the effect that:

- Nothing in sections 14, 45, 198, 199 and 229 shall be interpreted as requiring a physician
- (a) to continue to administer or to undertake medical treatment against the expressed wishes of the person for whom such treatment is intended;
  - (b) to continue to administer or undertake medical treatment, when such treatment has become therapeutically useless in the circumstances and is not in the best interests of the person for whom it is intended.

See Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Report No 20 (1983) 32. This recommendation does not appear to have been implemented.

11.464 The Commission is not aware that there have been any prosecutions of health providers who have withheld or withdrawn a life-sustaining measure under the legislation. However, it does not serve the legitimacy of the law that the protection of health providers who comply with the legislation should depend on prosecutorial discretion, rather than on certainty in the law. Accordingly, the law should be amended to ensure that criminal responsibility does not attach to a health provider who, in good faith, withholds or withdraws a life-sustaining measure in accordance with the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld) or in accordance with an order of the Supreme Court made in its *parens patriae* jurisdiction.

11.465 In Chapter 9 of this Report, the Commission has recommended that Chapter 5 of the *Guardianship and Administration Act 2000* (Qld) be amended to make it clear that nothing in that Act affects the operation at common law of an adult's consent to, or refusal of, health care given at a time when the adult had capacity to make decisions about the matter.<sup>960</sup> In view of that recommendation, the proposed protection from criminal responsibility should also extend to a health provider who, in good faith, withholds or withdraws a life-sustaining measure from an adult in accordance with a refusal of health care given by the adult at a time when he or she had capacity to make decisions about the health care. This amendment is framed in terms of the adult's capacity at the time the refusal is given, rather than at the time the measure is withheld or withdrawn. It will therefore apply not only where, at the time the measure is withheld or withdrawn, an adult has impaired capacity, but also where, at that time, an adult still has capacity. As a result, the proposed amendment addresses the concern raised by the respondent at [11.459] above, and would protect a health provider who withheld or withdrew a life-sustaining measure in the circumstances that arose in *Brightwater Care Group (Inc) v Rossiter*.<sup>961</sup>

11.466 The new provision should generally be modelled on section 259(2) of the Criminal Code (WA), except that it should use the language of the Queensland guardianship legislation and should refer to the specific ways in which a person may be authorised to withhold or withdraw a life-sustaining measure.

11.467 The purpose of requiring that the person has acted in good faith is to ensure that a person who withholds or withdraws a life-sustaining measure on the basis of consent given by the adult's substitute decision-maker, but who, for example, knows or ought to know that the substitute decision-maker's decision does not comply with the legislation, will not receive the benefit of the protection.

11.468 In keeping with the general approach in Queensland that excuses and defences are located in the Criminal Code (Qld), the recommended provision should be in the Code rather than in the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld).

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960 See Recommendation 9-26 of this Report.

961 [2009] WASC 229.

11.469 The Criminal Code (Qld) should therefore be amended to provide that a person is not criminally responsible for withholding or withdrawing, in good faith and with reasonable care and skill, a life-sustaining measure from an adult if the withholding or withdrawal of the life-sustaining measure:

- is in accordance with a valid refusal of the health care given by the adult at a time when he or she had capacity to make decisions about the health care;
- is authorised by the *Guardianship and Administration Act 2000* (Qld), the *Powers of Attorney Act 1998* (Qld) or another Act; or
- is authorised by an order of the Supreme Court.

11.470 This recommendation could be implemented by amending section 282A of the Criminal Code (Qld) or by inserting a separate provision.

11.471 As explained earlier, section 238(b) of the *Guardianship and Administration Act 2000* (Qld) and section 37(b) of the *Powers of Attorney Act 1998* (Qld) arguably have the effect of preventing section 80 of the *Guardianship and Administration Act 2000* (Qld) and section 101 of the *Powers of Attorney Act 1998* (Qld) from having their intended effect. However, if the provision recommended above is enacted in the Criminal Code (Qld), section 238(b) of the *Guardianship and Administration Act 2000* (Qld) and section 37 of the *Powers of Attorney Act 1998* (Qld) will no longer have that effect because the source of a health provider's protection will be the Code rather than the guardianship legislation.

11.472 Provided that the new provision is enacted in the Criminal Code (Qld), section 238 of the *Guardianship and Administration Act 2000* (Qld) and section 37 of the *Powers of Attorney Act 1998* (Qld) should be retained. They could be relevant if there was a lack of good faith on the part of a health provider who withheld or withdrew a life-sustaining measure and whose conduct was not therefore protected by the new provision in the Code. In that situation, it is important that these two provisions continue to operate.

### **Civil liability**

11.473 Although some of the other Australian jurisdictions deal expressly with a health provider's criminal and civil liability, the issue of a health provider's civil liability is adequately dealt with by section 80 of the *Guardianship and Administration Act 2000* (Qld) and section 101 of the *Powers of Attorney Act 1998* (Qld). Accordingly, it is not necessary for the legislation to be amended to give express protection from civil liability.

## RECOMMENDATIONS

### *The definition of 'health care'*

- 11-1 The definition of 'health care' in section 5 of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and section 5 of schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended by omitting from section 5(2) the words 'if the commencement or continuation of the measure for the adult [principal] would be inconsistent with good medical practice'.

### *The definition of 'life-sustaining measure'*

- 11-2 The definition of 'life-sustaining measure' in section 5A of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and section 5A of schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended by omitting section 5A(3), which provides that a blood transfusion is not a life-sustaining measure.

### *Withholding or withdrawal of a life-sustaining measure under an advance health directive*

- 11-3 Section 36(2) of the *Powers of Attorney Act 1998* (Qld) should be omitted.

### *Consent to the withholding or withdrawal of a life-sustaining measure by a substitute decision-maker*

- 11-4 A majority of the Commission recommends that the *Guardianship and Administration Act 2000* (Qld) should be amended by:

- (a) omitting section 66A of the Act; and
- (b) omitting the words 'and section 66A' from section 66B(2)(b) of the Act.

- 11-5 The *Guardianship and Administration Act 2000* (Qld) should be amended by inserting a new provision based generally on section 85 of the *Powers of Attorney Act 2006* (ACT):

#### Referral of health care decision to the adult guardian

- (1) In this section:

*relevant person*, in relation to an adult with impaired capacity for a health matter, means—

- (a) a health provider who is treating, or has at any time treated, the adult;
  - (b) a person in charge of a health care facility where the adult is being, or has at any time been, treated; or
  - (c) an interested person.
- (2) This section applies if—
- (a) a guardian or attorney for a health matter for an adult—
    - (i) refuses to make a decision about the health matter for the adult; or
    - (ii) makes a decision about the health matter for the adult; and
  - (b) a relevant person believes, on reasonable grounds, that the decision is not in accordance with the general principles and the health care principle.
- (3) The relevant person may tell the adult guardian about the decision and explain why the relevant person believes the decision is not in accordance with the general principles and the health care principle.

*Editor's notes*

- 1 Under section 43(1), the adult guardian may exercise power for the health matter if the requirements of paragraph (a) or (b) are satisfied.
- 2 Under section 247(1)(c), a person is not liable civilly, criminally or under an administrative process, for disclosing to the adult guardian information in accordance with this section.

- (4) In this section—

*attorney* means an attorney acting under an enduring document or a statutory health attorney.

**11-6 A minority of the Commission recommends that the *Guardianship and Administration Act 2000* (Qld) should be amended by:**

- (a) replacing section 66A(2) with a provision to the following effect:

A consent to the withholding or withdrawal of a life-sustaining measure for the adult does not operate if the adult's health provider reasonably considers the withholding or withdrawal of the measure for the adult would be inconsistent with good medical practice.

- (b) omitting the section heading for section 66A and inserting a section heading that better reflects the effect of the provision, such as ‘When consent to withholding or withdrawal of life-sustaining measure does not operate’;
- (c) inserting a new provision to the effect that if, under section 66A(2), a substitute decision-maker’s consent to the withholding or withdrawal of a life-sustaining measure for the adult does not operate:
  - (i) the adult’s health provider (if the adult’s substitute decision-maker is not the Adult Guardian) must take the steps specified in Recommendation 11-6(d); or
  - (ii) the Adult Guardian (if the Adult Guardian is the adult’s substitute decision-maker) must take the steps specified in Recommendation 11-6(g);

to resolve the disagreement about the withholding or withdrawal of the life-sustaining measure;
- (d) inserting a new provision to the effect that, if the adult’s substitute decision-maker is not the Adult Guardian:
  - (i) the adult’s health provider must, within two days of forming the relevant view under section 66A(2) about the substitute decision-maker’s consent, refer to the Adult Guardian the decision whether to withhold or withdraw the life-sustaining measure for the adult; and
  - (ii) despite section 66A(2), if the adult’s health provider does not refer the decision to the Adult Guardian within that time, the substitute decision-maker’s consent to the withholding or withdrawal of the life-sustaining measure becomes operative;
- (e) inserting a new provision, based in part on section 43(2)(a)–(b), (d) and (3) of the Act, to the effect that:
  - (1) If a health provider refers a decision about the withholding or withdrawal of a life-sustaining measure for an adult to the adult guardian under [*the provision that gives effect to Recommendation 11-6(d)(i)*], the adult guardian must exercise power for the matter.
  - (2) The adult guardian must advise the tribunal in writing of the following details:
    - (a) the name of the adult;
    - (b) the name of the guardian or attorney; and

(c) the decision made by the adult guardian; and

(3) In this section—

*attorney* means an attorney under an enduring document or a statutory health attorney.

- (f) inserting, in the provision that gives effect to Recommendation 11-6(d), a note that refers to the provision proposed by Recommendation 11-6(e), which requires the Adult Guardian to decide whether to withhold or withdraw a life-sustaining measure;
- (g) inserting a new provision to the effect that, if the Adult Guardian is the adult's substitute decision-maker:
- (i) the Adult Guardian must apply to the Tribunal for a declaration that the withholding or withdrawal of the life-sustaining measure for the adult is a valid exercise of the Adult Guardian's power; and
  - (ii) despite section 66A(2), if the Tribunal makes such a declaration, the Adult Guardian's consent to the withholding or withdrawal of the life-sustaining measure becomes operative.

***The withholding or withdrawal of a medically futile life-sustaining measure***

- 11-7 The *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be amended to provide that 'withholding a life-sustaining measure' does *not* include not commencing a life-sustaining measure if the adult's health provider reasonably considers that commencing the measure would not be consistent with good medical practice.
- 11-8 A minority of the Commission recommends that the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be amended to provide that 'the withdrawal of a life-sustaining measure' does *not* include the discontinuing of a life-sustaining measure if the adult's health provider reasonably considers that continuing the measure would not be consistent with good medical practice.

***The effect of an adult's objection to the withholding or withdrawal of a life-sustaining measure***

**11-9** Section 67 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that, for the purpose of that section, 'health care' does not include the withholding or withdrawal of a life-sustaining measure.

**11-10** The *Guardianship and Administration Act 2000* (Qld) should be amended to include a new provision to the following effect:

**67A** Effect of an adult's objection to the withholding or withdrawal of a life-sustaining measure

(1) Generally, the consent of an adult's guardian or attorney to the withholding or withdrawal of a life-sustaining measure for the adult does not operate if the health provider knows, or ought reasonably to know, the adult objects to the withholding or withdrawal of the measure.

(2) If an adult objects to the withholding or withdrawal of a life-sustaining measure—

(a) the adult guardian may consent to the withholding or withdrawal of a life-sustaining measure for the adult; and

(b) the adult guardian's consent is effective despite the adult's objection.

(3) The adult guardian may exercise power under subsection (2) whether or not the adult guardian is the adult's guardian or attorney.

(3) In this section—

*attorney* means an attorney under an enduring document or a statutory health attorney.

*object*, by an adult, to the withholding or withdrawal of a life-sustaining measure means—

(a) the adult indicates the adult does not wish to have the life-sustaining measure withheld or withdrawn; or

(b) the adult previously indicated the adult did not wish to have the life-sustaining measure withheld or withdrawn and since then the adult has not indicated otherwise.

***The Tribunal's power in relation to the withholding or withdrawal of a life-sustaining measure***

11-11 To support the Tribunal's function under section 81(1)(f) of the *Guardianship and Administration Act 2000* (Qld), the Act should be amended to confer on the Tribunal the express power to consent to the withholding or withdrawal of a life-sustaining measure.

11-12 Section 66 of the *Guardianship and Administration Act 2000* (Qld) should be amended to ensure that subsections (1) and (3) to (5) of that section do not limit the operation of the provision that gives effect to Recommendation 11-11.

11-13 Section 42 of the *Guardianship and Administration Act 2000* (Qld) should be amended by inserting a new subsection to the effect that section 42 does not limit the operation of the provision that gives effect to Recommendation 11-11.

11-14 Section 43 of the *Guardianship and Administration Act 2000* (Qld) should be amended by inserting a new subsection to the effect that section 43 does not limit the operation of the provision that gives effect to Recommendation 11-11.

***Potential criminal responsibility for withholding or withdrawing a life-sustaining measure***

11-15 The Criminal Code (Qld) should be amended to provide that a person is not criminally responsible for withholding or withdrawing, in good faith and with reasonable care and skill, a life-sustaining measure from an adult if the withholding or withdrawal of the life-sustaining measure:

- (a) is in accordance with a valid refusal of the health care given by the adult at a time when he or she had capacity to make decisions about the health care;
- (a) is authorised by the *Guardianship and Administration Act 2000* (Qld), the *Powers of Attorney Act 1998* (Qld) or another Act; or
- (b) is authorised by an order of the Supreme Court.

11-16 Provided that the Criminal Code (Qld) is amended to give effect to Recommendation 11-15, section 238 of the *Guardianship and Administration Act 2000* (Qld) and section 37 of the *Powers of Attorney Act 1998* (Qld) should be retained.



# Chapter 12

## The effect of an adult's objection to health care

INTRODUCTION .....	286
THE EFFECT OF AN ADULT'S OBJECTION AT COMMON LAW .....	286
AN OVERVIEW OF THE LAW IN QUEENSLAND .....	286
<i>Guardianship and Administration Act 2000</i> (Qld).....	286
Definition of 'object' .....	287
Order of priority for dealing with 'special health matters' and 'health matters' .....	288
OBJECTION TO HEALTH CARE GENERALLY .....	290
The law in Queensland .....	290
The law in other jurisdictions.....	295
Issues for consideration .....	297
Discussion Paper .....	298
Submissions .....	300
The Commission's view .....	301
OBJECTION TO TISSUE DONATION AND SPECIAL MEDICAL RESEARCH OR EXPERIMENTAL HEALTH CARE .....	305
The law in Queensland .....	305
The Commission's view .....	309
OBJECTION TO URGENT HEALTH CARE .....	309
The law in Queensland .....	309
The law in other jurisdictions.....	312
Discussion Paper .....	313
Submissions .....	314
The Commission's view .....	315
OBJECTION TO MINOR AND UNCONTROVERSIAL HEALTH CARE.....	320
The law in Queensland .....	320
The law in other jurisdictions.....	321
Discussion Paper .....	322
Submissions .....	322
The Commission's view .....	322
PRESENT AND PREVIOUS OBJECTIONS .....	323
The law in Queensland .....	323
Discussion Paper .....	328
Submissions .....	328
The Commission's view .....	328
RECOMMENDATIONS .....	328

## INTRODUCTION

12.1 The Commission's terms of reference direct it, in reviewing the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld), to review the law in relation to 'the ability of an adult with impaired capacity to object to receiving medical treatment'.<sup>962</sup>

12.2 This chapter gives an overview of the current scheme under the Queensland guardianship legislation for dealing with the effect of an adult's objection to health care and, where relevant, outlines approaches taken in other jurisdictions. It also makes recommendations about a number of issues arising under the legislation.

12.3 A scheme for the involuntary treatment of people who have a mental illness is also provided under the *Mental Health Act 2000* (Qld).<sup>963</sup> The Commission's terms of reference do not extend to that separate regime. Accordingly, the *Mental Health Act 2000* (Qld) is not dealt with in this chapter.

## THE EFFECT OF AN ADULT'S OBJECTION AT COMMON LAW

12.4 At common law, an adult with capacity may refuse any medical treatment that is offered, even if the adult's refusal of the treatment may lead to his or her death.<sup>964</sup> However, the same principle does not apply to any adult who does not have capacity. Generally, the adult's objection can be overridden provided that the medical treatment is considered to be in the best interests of the adult.<sup>965</sup>

## AN OVERVIEW OF THE LAW IN QUEENSLAND

### *Guardianship and Administration Act 2000* (Qld)

12.5 The *Guardianship and Administration Act 2000* (Qld) has a number of provisions that govern the effect of an adult's objection to particular types of health care.

12.6 Some of these provisions deal with the effect of an adult's objection to health care that may be carried out only with the consent of the adult's substitute decision-maker (for a health matter) or the Tribunal (for a special health matter):

<sup>962</sup> The terms of reference are set out in Appendix 1.

<sup>963</sup> See *Mental Health Act 2000* (Qld) ch 4. For the purposes of that Act, '**treatment**, of a person who has a mental illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person's illness': *Mental Health Act 2000* (Qld) sch 2.

<sup>964</sup> *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [23]–[26] (Martin CJ); *Re B* [2002] 2 All ER 449, 455–6 (Butler-Sloss P); *Re MB* [1997] 2 FLR 426, 423 (Butler-Sloss LJ); *Airedale NHS Trust v Bland* [1993] AC 789, 857 (Lord Keith).

<sup>965</sup> See eg *State of Qld v D* [2004] 1 Qd R 426, where the Supreme Court, in the exercise of its *parens patriae* jurisdiction, authorised medical and surgical treatment of the adult.

- health care generally (section 67);
- donation of tissue (section 69); and
- special medical research or experimental health care (section 72).

12.7 In certain circumstances, an adult's objection will be effective to prevent the adult's substitute decision-maker or the Tribunal from consenting to the health care.

12.8 The *Guardianship and Administration Act 2000* (Qld) also provides that, in specified circumstances, health care may be carried out without consent. Each of the provisions that authorises the carrying out of health care without consent also deals with the effect of an adult's objection to that health care. The relevant provisions are:

- urgent health care without consent (section 63);
- withholding or withdrawal of a life-sustaining measure without consent in an acute emergency (section 63A);<sup>966</sup> and
- minor and uncontroversial health care without consent (section 64).

12.9 In certain circumstances, an adult's objection will be effective to prevent the health care from being carried out without consent.

12.10 The various provisions are considered below. A table summarising the effect of an adult's objection to the different types of health care is set out later in this chapter.<sup>967</sup>

### Definition of 'object'

12.11 The term 'object, by an adult in relation to health care,' is defined in the *Guardianship and Administration Act 2000* (Qld) as follows:<sup>968</sup>

**object**, by an adult, to health care means—

- (a) the adult indicates the adult does not wish to have the health care; or
- (b) the adult previously indicated, in similar circumstances, the adult did not then wish to have the health care and since then the adult has not indicated otherwise.

<sup>966</sup> *Guardianship and Administration Act 2000* (Qld) s 63A is discussed in Chapter 11 of this Report and is not generally considered in this chapter.

<sup>967</sup> See Table 12.1 at [12.154] below.

<sup>968</sup> *Guardianship and Administration Act 2000* (Qld) sch 4.

*Example—*

An indication may be given in an enduring power of attorney or advance health directive or in another way, including, for example, orally or by conduct.

### **Order of priority for dealing with ‘special health matters’ and ‘health matters’**

12.12 The provisions dealing with the effect of an adult’s objection to health care need to be considered in light of the overall framework of the provisions in the *Guardianship and Administration Act 2000* (Qld) that deal with health care.

12.13 Of particular significance is the order of priority for dealing with special health matters and health matters where the health care does not fall under any of the exceptions that authorise the health care to be carried out without consent.

12.14 Section 65 of the Act sets out the order of priority for dealing with special health matters. It provides:

**65 Adult with impaired capacity—order of priority in dealing with special health matter**

- (1) If an adult has impaired capacity for a special health matter, the matter may only be dealt with under the first of the following subsections to apply.
- (2) If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.
- (3) If subsection (2) does not apply and an entity other than the tribunal is authorised to deal with the matter, the matter may only be dealt with by the entity.
- (4) If subsections (2) and (3) do not apply and the tribunal has made an order about the matter, the matter may only be dealt with under the order.

*Editor’s note—*

However, the tribunal may not consent to electroconvulsive therapy or psychosurgery—section 68(1).

12.15 Section 66 of the Act sets out the order of priority for dealing with health matters. It provides:

**66 Adult with impaired capacity—order of priority in dealing with health matter**

- (1) 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.
- (2) If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.

- (3) If subsection (2) does not apply and the tribunal has appointed 1 or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian or guardians or under the order.

*Editor's note—*

If, when appointing the guardian or guardians, the tribunal was unaware of the existence of an enduring document giving power for the matter to an attorney, see section 23 (Appointment without knowledge of enduring document), particularly subsection (2).

- (4) If subsections (2) and (3) do not apply and the adult has made 1 or more enduring documents appointing 1 or more attorneys for the matter, the matter may only be dealt with by the attorney or attorneys for the matter appointed by the most recent enduring document.
- (5) If subsections (2) to (4) do not apply, the matter may only be dealt with by the statutory health attorney.
- (6) This section does not apply to a health matter relating to health care that may be carried out without consent under division 1.

12.16 For both special health matters and health matters, if an adult with impaired capacity has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.<sup>969</sup> In this situation, the Tribunal may not exercise power for a special health matter and a guardian, attorney or statutory health attorney may not exercise power for a health matter.

12.17 The guardianship legislation also provides that a person or other entity<sup>970</sup> who performs a function or exercises a power<sup>971</sup> under the legislation for a health matter or special health matter in relation to an adult with impaired capacity must apply the General Principles and the Health Care Principle.<sup>972</sup>

12.18 The General Principles require the adult's views and wishes to be sought and taken into account, and require a power under the legislation to be exercised in the way that is least restrictive of the adult's rights.<sup>973</sup>

12.19 The Health Care Principle requires a power for a health matter or special health matter to be exercised 'in the way least restrictive of the adult's rights' and requires the adult's views and wishes to be sought and taken into account in deciding whether the exercise of the power is appropriate.<sup>974</sup> The Health Care

969 *Guardianship and Administration Act 2000* (Qld) ss 65(1)–(2), 66(1)–(2).

970 In this context, the person or entity will be a substitute decision-maker for a health matter, the Tribunal for a special health matter, or a health provider.

971 'Power' includes 'authority': *Acts Interpretation Act 1954* (Qld) s 36.

972 *Guardianship and Administration Act 2000* (Qld) s 11(1); *Powers of Attorney Act 1998* (Qld) s 76.

973 *Guardianship and Administration Act 2000* (Qld) sch 1 s 7(3)(b)–(c), (4); *Powers of Attorney Act 1998* (Qld) sch 1 s 7(3)(b)–(c), (4).

974 *Guardianship and Administration Act 2000* (Qld) sch 1 s 12(1)(a), (2)(a); *Powers of Attorney Act 1998* (Qld) sch 1 s 12(1)(a), (2)(a).

Principle also acknowledges that it ‘does not affect any right an adult has to refuse health care’.<sup>975</sup>

## OBJECTION TO HEALTH CARE GENERALLY

### The law in Queensland

12.20 The situation may sometimes arise where an adult’s substitute decision-maker,<sup>976</sup> in exercising power for a health matter, consents to particular health care to which the adult objects. A similar situation can also arise where the Tribunal is exercising power for a special health matter for an adult.

12.21 Section 67 of the *Guardianship and Administration Act 2000* (Qld) deals generally with the effect of an adult’s objection to health care. It provides:

#### 67 Effect of adult’s objection to health care

- (1) Generally, the exercise of power for a health matter or special health matter is ineffective to give consent to health care of an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care.

*Editor’s note—*

**Object** is defined in schedule 4 (Dictionary). Note also the *Powers of Attorney Act 1998*, section 35(2)(a) (Advance health directives) provides that ‘by an advance health directive [a] principal may give a direction—

- (a) consenting, in the circumstances specified, to particular future health care of the principal when necessary and despite objection by the principal when the health care is provided’.<sup>977</sup>
- (2) However, the exercise of power for a health matter or special health matter is effective to give consent to the health care despite an objection by the adult to the health care if—
- (a) the adult has minimal or no understanding of 1 of the following—

975 *Guardianship and Administration Act 2000* (Qld) sch 1 s 12(4); *Powers of Attorney Act 1998* (Qld) sch 1 s 12(4).

976 That is, a guardian, attorney or statutory health attorney for an adult in accordance with the priority prescribed by s 66(3)–(5) of the *Guardianship and Administration Act 2000* (Qld).

977 The reference in the Editor’s note to s 35(2)(a) of the *Powers of Attorney Act 1998* (Qld) is potentially confusing, as it could suggest that s 35(2)(a) is relevant to the operation of s 67(1) of the *Guardianship and Administration Act 2000* (Qld). However, s 67 of the *Guardianship and Administration Act 2000* (Qld) deals with the effect of an adult’s objection to health care where consent is given under an ‘exercise of power’ for the health matter or special health matter. Such consent may be given by a substitute decision-maker (that is — by a guardian, attorney or statutory health attorney in that order) for a health matter or by the Tribunal for a special health matter. As explained at [12.16] above, if the adult has made an advance health directive giving a direction about the special health matter or health matter (including a direction consenting to future health care under s 35(2)(a) of the *Powers of Attorney Act 1998* (Qld)), the matter may only be dealt with under the direction: *Guardianship and Administration Act 2000* (Qld) ss 65(2), 66(2).

- (i) what the health care involves;
  - (ii) why the health care is required; and
- (b) the health care is likely to cause the adult—
  - (i) no distress; or
  - (ii) temporary distress that is outweighed by the benefit to the adult of the proposed health care.
- (3) Subsection (2) does not apply to the following health care—
  - (a) removal of tissue for donation;
  - (b) participation in special medical research or experimental health care or approved clinical research. (note added)

12.22 As explained earlier, sections 65 and 66 of the *Guardianship and Administration Act 2000* (Qld) provide respectively that, if an adult has impaired capacity for a special health matter or health matter and has made an advance health directive giving a direction about the matter, the matter may only be dealt with under that direction.<sup>978</sup> A person or entity lower in the hierarchy may not exercise power for the matter. Accordingly, if the advance health directive contains an objection to particular health care, the matter must be dealt with in accordance with that direction and there is no scope for the Tribunal to exercise a power for the special health matter or for a substitute decision-maker to exercise a power for the health matter. As a result, section 67 has no application in these circumstances. In practical terms, this means that section 67 deals with the effect of an objection that is made other than in an advance health directive.

12.23 Under section 67(1) an adult's objection to health care will generally be effective if the health provider knows, or ought reasonably to know, that the adult objects to the health care.

12.24 In order for a substitute decision-maker's consent, or the Tribunal's consent, to override an adult's objection to health care, the test in section 67(2) must be satisfied. That test will be satisfied if:

- the adult has minimal or no understanding of one of the following:
  - what the health care involves; or
  - why the health care is required; and
- the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

12.25 The first limb of this test focuses on the current adult's level of understanding of the health care. This test was formulated by the Queensland Law

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See [12.14]–[12.16] above.

Reform Commission in its original 1996 Report.<sup>979</sup> In that Report, the Commission recommended a provision to the effect of what is now section 67 of the *Guardianship and Administration Act 2000* (Qld). The Commission referred to the earlier discussion of this issue in its Draft Report and stated:<sup>980</sup>

The Commission also expressed the view that the legislation should provide for the situation where the patient indicates in any way, or has previously indicated, in similar circumstances, that he or she does not wish the proposed treatment to be carried out. The Commission considered that, generally, a consent given under its proposed legislation on behalf of a person whose decision-making capacity is impaired should be ineffective if the treatment provider is aware, or ought reasonably to be aware, that the patient objects to the carrying out of the treatment.

12.26 However, the Commission did not propose that the adult's objection should be paramount in all circumstances. It further recommended that an objection should be able to be overridden if the patient has little or no understanding of the proposed treatment and if 'the treatment is likely to cause the patient no distress, or if it may cause the patient some degree of distress which is temporary and which is outweighed by the benefit of the treatment to the patient'.<sup>981</sup> The Commission explained how this test was intended to operate in practice:<sup>982</sup>

A doctor would have to consider, firstly, whether the patient had more than a minimal understanding of the proposed treatment. If so, the patient's objection would override substituted consent given by a decision-maker, and the consent would be ineffective. If not, the doctor would then have to consider whether the proposed treatment would be likely to cause the patient distress. If the proposed treatment would be likely to cause the patient a degree of distress that would be more than temporary or that would outweigh the benefit of the proposed treatment to the patient, the patient's objection would override the substituted consent given by a decision-maker, and the consent would be ineffective.

In other words, where a patient objects to proposed treatment, a substituted consent for that treatment will be effective only if the patient has minimal or no understanding of what the health care entails and if the proposed treatment is likely to cause the patient no distress or only a degree of temporary distress which is outweighed by the benefit of the treatment to the patient.

12.27 The rationale for enabling the adult's objection to be overridden in some circumstances is that, if the adult has minimal or no understanding of what is proposed and the adult's objection prevails, it might mean that the adult would not receive necessary treatment.<sup>983</sup>

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979 Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 362.

980 Ibid 361–2.

981 Ibid 362–3.

982 Ibid.

983 Ibid.

12.28 In *Re L*,<sup>984</sup> the Tribunal considered the test in section 67(2)(a) of the *Guardianship and Administration Act 2000* (Qld):<sup>985</sup>

On a first reading it would seem that two different standards are contemplated by the term 'capacity' in Schedule 4 and 'understand' in section 67(2). It may be possible for an adult to lack 'capacity' as defined in Schedule 4, yet have an 'understanding' of the kind referred to in section 67(2).

12.29 However, in the later decision of *Re CJ*,<sup>986</sup> where the adult was refusing treatment for schizophrenia and diabetes, the Tribunal equated the minimal or no understanding test in section 67(2)(a) with the general test under the legislation for impaired capacity:<sup>987</sup>

Section 67 essentially says a consent can prevail over an objection if the person with impaired capacity has 'minimal or no understanding' of 'what the health care involves' or 'why the health care is required'. What does this mean? Does this section import a different test for capacity to that set out in the other sections of the Act? At first glance it would seem to imply that the test for capacity in the Act is not needed to be fulfilled in this instance, but that a lower test of capacity is required which is simply that you need an understanding of the health care and why it's required, rather than the stricter test for capacity in the Act which provides that to have capacity a person must understand not just the decision but the nature and effect of decisions, be able to freely and voluntarily make the decision and also communicate the decision.

... The Tribunal agrees that the section is not clearly expressed but is satisfied that the section does not impose a different test for capacity but simply restates in a different way the test for capacity as set out in the rest of the Act. The Tribunal bases its view in this regard by relying on the use of the word 'understanding' in Section 67. It is the use of this word which imports the same test for capacity because understanding means, in the Australian Concise Oxford Dictionary, to 'perceive the meaning of ...' or 'perceive the significance or explanation or cause of'. In the context of the Act 'understanding' connotes an ability to comprehend the nature, purpose and effect of the proposed health care. It implies a capacity to make an informed decision. The Tribunal is satisfied that understanding in Section 67 means understanding the nature and effect of the decision. That is the consequences of a decision and all its ramifications.

... what is required in Section 67 to validly object is not simply an ability to technically know what the procedure involves and what it is used for but an ability to understand the true nature and effect of a decision.

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If section 67 applies the same test as set out in the rest of the Act what is the point of the section? The true purpose of section 67 is to essentially operate as a warning bell. The right of a person to make decisions for themselves is a highly prized right which is recognised in the Act, not just in section (s 6(a)) but

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984 [2005] QGAAT 13.

985 Ibid [55].

986 [2006] QGAAT 11.

987 Ibid [31]–[35], [39]–[41].

in the General Principles in Schedule 1. Because autonomy in decision making is such a recognised right if a person objects to treatment a substitute decision maker (a guardian in this case) has to stop and essentially double check that they should proceed with authorising the treatment.

12.30 In the Commission's view, section 67(2)(a) of the *Guardianship and Administration Act 2000* (Qld) does not admit of the interpretation given to that section in *Re CJ*. As a matter of statutory interpretation, 'all words must prima facie be given some meaning and effect'.<sup>988</sup> On the Tribunal's interpretation, however, the test in section 67(2)(a) would always be satisfied, as an adult would be subject to section 67 only if he or she had impaired capacity for the health matter or special health matter. Accordingly, for a consent to override an adult's objection, it would, in effect, be necessary only to satisfy the test in section 67(2)(b) — namely, that the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

12.31 Further, in interpreting legislation, an Act must be read as a whole.<sup>989</sup> Section 67(2)(a) is not the only provision of the *Guardianship and Administration Act 2000* (Qld) to use the expression 'minimal or no understanding'; the expression also appears in section 63 of the Act. The fact that section 63 uses the expression 'impaired capacity' in subsection (1)(a) and the expression 'minimal or no understanding' in subsection (3)(a) supports the argument that the two expressions are not intended to have the same meaning.

12.32 Section 67(1) and (2) deal primarily with the effect of an adult's objection to health care for the following:

- health matters generally (other than participation in approved clinical research) where the consent of the adult's substitute decision-maker is required;<sup>990</sup> and
- two types of special health care — sterilisation and termination of pregnancy — where the Tribunal's consent is required.

12.33 However, section 67(2) does not apply to the following health care:<sup>991</sup>

- removal of tissue for donation;
- participation in special medical research or experimental health care; or
- participation in approved clinical research.

988 DC Pearce and RS Geddes, *Statutory Interpretation in Australia* (6th ed, 2006) [2.22].

989 *Ibid* [4.2].

990 Although the withholding or withdrawal of a life-sustaining measure is a health matter, the application of s 67 of the *Guardianship and Administration Act 2000* (Qld) to the withholding or withdrawal of a life-sustaining measure is considered separately in Chapter 11 of this Report.

991 *Guardianship and Administration Act 2000* (Qld) s 67(3).

12.34 Because the removal of tissue for donation and participation in special medical research or experimental health care are both categories of special health care, they require the Tribunal's consent. As explained later in this chapter, the Tribunal may not consent to these forms of special health care if the adult objects.<sup>992</sup> It is possible, however, that, when the Tribunal gives its consent, the adult does not object to the health care, but that the adult later objects, perhaps when the health care is about to be carried out. Because section 67(3) does not exclude the operation of section 67(1), that provision will still apply in this situation. Accordingly, the Tribunal's exercise of power for the special health matter will be ineffective to give consent to the health care if the health provider knows, or ought reasonably to know, that the adult objects to the health care at any time.

12.35 The participation of an adult in approved clinical research is a health matter, for which consent may be given by the adult's substitute decision-maker. However, because section 67(2) does not apply to this type of health care, there is no scope for the adult's substitute decision-maker to override the adult's objection. The effect of section 67(1) is that the substitute decision-maker's exercise of power for the health matter will be ineffective to give consent to the health care if the health provider knows, or ought reasonably to know, that the adult objects to the health care.

### The law in other jurisdictions

12.36 The guardianship legislation in New South Wales contains a provision that deals with the effect of an adult's objection to medical or dental treatment. Section 46 of the *Guardianship Act 1987* (NSW) provides:<sup>993</sup>

#### **46 Effect of consent**

- (1) Subject to subsections (2) and (3), a consent given under this Part in respect of the carrying out of medical or dental treatment on a patient to whom this Part applies has effect:
  - (a) as if the patient had been capable of giving consent to the carrying out of the treatment, and
  - (b) as if the treatment had been carried out with the patient's consent.
- (2) A consent given by a person responsible for, or the guardian of, the patient has no effect:
  - (a) if the person carrying out or supervising the proposed treatment is aware, or ought reasonably to be aware, that the patient objects to the carrying out of the treatment, or

<sup>992</sup> See [12.83], [12.89] below.

<sup>993</sup> *Guardianship Act 1987* (NSW) s 46 formed the basis for s 67 of the *Guardianship and Administration Act 2000* (Qld): Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report No 49 (1996) vol 1, 362, nn 1045, 1046; 368.

- (b) if the proposed treatment is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the patient.
- (3) A consent given by the guardian of the patient has effect despite any objection made by a patient to the carrying out of the treatment if the guardian has consented to that treatment in accordance with the authority of the Tribunal under section 46A.
- (4) For the purposes of this section, an objection by a patient to the carrying out of proposed medical or dental treatment is to be disregarded if:
  - (a) the patient has minimal or no understanding of what the treatment entails, and
  - (b) the treatment will cause the patient no distress or, if it will cause the patient some distress, the distress is likely to be reasonably tolerable and only transitory.
- (5) Nothing in this Part precludes the Tribunal, a person responsible or a guardian from giving consent to the carrying out on a patient to whom this Part applies of medical or dental treatment specifically excluded from the definition of that expression in section 33(1). This section applies to any such consent as if that treatment were not excluded from that definition.

12.37 The effect of section 46(2) is that, generally, the consent given by a patient's guardian or person responsible (the equivalent of a statutory health attorney) is of no effect if:

- the person carrying out the treatment is aware, or ought reasonably to be aware, that the patient objects to the treatment; or
- the proposed treatment is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the patient.

12.38 However, section 46(4) provides that a patient's objection is to be disregarded if:

- the patient has minimal or no understanding of what the treatment entails; and
- the treatment will cause the patient no distress or, if it will cause the patient some distress, the distress is likely to be reasonably tolerable and only transitory.

12.39 Section 46 of the *Guardianship Act 1987* (NSW) is supplemented by section 46A of that Act, which provides that, in specified circumstances, the NSW Guardianship Tribunal may confer on a guardian the power to override an adult's objection to medical or dental treatment.

12.40 Section 46A provides:

**46A Power of guardian to override patient's objection to treatment when authorised by the Tribunal**

- (1) The Tribunal may confer on the guardian of a patient to whom this Part applies authority to override the patient's objection to the carrying out on the patient of major or minor treatment.
- (2) The Tribunal may confer such an authority only at the request or with the consent of the guardian and only if it is satisfied that any such objection will be made because of the patient's lack of understanding of the nature of, or reason for, the treatment.
- (3) The Tribunal may at any time:
  - (a) impose conditions or give directions as to the exercise of such an authority, or
  - (b) revoke such an authority.
- (4) The guardian may exercise such an authority only if satisfied that the proposed treatment is manifestly in the best interests of the patient.

12.41 The other Australian jurisdictions do not have specific provisions in their guardianship legislation dealing with the effect of an adult's objection to health care.

**Issues for consideration**

12.42 Under section 67 of the *Guardianship and Administration Act 2000* (Qld), an adult's objection to health care will prevail unless:

- the adult has minimal or no understanding of what the health care involves or why the health care is required; and
- the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

12.43 In the absence of this provision, the General Principles and the Health Care Principle would still require a person making a health care decision for the adult to seek and take into account the adult's views and wishes.<sup>994</sup>

12.44 This raises the issue of whether the legislation should continue to provide that an adult's objection will prevail in the specified circumstances or whether an adult's objection should simply be taken into account in the decision-making process. The Commission notes that the absolute effect given to an adult's objection in the specified circumstances differs from the approach taken under the legislation in relation to other types of decisions, where the adult's views and wishes must be taken into account, but do not determine the particular issue.

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*Guardianship and Administration Act 2000* (Qld) sch 1 ss 7(3)(b), (4), 12(2)(a); *Powers of Attorney Act 1998* (Qld) sch 1 ss 7(3)(b), (4), 12(2)(a).

12.45 Section 67 gives maximum effect to the autonomy of an adult who has more than minimal understanding of what the health care involves and why the health care is required. However, it also has the effect, in those circumstances, of giving the final decision-making power to an adult who necessarily has impaired capacity for the relevant health matter or special health matter.<sup>995</sup>

12.46 This means that, in the specified circumstances, neither a substitute decision-maker nor the Tribunal is capable of consenting to the health care for the adult.<sup>996</sup> In that situation, only the Supreme Court, exercising its *parens patriae* jurisdiction, may authorise the health care.<sup>997</sup>

12.47 As mentioned earlier, section 46A of the *Guardianship Act 1987* (NSW) enables the NSW Guardianship Tribunal to confer on a guardian the authority to override an adult's objection to medical or dental treatment, even though the adult has sufficient understanding of the proposed treatment to prevent it from being carried out under section 46 of that Act.<sup>998</sup> The Tribunal may confer such authority only at the request, or with the consent of, the guardian and only if it is satisfied that the objection will be made because of the adult's lack of understanding of the nature of, or reason for, the treatment.<sup>999</sup> The guardian may exercise the power only if he or she is satisfied that the proposed treatment is manifestly in the best interests of the adult.<sup>1000</sup>

12.48 The effect of the New South Wales legislation is that, unlike the position in Queensland, it is not necessary to apply to the Supreme Court to authorise the treatment; an application to the Tribunal will suffice.

## Discussion Paper

12.49 In the Discussion Paper, the Commission observed that, by limiting the circumstances in which the objection of an adult with more than minimal understanding of the relevant matters may be overridden, section 67 of the *Guardianship and Administration Act 2000* (Qld) provides a greater safeguard for the adult against unwanted medical intervention. However, the Commission also acknowledged that, by making the adult's objection paramount in the relevant circumstances, the adult may be deprived of appropriate health care.<sup>1001</sup>

995 As explained at [12.22] above, the effect of ss 65(2) and 66(2) of the *Guardianship and Administration Act 2000* (Qld) is that, in practical terms, s 67 deals with the effect of an objection that is made other than in an advance health directive.

996 See *Re L* [2005] QGAAT 13, [81].

997 *Guardianship and Administration Act 2000* (Qld) s 240 provides that the Act does not affect the court's inherent jurisdiction, including its *parens patriae* jurisdiction.

998 *Guardianship Act 1987* (NSW) s 46A is set out at [12.39] above.

999 *Guardianship Act 1987* (NSW) s 46A(2).

1000 *Guardianship Act 1987* (NSW) s 46A(4).

1001 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, [14.68].

12.50 The Commission suggested that, if it is considered desirable to have greater flexibility to override an adult's objection to health care, one approach would be for the *Guardianship and Administration Act 2000* (Qld) to be amended to include a provision to the effect of section 46A of the *Guardianship Act 1987* (NSW). Another approach would be to amend the *Guardianship and Administration Act 2000* (Qld) so that it does not provide that, in specified circumstances, the adult's objection prevails. The Commission noted that, if the latter change were made, the adult's objection would still be a matter to be taken into account by the substitute decision-maker or the Tribunal in deciding whether to consent to health care for the adult.

12.51 The Commission sought submissions on the following questions:<sup>1002</sup>

- 14-1 Is it appropriate that section 67 of the *Guardianship and Administration Act 2000* (Qld) provides that, in relevant circumstances, an adult's objection to health care prevails over a substitute decision-maker's or the Tribunal's consent?
- 14-2 If yes to Question 14-1, should the adult's objection to health care prevail unless the matters specified in section 67(2)(a) and (b) are satisfied — namely, that:
- (a) the adult has minimal or no understanding of one or both of the following—
    - (i) what the health care involves;
    - (ii) why the health care is required; and
  - (b) the health care is likely to cause the adult:
    - (i) no distress; or
    - (ii) temporary distress that is outweighed by the benefit to the adult of the proposed health care?
- 14-3 Alternatively, should section 67 of the *Guardianship and Administration Act 2000* (Qld) specify different circumstances in which the adult's objection to health care should prevail? If so, under what circumstances should the adult's objection prevail?
- 14-4 If no to Question 14-1, should the *Guardianship and Administration Act 2000* (Qld) be amended so that, although an adult's views and wishes about the health care are to be sought and taken into account by a substitute decision-maker or the Tribunal in deciding whether to consent to the health care, the adult's objection to the health care does not determine the issue?

12.52 These questions were directed to the effect of an objection to health care that did not involve the commencement or continuation of a life-sustaining measure or the withholding or withdrawal of a life-sustaining measure. The effect of an

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Ibid 379–80.

adult's objection to health care in those circumstances was considered separately.<sup>1003</sup>

## Submissions

12.53 A submission from the parents of an adult with impaired capacity considered it appropriate that an adult's objection to health care prevails over the consent of a substitute decision-maker or the Tribunal unless the requirements of section 67(2) of the *Guardianship and Administration Act 2000* (Qld) are satisfied.<sup>1004</sup>

12.54 In response to the question about whether there were other circumstances in which the adult's objection should prevail, these respondents emphasised the need for flexibility. They considered that it could become too prescriptive to specify other circumstances and that common sense should prevail.<sup>1005</sup>

12.55 However, the Adult Guardian was of the view that section 67 should not provide that an adult's objection will, in certain circumstances, prevail. The preferred approach of the Adult Guardian was that the adult's views and wishes about the health care should be sought and taken into account by the substitute decision-maker or the Tribunal, as the case may be, but should not determine the issue.<sup>1006</sup>

12.56 The Christian Science Committee on Publication for Queensland commented generally that it supports measures that recognise and support a person's right to define his or her preferred type of health care.<sup>1007</sup>

12.57 The Queensland Centre for Intellectual and Development Disability, which is part of the School of Medicine of the University of Queensland, did not comment on the terms of section 67 but referred generally to the need for health providers to be more aware of signs that an adult may be objecting to particular treatment:<sup>1008</sup>

It may in fact be the case that people with intellectual disability, especially those who are not seen as having cognitive or communication capacity, are never asked if they wish to proceed with a particular treatment or procedure. Whilst a good health practitioner would be guided by a person's discomfort, the pervasive devaluing of people with intellectual disability drives the myths, for example, that they do not feel pain. There are no guidelines for practitioners (other than those developed for women with intellectual disability around pap tests and breast checks) to detect signs of objection or unwillingness to proceed, or indeed to promote the right to say no. Neither are there adequate guidelines for gaining consent to a procedure.

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1003 Ibid [12.111]–[12.120].

1004 Submission 54A.

1005 Ibid.

1006 Submission 164.

1007 Submission 151.

1008 Submission 153.

Communication difficulties mean that there can be significant difficulties interpreting when a person is wishing to object to a procedure and when the person's behaviour is communicating another intention, has been inadequately prepared for the procedure or is reacting to an unfamiliar or frightening situation. Without involvement of people who know the person well, and/or without access to a communication system which works for the individual, it is likely that many misinterpretations about objections to treatment will occur.

## The Commission's view

### **Health matters other than life-sustaining measures**<sup>1009</sup>

12.58 Subject to the qualification mentioned below, the Commission is of the view that section 67 of the *Guardianship and Administration Act 2000* (Qld) deals appropriately with the effect of an adult's objection to health care. In particular, the Commission considers it appropriate that section 67 differentiates, in terms of the effect of an adult's objection, between an adult with minimal or no understanding of what the health care involves or why the health care is necessary and an adult who has more than a minimal understanding of both of those matters.<sup>1010</sup>

12.59 The objection of an adult who has more than a minimal understanding of what the health care involves and why the health care is required should not simply be a matter to be taken into account by the substitute decision-maker in making a health care decision for the adult.

12.60 However, if an adult with impaired capacity objects to health care and there is no reasonable means for that objection to be overridden, it is possible that the adult could be deprived of health care that it would be in his or her interests to receive. Although the Supreme Court could authorise the health care in the exercise of its *parens patriae* jurisdiction, the Commission considers that many substitute decision-makers who are concerned that they are not able to give an effective consent because of an adult's objection would not be able to afford to bring proceedings in the Supreme Court to authorise the health care and may find bringing such a proceeding in the Supreme Court to be a daunting process. It is more appropriate for the legislation to be amended to enable the Tribunal to deal with this issue.

12.61 The Commission considered whether the Tribunal should be given the power to override an adult's objection in particular circumstances and itself consent to the health care. However, the Tribunal does not ordinarily have power in relation to health matters<sup>1011</sup> (as distinct from special health matters). Further, because section 66 of the *Guardianship and Administration Act 2000* (Qld) governs the order of priority in relation to decision-making for health matters, it would be necessary to

<sup>1009</sup> The effect of an adult's objection to the provision of, or to the withholding or withdrawal of, a life-sustaining measure is considered in Chapter 11 of this Report.

<sup>1010</sup> Note, if an adult has more than a minimal understanding of only *one* of the matters mentioned in s 67(2)(a), the condition in s 67(2)(a) for overriding an adult's objection to health care will have been satisfied.

<sup>1011</sup> The exception is the Tribunal's function of consenting to the withholding or withdrawal of a life-sustaining measure: see *Guardianship and Administration Act 2000* (Qld) s 81(1)(f).

amend the legislation to accommodate any new power in relation to health matters that was conferred on the Tribunal.

12.62 The Commission is therefore of the view that the better approach is for the *Guardianship and Administration Act 2000* (Qld) to be amended to enable the Tribunal to confer on an adult's substitute decision-maker the power to override the adult's objection and consent to the health care. Subject to the following matters, the new provision should be based on section 46A of the *Guardianship Act 1987* (NSW). Section 46A(1) refers to the conferral of that power on a guardian. Given the framework of the Queensland guardianship legislation, the new provision should enable the Tribunal to confer the relevant power on an adult's guardian, attorney or statutory health attorney. However, the new provision should not include a provision to the effect of section 46A(4) of the New South Wales Act. That section provides that the guardian may exercise the authority to override the adult's objection 'only if the proposed treatment is manifestly in the best interests' of the adult. Under the *Guardianship and Administration Act 2000* (Qld), a guardian who is exercising this power will be required to comply with the General Principles and the Health Care Principle. The Commission does not consider it desirable to introduce a different test for the exercise of this power.

12.63 Section 67 of the *Guardianship and Administration Act 2000* (Qld) should also be amended to provide that, in addition to and without limiting subsection (2), if an adult's substitute decision-maker exercises power for a health matter in accordance with the authority conferred by the Tribunal under the provision recommended at [12.62] above, the exercise of power for the health matter is effective to give consent to the health care despite an objection by the adult to the health care.

12.64 The effect of these recommendations is that, ordinarily, if the conditions in section 67(2) of the Act are not satisfied, a substitute decision-maker may not override the adult's objection. However, the Tribunal will have the power, in appropriate circumstances, to confer on the adult's substitute decision-maker the power to override the adult's objection. This ensures that an adult's objections are not too readily discounted, but also that there is a means to override an adult's objection that does not involve an application to the Supreme Court.

### **Special health matters: Sterilisation and termination of pregnancy<sup>1012</sup>**

12.65 The effect of an adult's objection to a sterilisation or termination of pregnancy is governed by section 67(1) and (2) of the *Guardianship and Administration Act 2000* (Qld). At present, if an adult objects to the health care and has more than a minimal understanding of what the health care involves and why the health care is required, section 67(2)(a) will not be satisfied. As a result, the Tribunal will not be able to override the adult's objection and consent to the health care.

<sup>1012</sup> The effect of an adult's objection to tissue donation and special medical research or experimental health care is considered at [12.75] below.

12.66 In the Commission's view, section 67(2) ensures that an adult's objection to health care is not too readily discounted. It is therefore important that it should continue to apply to an adult's objection to a sterilisation or termination of pregnancy.

12.67 However, the Commission also recognises that there may be times when, although an adult has more than a minimal understanding of what the health care involves and why it is required, it may nevertheless be in the adult's interests to receive the health care (despite the adult's objection). In this situation, only the Supreme Court, acting in its *parens patriae* jurisdiction, may presently authorise the sterilisation or termination of pregnancy.

12.68 The Commission considers, for the reasons mentioned above, that the Tribunal is generally a more appropriate forum for guardianship proceedings than the Supreme Court.<sup>1013</sup> There are also advantages, in terms of the Tribunal's expertise in guardianship matters, in enabling the Tribunal, in limited circumstances, to override an adult's objection to a sterilisation or termination of pregnancy. Given the seriousness of these forms of health care, however, these circumstances should be narrowly confined. The Commission is of the view that an appropriate limitation would be to enable the Tribunal to override the adult's objection only if the Tribunal is constituted by, or includes, a judicial member.

12.69 For a proceeding for the Tribunal's consent to the sterilisation of an adult or the termination of an adult's pregnancy, a judicial member would be:

- the President of QCAT, who is required by the QCAT Act to be a Supreme Court judge;<sup>1014</sup>
- the Deputy President of QCAT, who is required by the QCAT Act to be a District Court judge;<sup>1015</sup> or
- a supplementary member of QCAT<sup>1016</sup> who is a Supreme Court judge or a District Court judge.<sup>1017</sup>

12.70 To give effect to this recommendation, section 67 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that, in addition to and without limiting subsection (2), the exercise of power by the Tribunal for the sterilisation of an adult or the termination of an adult's pregnancy is effective to give consent to the health care, despite an objection by the adult to the health care, if

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1013 See [12.68] above.

1014 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 175(1), sch 3 (definition of 'judicial member' para (a)(i)).

1015 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 176(1), sch 3 (definition of 'judicial member' para (a)(ii)).

1016 Although a magistrate may be appointed as a supplementary member of QCAT, a magistrate is not a judicial member: *Queensland Civil and Administrative Tribunal Act 2009* (Qld) s 192(2), sch 3 (definition of 'judicial member').

1017 *Queensland Civil and Administrative Tribunal Act 2009* (Qld) sch 3 (definition of 'judicial member' para (a)(iii)).

the Tribunal was constituted by, or included, a judicial member for the proceeding in which it consented to the health care.

12.71 In addition, because the Tribunal will have the power, in limited circumstances, to override an adult's objection, sections 70 (Sterilisation) and 71 (Termination of pregnancy) of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that, in deciding whether to consent to the health care, the Tribunal must take into account any objection by the adult and any other matter relevant to the decision. Although the General Principles and the Health Care Principle require the Tribunal to seek and take into account the adult's views and wishes,<sup>1018</sup> the recommended amendment of sections 70 and 71 is justified given the wider power of the Tribunal to override an adult's objection.

12.72 The effect of the Commission's recommendations is that, ordinarily, the Tribunal's consent to the sterilisation of an adult or to the termination of an adult's pregnancy will be effective only if the requirements of section 67(2) are satisfied. However, even if those requirements are not satisfied, the Tribunal will have the power to consent to these forms of health care, despite the adult's objection, if the Tribunal is constituted by, or includes, a judicial member. This recommendation ensures that it continues to be the case that the objection of an adult who has more than a minimal understanding of what the health care involves and why it is required can only be overridden by a judge.

12.73 This does not mean that every application for the Tribunal's consent to the sterilisation of an adult or to the termination of an adult's pregnancy will need to be heard by a Tribunal panel that is constituted by, or includes, a judicial member. In many cases, it may be known in advance that the adult does not object to the health care or that the requirements of section 67(2) will be satisfied. Those cases would not need to be heard by a Tribunal panel that is constituted by, or includes, a judicial member. The Tribunal should, however, develop a Practice Direction to facilitate the identification of those applications for the Tribunal's consent that should be heard by a Tribunal panel that is constituted by, or includes, a judicial member.

12.74 In some cases, it might only become apparent during the hearing of the application that the adult objects to the health care or that the Tribunal might make a finding that the adult has more than a minimal understanding of what the health care involves and why it is required. To deal with this situation, the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that:

- in the hearing of an application for the Tribunal's consent to the sterilisation of an adult or the termination of an adult's pregnancy, the Tribunal may adjourn the hearing and direct that, for the further hearing of the application, the Tribunal is to be constituted by, or is to include, a judicial member; and
- if the Tribunal, as constituted by or including a judicial member, decides the application, that decision is taken to be the Tribunal's decision.

<sup>1018</sup>

*Guardianship and Administration Act 2000* (Qld) sch 1 ss 7(3)(b), 12(2)(a). See now the new General Principles 8(4) and 9(3) recommended in Chapter 4 of this Report and the new Health Care Principle 10 recommended in Chapter 5 of this Report.

## OBJECTION TO TISSUE DONATION AND SPECIAL MEDICAL RESEARCH OR EXPERIMENTAL HEALTH CARE

### The law in Queensland

12.75 Sections 69 and 72 of the *Guardianship and Administration Act 2000* (Qld) deal, respectively, with the effect of an adult's objection to tissue donation and special medical research or experimental health care. The effect of an adult's objection to these two types of health care is not governed by section 67(2) of the Act.<sup>1019</sup>

12.76 As mentioned earlier, section 65 of the *Guardianship and Administration Act 2000* (Qld) prescribes an order of priority for dealing with special health matters for an adult with impaired capacity:<sup>1020</sup>

- If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.
- If the adult does not have an advance health directive giving a direction about the matter and an entity other than the Tribunal is authorised to deal with the matter,<sup>1021</sup> the matter may only be dealt with by the entity.
- If neither of the above applies and the Tribunal has made an order about the matter, the matter may only be dealt with under the order.

12.77 The effect of section 65 is that, if an adult objects in an advance health directive to donating tissue or participating in special medical research or experimental health care, the Tribunal may not exercise power for the particular matter. This means that the opportunity does not even arise for the Tribunal to consider whether to consent to the particular special health matter. As a result, although sections 69 and 72 refer simply to an 'objection', they are confined in practical terms to the effect of an objection that is made other than in an advance health directive.

### Removal and donation of tissue

12.78 Under the guardianship legislation, the removal of tissue from an adult with impaired capacity, while alive, for donation to another person is special health care.<sup>1022</sup>

<sup>1019</sup> *Guardianship and Administration Act 2000* (Qld) s 67(3).

<sup>1020</sup> *Guardianship and Administration Act 2000* (Qld) s 65 is set out at [12.14] above.

<sup>1021</sup> For example, the Mental Health Review Tribunal has the power to consent to electroconvulsive therapy and psychosurgery for an adult: see *Mental Health Act 2000* (Qld) ss 229–234. Although electroconvulsive therapy and psychosurgery are categories of special health care under the *Guardianship and Administration Act 2000* (Qld), QCAT may not consent to electroconvulsive therapy or psychosurgery for an adult: *Guardianship and Administration Act 2000* (Qld) s 68(1), sch 2 s 7(e).

<sup>1022</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 7(a); *Powers of Attorney Act 1998* (Qld) sch 2 s 7(a). The removal and donation of tissue after the death of a person is regulated by the *Transplantation and Anatomy Act 1979* (Qld) pt 3.

12.79 The 'removal of tissue for donation' is defined in the following terms:<sup>1023</sup>

**8 Removal of tissue for donation**

- (1) For an adult, **removal of tissue for donation** to someone else includes removal of tissue from the adult so laboratory reagents, or reference and control materials, derived completely or partly from pooled human plasma may be given to the other person.
- (2) **Tissue** is—
- (a) an organ, blood or part of a human body; or
  - (b) a substance that may be extracted from an organ, blood or part of a human body.

12.80 This would include, for example, the removal for donation of a kidney or bone marrow.

12.81 If, while an adult had capacity for the special health matter, he or she made an advance health directive giving a direction about the removal and donation of tissue,<sup>1024</sup> the matter may only be dealt with under that direction.<sup>1025</sup> If there is no relevant advance health directive, the Tribunal may make an order consenting to the removal and donation of tissue,<sup>1026</sup> and the matter may only be dealt with under that order.<sup>1027</sup>

12.82 Section 69 of the *Guardianship and Administration Act 2000* (Qld), which deals with the removal of tissue for donation, provides:

**69 Donation of tissue**

- (1) The tribunal may consent, for an adult with impaired capacity for the special health matter concerned, to removal of tissue from the adult for donation to another person only if the tribunal is satisfied—
- (a) the risk to the adult is small; and
  - (b) the risk of failure of the donated tissue is low; and
  - (c) the life of the proposed recipient would be in danger without the donation; and
  - (d) no other compatible donor is reasonably available; and

<sup>1023</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 8(2); *Powers of Attorney Act 1998* (Qld) sch 2 s 8(2).

<sup>1024</sup> *Powers of Attorney Act 1998* (Qld) s 35(1)(a).

<sup>1025</sup> *Guardianship and Administration Act 2000* (Qld) s 65(2).

<sup>1026</sup> *Guardianship and Administration Act 2000* (Qld) ss 68(1), 69(1).

<sup>1027</sup> *Guardianship and Administration Act 2000* (Qld) s 65(4). Guardians, attorneys and statutory health attorneys do not have the power to consent to the removal and donation of tissue as their powers apply in relation to health matters and do not extend to special health matters: see *Guardianship and Administration Act 2000* (Qld) ss 65–66.

- (e) there is, or has been, a close personal relationship between the adult and proposed recipient.
- (2) The tribunal may not consent if the adult objects to the removal of tissue for donation.

*Editor's note—*

Section 67, which effectively enables an adult's objection to be overridden in some cases, does not apply.

- (3) If the tribunal consents to removal of tissue for donation, the tribunal's order must specify the proposed recipient.

12.83 Section 69(1) sets out the circumstances in which the Tribunal may consent to the removal of tissue from an adult for the purpose of donation. Importantly, section 69(2) provides that the Tribunal 'may not consent if the adult objects to the removal of tissue for donation'. The effectiveness of the adult's objection does not depend on the adult's level of understanding.<sup>1028</sup> The giving of what is, in effect, an absolute power of veto to the adult reflects the fact that the removal of tissue from the adult for donation to another person is not health care undertaken for the benefit (or at least for the direct benefit) of the adult.

### ***Special medical research or experimental health care***

12.84 Under the guardianship legislation, the participation by an adult with impaired capacity in special medical research or experimental health care is special health care.<sup>1029</sup> 'Special medical research or experimental health care' is defined in the following terms:<sup>1030</sup>

#### **12 Special medical research or experimental health care**

- (1) ***Special medical research or experimental health care***, for an adult, means—
  - (a) medical research or experimental health care relating to a condition the adult has or to which the adult has a significant risk of being exposed; or
  - (b) medical research or experimental health care intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition the adult has or has had.

<sup>1028</sup> Cf *Guardianship and Administration Act 2000* (Qld) s 67(2).

<sup>1029</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 7(d); *Powers of Attorney Act 1998* (Qld) sch 2 s 7(d).

<sup>1030</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 12(1); *Powers of Attorney Act 1998* (Qld) sch 2 s 12(1).

12.85 However, ‘special medical research or experimental health care’ does not include psychological research or approved clinical research.<sup>1031</sup>

12.86 If, while an adult had capacity for the special health matter, he or she made an advance health directive giving a direction about his or her participation in special medical research or experimental health care,<sup>1032</sup> the matter may only be dealt with under that direction.<sup>1033</sup> If there is no relevant advance health directive, the Tribunal may make an order consenting to the adult’s participation in such research or health care,<sup>1034</sup> and the matter may only be dealt with under that order.<sup>1035</sup>

12.87 The circumstances in which the Tribunal may consent to an adult’s participation in special medical research or experimental health care are set out in section 72(1) and (2) of the *Guardianship and Administration Act 2000* (Qld), and are considered separately in Chapter 13 of this Report.

12.88 Section 72(3) deals with the effect of an adult’s objection. It provides:

**72 Special medical research or experimental health care**

...

- (3) The tribunal may not consent to the adult’s participation in special medical research or experimental health care if—
- (a) the adult objects to the special medical research or experimental health care; or
  - (b) the adult, in an enduring document, indicated unwillingness to participate in the special medical research or experimental health care.

12.89 As is the case with tissue donation, the effectiveness of the adult’s objection does not depend on the adult’s level of understanding, but operates as an absolute veto.

<sup>1031</sup> ‘Approved clinical research’ is clinical research approved by the Tribunal: *Guardianship and Administration Act 2000* (Qld) sch 2 s 13(2); *Powers of Attorney Act 1998* (Qld) sch 2 s 13(2). ‘Clinical research’ is defined as (*Guardianship and Administration Act 2000* (Qld) sch 2 s 13(1); *Powers of Attorney Act 1998* (Qld) sch 2 s 13(1)):

- (a) medical research intended to diagnose, maintain or treat a condition affecting the participants in the research; or
- (b) a trial of drugs or techniques involving the carrying out of health care that may include the giving of placebos to some of the participants in the trial.

<sup>1032</sup> *Powers of Attorney Act 1998* (Qld) s 35(1)(a).

<sup>1033</sup> *Guardianship and Administration Act 2000* (Qld) s 65(2).

<sup>1034</sup> *Guardianship and Administration Act 2000* (Qld) ss 68(1), 72(1).

<sup>1035</sup> *Guardianship and Administration Act 2000* (Qld) s 65(4). Guardians, attorneys and statutory health attorneys do not have the power to consent to the adult’s participation in special medical research or experimental health care, as their powers apply in relation to health matters and do not extend to special health matters: see *Guardianship and Administration Act 2000* (Qld) ss 65–66.

## The Commission's view

12.90 In the Commission's view, it is appropriate that, if an adult objects to donating tissue or to participating in special medical research or experimental health care, the Tribunal may not consent to the particular health care. Both forms of special health care have the potential to be extremely invasive and, with the exception of some special medical research or experimental health care, are not undertaken primarily for the direct benefit of the adult.

12.91 The effect of an adult's objection to other forms of special health care is addressed by the Commission's earlier recommendations in relation to section 67 of the *Guardianship and Administration Act 2000* (Qld).<sup>1036</sup>

## OBJECTION TO URGENT HEALTH CARE

### The law in Queensland

12.92 Section 63 of the *Guardianship and Administration Act 2000* (Qld) provides for the circumstances in which urgent health care (other than special health care or the withholding or withdrawal of a life-sustaining measure<sup>1037</sup>) may be carried out without consent. It provides:

#### **63 Urgent health care**

- (1) Health care, other than special health care, of an adult may be carried out without consent if the adult's health provider reasonably considers—
  - (a) the adult has impaired capacity for the health matter concerned; and
  - (b) either—
    - (i) the health care should be carried out urgently to meet imminent risk to the adult's life or health; or
    - (ii) the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may give it under this Act or the *Powers of Attorney Act 1998*.
- (2) However, the health care mentioned in subsection (1)(b)(i) may not be carried out without consent if the health provider knows the adult objects to the health care in an advance health directive.

<sup>1036</sup> See [12.65]–[12.74] above.

<sup>1037</sup> *Guardianship and Administration Act 2000* (Qld) s 63A deals with the circumstances in which a life-sustaining measure may be withheld or withdrawn without consent. Section 63A is considered in Chapter 11 of this Report.

- (3) However, the health care mentioned in subsection (1)(b)(ii) may not be carried out without consent if the health provider knows the adult objects to the health care unless—
- (a) the adult has minimal or no understanding of 1 or both of the following—
- (i) what the health care involves;
- (ii) why the health care is required; and
- (b) the health care is likely to cause the adult—
- (i) no distress; or
- (ii) temporary distress that is outweighed by the benefit to the adult of the health care.
- (4) The health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out because of this section.
- (5) In this section—

**health care**, of an adult, does not include withholding or withdrawal of a life-sustaining measure for the adult.

12.93 Although section 63 does not apply to the *withholding or withdrawal* of a life-sustaining measure without consent,<sup>1038</sup> it nevertheless governs the circumstances in which a health provider is authorised *to provide* a life-sustaining measure<sup>1039</sup> urgently and without consent. It also governs the circumstances in which a health provider is authorised to provide health care that does not amount to a life-sustaining measure urgently and without consent. However, it has no application in relation to special health care.<sup>1040</sup>

12.94 Generally, section 63(1) authorises a health provider to carry out health care without consent if he or she reasonably considers that the adult has impaired capacity for the relevant health matter and that either:

- the health care should be carried out urgently to meet imminent risk to the adult's life or health; or
- the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may give consent under the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld).

1038 *Guardianship and Administration Act 2000* (Qld) s 63(5).

1039 Note Recommendation 11-2 of this Report, where the Commission has recommended that the definition of 'life-sustaining measure' in sch 2 s 5A of the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) be amended by omitting s 5A(3), which currently excludes a blood transfusion from the definition.

1040 *Guardianship and Administration Act 2000* (Qld) s 63(1).

12.95 Section 63(2) and (3) deals with the effect of an adult's objection to the health care in these circumstances.

***Health care to meet imminent risk to the adult's life or health: section 63(1)(b)(i)***

12.96 Section 63(2) limits the circumstances in which health care may be carried out urgently, without consent, to meet imminent risk to an adult's life or health. If the health provider knows that the adult objects to the health care in an advance health directive, the health provider is not authorised to carry out the health care under section 63.<sup>1041</sup>

12.97 However, if the adult's objection to the health care is made other than in an advance health directive, the objection has no effect on the health provider's authority to carry out the health care without consent under section 63(1)(b)(i) to meet imminent risk to the adult's life or health.

12.98 The use of the word 'knows' in section 63(2) (and in section 63(3)) appears to be a reference to actual knowledge on the part of the health provider.<sup>1042</sup>

12.99 Commentators have suggested that, in an emergency context, it may be unclear when a health provider 'knows' of an adult's objection in an advance health directive:<sup>1043</sup>

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.

12.100 The following scenario is given as an example of a situation where it may not be clear whether the health provider 'knows' of the adult's objection:<sup>1044</sup>

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.

<sup>1041</sup> *Guardianship and Administration Act 2000* (Qld) s 63(2) provides that, in this situation, 'the health care mentioned in subsection (1)(b)(i) may not be carried out *without consent*'. However, the effect of s 66 of the Act is that, if the adult has objected to the health care in an advance health directive, no-one else will be authorised to consent to the health care for the adult.

<sup>1042</sup> Other provisions in Chapter 5 of the *Guardianship and Administration Act 2000* (Qld) use expressions such as 'knows, or could reasonably be expected to know' (s 64(2)) and 'knows, or ought reasonably to know' (s 67(1)). These expressions are not limited to actual knowledge but also encompass constructive knowledge.

<sup>1043</sup> B White and L Willmott, *Rethinking Life-Sustaining Measures: Questions for Queensland* (2005) 53.

<sup>1044</sup> *Ibid* 52.

12.101 It is suggested, however, that Gary does not have knowledge of the adult's objection, in which case the health care that he provides is authorised under section 63(1) of the Act:<sup>1045</sup>

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.

12.102 This issue is not confined to ambulance officers but is also particularly relevant to doctors and other health providers in hospital emergency departments.

***Health care to meet significant pain or distress to the adult: section 63(1)(b)(ii)***

12.103 Section 63(3) limits the circumstances in which health care may be carried out urgently, without consent, to prevent significant pain or distress to the adult. If the health care provider knows that the adult objects to the health care (whether the objection is made in an advance health directive or otherwise), the health care may be carried out only if:

- the adult has minimal or no understanding of what the health care involves or why the health care is required; and
- the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the health care.

12.104 Under section 63(3), the effect of an adult's objection, whenever made and regardless of the way in which it was made, depends on an adult's *current* level of understanding of the proposed health care. Accordingly, an objection that is made in an adult's advance health directive will not be effective if the adult no longer has more than minimal understanding of what the health care involves or why it is required.

**The law in other jurisdictions**

12.105 The legislation in New South Wales,<sup>1046</sup> Tasmania,<sup>1047</sup> Victoria<sup>1048</sup> and Western Australia<sup>1049</sup> authorises urgent treatment to be carried out in specified circumstances without consent. The provisions in these jurisdictions do not include, as a specified circumstance, that the adult does not object to the proposed treatment. Accordingly, the fact that the adult may object to the treatment does not affect the health provider's authority to carry out the treatment.

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1045 Ibid 54.

1046 *Guardianship Act 1987* (NSW) s 37(1).

1047 *Guardianship and Administration Act 1995* (Tas) s 40.

1048 *Guardianship and Administration Act 1986* (Vic) s 42A.

1049 *Guardianship and Administration Act 1990* (WA) s 110ZI, which is set out at [12.106] below.

12.106 The Western Australian legislation contemplates that an adult could have an advance health directive that contains a relevant direction. Section 110ZI of the *Guardianship and Administration Act 1990 (WA)* provides:

**110ZI Urgent treatment generally**

- (1) Subsection (2) applies if —
- (a) a patient needs urgent treatment; and
  - (b) the patient is unable to make reasonable judgments in respect of the treatment; and
  - (c) it is not practicable for the health professional who proposes to provide the treatment to determine whether or not the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment; and
  - (d) it is not practicable for the health professional to obtain a treatment decision in respect of the treatment from the patient's guardian or enduring guardian or the person responsible for the patient under section 110ZD.
- (2) The health professional may provide the treatment to the patient in the absence of a treatment decision in relation to the patient.

12.107 The effect of section 110ZI(1)(c) is that the urgent treatment will not be authorised if it *is* practicable for the health professional to determine whether or not the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment.

## Discussion Paper

12.108 In the Discussion Paper, the Commission sought submissions on the following questions:<sup>1050</sup>

- 14-5 Is it appropriate that an adult's objection to the carrying out of urgent health care without consent to meet imminent risk to the adult's life or health is effective only if the objection is made in an advance health directive?
- 14-6 Is it appropriate that, despite an adult's known objection to particular health care, the health care may be carried out urgently without consent to prevent significant pain or distress to the adult if:
- (a) the adult has minimal or no understanding of one or both of the following:
    - (i) what the health care involves;
    - (ii) why the health care is required; and

<sup>1050</sup>

Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 381.

- (b) the health care is likely to cause the adult:
  - (i) no distress; or
  - (ii) temporary distress that is outweighed by the benefit to the adult of the health care?

## Submissions

12.109 A submission from the parents of an adult with impaired capacity considered it appropriate that, under section 63(2), an adult's objection to the carrying out of urgent health care without consent to meet imminent risk to the adult's life or health is effective only if the objection is made in an advance health directive.<sup>1051</sup> The Adult Guardian was also of this view.<sup>1052</sup>

12.110 However, another respondent disagreed with that view.<sup>1053</sup>

12.111 Several respondents, including the Adult Guardian, also commented on section 63(3), which specifies the circumstances in which an adult's objection to health care to prevent significant pain and distress will be effective. These respondents were of the view that the current provision is appropriate.<sup>1054</sup>

12.112 The Christian Science Committee on Publication for Queensland commented generally that any legislation relating to decisions on the use of medical care should continue to include due respect for the wishes and beliefs of the person.<sup>1055</sup>

12.113 However, a concern was raised at one of the Commission's health forums about the lack of certainty about whether section 103 of the *Powers of Attorney Act 1998* (Qld) protected a health provider who carried out health care under section 63, despite knowing that the adult objected to the health care in an advance health directive. This was mentioned as being a particular problem in relation to blood transfusions where the adult's advance health directive included a direction that blood not be given. The issue raised was whether a health provider who did not comply with the direction would be protected by section 103 of the *Powers of Attorney Act 1998* (Qld), which provides that a health provider does not incur liability for not acting in accordance with a direction in an advance health directive if, among other matters, the health provider has reasonable grounds to believe that the direction is inconsistent with good medical practice.

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1051 Submission 54A.

1052 Submission 164.

1053 Submission 165.

1054 Submissions 54A, 164, 165.

1055 Submission 151.

## The Commission's view

### **Health care to meet imminent risk to the adult's life or health: section 63(1)(b)(i)**

12.114 Section 63(1)(a) and (b)(i) of the *Guardianship and Administration Act 2000* (Qld) provides that health care may be carried out without consent if the adult's health provider reasonably considers that:

- the adult has impaired capacity; and
- the health care should be carried out urgently to meet imminent risk to the adult's life or health.

12.115 In the Commission's view, section 63(1)(b)(i) should be amended to add the words 'and it is not reasonably practicable to get consent from a person who may give it under this Act or the *Powers of Attorney Act 1998*'. In this respect, the subparagraph should be consistent with section 63(1)(b)(ii). The inclusion of this additional requirement will ensure that, where practicable, health care is carried out with the consent of a person with the appropriate authority.<sup>1056</sup>

12.116 The Commission also considers that section 63(2), which operates as a constraint on the provision of the health care mentioned in section 63(1)(b)(i), is too narrow. At present, the only limitation on carrying out the health care is that the health provider knows that the adult objects to the health care in an advance health directive. This would not cover the situation where a patient, before surgery, said that, if the need arises during the surgery for particular health care, for example, a blood transfusion or cardiopulmonary resuscitation, the particular health care is refused. Such a refusal would not normally be given by way of an advance health directive.

12.117 Section 63(2) should therefore be amended to add, as a further limitation on carrying out the health care mentioned in section 63(1)(b)(i), that the health provider knows that, at a time when the adult had capacity to make decisions about the health care, he or she refused the health care. This limitation imports the common law requirements for a valid refusal of health care.<sup>1057</sup> As a result, an 'advance directive' that is effective at common law would operate as a constraint on carrying out the health care mentioned in section 63(1)(b)(i) if the health knew that the adult refused the health care in the directive. However, if the health provider does not know of the refusal, the health care will still be authorised under section 63(1).

<sup>1056</sup> Note, if it is practicable to get consent from a person who may give it under the *Guardianship and Administration Act 2000* (Qld) or the *Powers of Attorney Act 1998* (Qld), the health care is being carried out with consent and not under the authority of s 63 of the *Guardianship and Administration Act 2000* (Qld). Accordingly, s 66 will determine who may give consent to the health care. If the adult has a relevant advance health directive, the adult's guardian, attorney or statutory health attorney will not have the power in relation to the health matter: *Guardianship and Administration Act 2000* (Qld) s 66(2). This would also be the case in relation to s 63(1)(b)(ii).

<sup>1057</sup> These requirements are considered at [9.376] above.

**Health care to prevent significant pain or distress: section 63(1)(b)(ii)**

12.118 The Commission considers it appropriate that health care of the kind mentioned in section 63(1)(b)(ii) of the *Guardianship and Administration Act 2000* (Qld)<sup>1058</sup> may not be carried out without consent if the adult objects to the health care and the test in section 63(3) is not satisfied.

12.119 However, the test in section 63(3) should not be the sole circumstance in which the health care mentioned in section 63(1)(b)(ii) may not be carried out without consent. The fact that an adult currently has minimal or no understanding of what the health care involves or why it is required is no reason to discount an objection made by the adult in an advance health directive at a time when the adult had capacity or a refusal of the health care made by the adult at a time when he or she had capacity.

12.120 Section 63(3) should be amended to provide, in addition to the circumstance mentioned in that subsection, that the health care mentioned in subsection (1)(b)(ii) may not be carried out without consent if the health provider knows that:

- the adult objects to the health care in an advance health directive; or
- at a time when the adult had capacity to make decisions about the health care, he or she refused the health care.

12.121 As mentioned above, the second of these additional limitations imports the common law requirements for a valid refusal of health care.<sup>1059</sup>

**Knowledge that an adult objects to the health care in an advance health directive**

12.122 The Commission notes the concern that has been raised about the meaning in section 63(2) of the *Guardianship and Administration Act 2000* (Qld) of the phrase ‘knows the adult objects to the health care in an advance health directive’,<sup>1060</sup> especially in relation to ambulance officers who may be unsure whether an adult has objected to health care in an advance health directive.<sup>1061</sup>

12.123 The use of ‘knows’ in section 63 differs from other provisions of the Act that use expressions such as ‘knows, or could reasonably be expected to know’<sup>1062</sup>

<sup>1058</sup> *Guardianship and Administration Act 2000* (Qld) s 63(1)(b)(ii) refers to health care carried out to meet significant pain or distress to the adult.

<sup>1059</sup> See [12.117] above.

<sup>1060</sup> See [12.99]–[12.102] above. Note, the Commission has recommended that a similar limitation be added to s 63(3) of the *Guardianship and Administration Act 2000* (Qld).

<sup>1061</sup> The *Powers of Attorney Act 1998* (Qld) s 100 would protect a health provider who, without knowing that an advance health directive was invalid, acted in reliance on the directive (that is, did not provide health care to which the adult objected). However, in the situation raised, the concern is about the position of an ambulance officer who provides urgent health care because he or she is unsure whether or not the adult has objected to the health care in an advance health directive.

<sup>1062</sup> *Guardianship and Administration Act 2000* (Qld) s 64(2).

and 'knows, or ought reasonably to know'.<sup>1063</sup> These other expressions encompass not only actual knowledge, but also constructive knowledge. It has been held that a person has constructive knowledge of facts 'if he wilfully shuts his eyes to the relevant facts which would be obvious if he opened his eyes'.<sup>1064</sup> A person may also be treated 'as having constructive knowledge of the facts ... if he has actual knowledge of circumstances which would indicate the facts to an honest and reasonable man'.<sup>1065</sup>

12.124 Given the context of the health care that is authorised by section 63 and the different, and broader, expressions used elsewhere in the Act, the Commission considers that the word 'knows' in section 63(2) is a reference to actual knowledge of the health provider that the adult objects to the health care in an advance health directive.<sup>1066</sup> A health provider will not have actual knowledge of such an objection if he or she is simply told that an adult has an advance health directive, but is not aware of the contents of the directive, or if the health provider merely suspects that an adult may have an advance health directive, but does not make inquiries. In these situations, section 63(2) will not have the effect that the urgent health care is not authorised.

12.125 Given that section 63(2) is already framed in terms of the narrowest category of knowledge, the Commission is of the view that the section does not require amendment.

***The relationship between section 63(2) of the Guardianship and Administration Act 2000 (Qld) and section 103 of the Powers of Attorney Act 1998 (Qld)***

12.126 As mentioned above,<sup>1067</sup> health providers have raised a concern about the relationship between section 63(2) of the *Guardianship and Administration Act 2000* (Qld) and section 103 of the *Powers of Attorney Act 1998* (Qld).

12.127 The effect of section 63(2) of the *Guardianship and Administration Act 2000* (Qld) is that health care mentioned in section 63(1)(b)(i) — that is, health care to meet imminent risk to the adult's life or health — may not be carried out without consent if the health provider knows that the adult objects to the health care in an advance health directive.

12.128 However, section 103 of the *Powers of Attorney Act 1998* (Qld) provides:

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<sup>1063</sup> *Guardianship and Administration Act 2000* (Qld) s 67(1).

<sup>1064</sup> *Baden v Société Générale pour Favoriser le Développement du Commerce et de l'Industrie en France SA* [1993] 1 WLR 509, 576 (Peter Gibson J).

<sup>1065</sup> *Ibid.*

<sup>1066</sup> See n 1042 above.

<sup>1067</sup> See [12.113] above.

**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.

12.129 The concern raised was whether section 103 of the *Powers of Attorney Act 1998* (Qld) would protect a health provider who provided treatment under section 63 of the *Guardianship and Administration Act 2000* (Qld) if the health provider knew that the adult objected to the health care in an advance health directive, but considered the adult's direction in the advance health directive to be inconsistent with good medical practice.

12.130 On its face, section 103 of the *Powers of Attorney Act 1998* (Qld) appears to protect a health provider from liability for not acting in accordance with a direction in an advance health directive if the health provider has reasonable grounds to believe that:

- the direction is uncertain;
- the direction is inconsistent with good medical practice; or
- circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.

12.131 However, section 103 of the *Powers of Attorney Act 1998* (Qld) does not go as far as to provide that the direction is invalid or is taken not to have been made. Arguably, the direction in the advance health directive still constitutes an operative objection for the purpose of section 63(2) of the *Guardianship and Administration Act 2000* (Qld).

12.132 Section 63 of the *Guardianship and Administration Act 2000* (Qld) was enacted two years after section 103 of the *Powers of Attorney Act 1998* (Qld) and deals with the effect of an advance health directive in a more specific situation than is contemplated by section 103.<sup>1068</sup> In addition, section 8(2) of the *Guardianship*

<sup>1068</sup>

Although the *Powers of Attorney Act 1998* (Qld) originally contained provisions to the effect of ss 64 and 67 of the *Guardianship and Administration Act 2000* (Qld) (see ss 91 and 92 of the *Powers of Attorney Act 1998* (Qld), as passed), it did not contain a provision to the effect of s 63 of the *Guardianship and Administration Act 2000* (Qld).

and *Administration Act 2000* (Qld) provides that, if there is an inconsistency between that Act and the *Powers of Attorney Act 1998* (Qld), the *Guardianship and Administration Act 2000* (Qld) prevails. These factors tend to support an argument that section 63(2) is not subject to section 103.

12.133 This tension in the legislation has been resolved by the Commission's recommendations in Chapter 9 of this Report in relation to advance health directives. The Commission has recommended that section 103 of the *Powers of Attorney Act 1998* (Qld) be amended by omitting from section 103(1) the reference to a direction being inconsistent with good medical practice.<sup>1069</sup>

12.134 The Commission also recommended in Chapter 9 that section 36 of the *Powers of Attorney Act 1998* (Qld) be amended to provide that a direction in an advance health directive does not operate if:

- the direction is uncertain; or
- circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

12.135 The effect of these recommendations on the scenario raised in the Commission's health forum is that, if a health provider knows that an adult objects to a blood transfusion in his or her advance health directive, but the health provider considers the objection to be inconsistent with good medical practice, section 63 of the *Guardianship and Administration Act 2000* (Qld) will not authorise the health provider to give the blood transfusion contrary to the adult's objection. The adult's direction will be effective, and section 103 of the *Powers of Attorney Act 1998* (Qld) will not provide any protection from liability for acting not in accordance with the advance health directive. It will be irrelevant that the health provider may have reasonable grounds to believe that the direction refusing the blood transfusion is inconsistent with good medical practice.

12.136 However, if the health provider has reasonable grounds to believe that the direction refusing the blood transfusion is uncertain, or that circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate, the recommended amendment to section 36 of the *Powers of Attorney Act 1998* (Qld) will have the effect that the direction does not operate, in which case it will not constitute an objection for the purpose of section 63(2) of the Act. Accordingly, provided that the requirements of section 63(1) are satisfied, the health provider will be authorised to give the blood transfusion despite the direction in the advance health directive.

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See Recommendation 9-18(a)(i) of this Report.

## OBJECTION TO MINOR AND UNCONTROVERSIAL HEALTH CARE

### The law in Queensland

12.137 Section 64 of the *Guardianship and Administration Act 2000* (Qld) authorises a health provider, in specified circumstances, to carry out minor and uncontroversial health care without consent. However, the health provider is not authorised to carry out the health care without consent if he or she knows, or could reasonably be expected to know, that the adult objects to the health care.<sup>1070</sup>

12.138 Section 64 provides:

#### **64 Minor, uncontroversial health care**

- (1) Health care, other than special health care, of an adult may be carried out without consent if the adult's health provider—
- (a) reasonably considers the adult has impaired capacity for the health matter concerned; and
  - (b) reasonably considers the health care is—
    - (i) necessary to promote the adult's health and wellbeing; and
    - (ii) of the type that will best promote the adult's health and wellbeing; and
    - (iii) minor and uncontroversial; and
  - (c) does not know, and can not reasonably be expected to know, of—
    - (i) a decision about the health care made by a person who is able to make the decision under this Act or the *Powers of Attorney Act 1998*; or
    - (ii) any dispute among persons the health provider reasonably considers have a sufficient and continuing interest in the adult about—
      - (A) the carrying out of the health care; or
      - (B) the capacity of the adult for the health matter.

*Examples of minor and uncontroversial health care mentioned in paragraph (b)(iii)—*

- the administration of an antibiotic requiring a prescription
- the administration of a tetanus injection

<sup>1070</sup>

*Guardianship and Administration Act 2000* (Qld) s 64(2).

- (2) However, the health care may not be carried out without consent if the health provider knows, or could reasonably be expected to know, the adult objects to the health care.
- (3) The health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out because of this section.

12.139 If a health provider knows, or could reasonably be expected to know, that the adult objects to the health care, the health provider may not carry out the minor and uncontroversial health care without consent. This does not mean that the adult will necessarily be deprived of that health care. In that situation, the health provider will need to obtain consent from a substitute decision-maker. The effect of the adult's objection on any purported consent by the substitute decision-maker will then be governed by section 67.<sup>1071</sup>

### The law in other jurisdictions

12.140 The New South Wales legislation provides that, in specified circumstances, minor treatment may be carried out without consent. Section 37 of the *Guardianship Act 1987* (NSW) provides in part:

**37 When treatment may be carried out without any such consent**

...

- (2) Minor treatment may (subject to subsection (3)) also be carried out on a patient to whom this Part applies without any consent given in accordance with this Part if:
  - (a) there is no person responsible for the patient, or
  - (b) there is such a person but that person either cannot be contacted or is unable or unwilling to make a decision concerning a request for that person's consent to the carrying out of the treatment.
- (3) The medical practitioner or dentist carrying out, or supervising the carrying out of, minor treatment in accordance with subsection (2) is required to certify in writing in the patient's clinical record that:
  - (a) the treatment is necessary and is the form of treatment that will most successfully promote the patient's health and well-being, and
  - (b) the patient does not object to the carrying out of the treatment.

12.141 The effect of section 37(3)(b) is that minor treatment may be carried out without consent only if the patient does not object. This is consistent with the effect

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<sup>1071</sup> The effect of s 67 of the *Guardianship and Administration Act 2000* (Qld) is considered at [12.20]–[12.35] above.

of an adult's objection under section 64 of the *Guardianship and Administration Act 2000* (Qld).

12.142 In Tasmania, section 41 of the *Guardianship and Administration Act 1995* (Tas) authorises the carrying out of medical and dental treatment where there is no person responsible for the adult, provided that the treatment is necessary and is the form of treatment that will most successfully promote the adult's health and well-being, and the adult does not object to the carrying out of the treatment.<sup>1072</sup>

### Discussion Paper

12.143 In the Discussion Paper, the Commission sought submissions on whether it is appropriate that an adult's objection to minor and uncontroversial health care is effective to prevent minor and uncontroversial health care from being carried out without consent.<sup>1073</sup>

### Submissions

12.144 Two respondents, including the parents of an adult with impaired capacity, were of the view that it was not appropriate that an adult's objection to minor and uncontroversial health care is effective to prevent health care from being carried out without consent.<sup>1074</sup>

12.145 However, the Adult Guardian agreed with the current approach in section 64 of the *Guardianship and Administration Act 2000* (Qld). In her view:<sup>1075</sup>

In respect of minor and uncontroversial health care, the view of the Adult Guardian is that the objection changes the nature of the context of the health care and that when the adult objects in that context, a substitute decision maker (usually a [statutory health attorney], attorney or guardian) should decide whether the health care should proceed on the basis that one of the considerations will be the objection and the need to weigh its impact upon the adult and how, in the face of the objection, the health care is best provided.

12.146 The Christian Science Committee on Publication for Queensland commented generally that it supports measures that recognise and support a person's right to define his or her preferred type of health care.<sup>1076</sup>

### The Commission's view

12.147 In the Commission's view, it is appropriate that section 64 of the *Guardianship and Administration Act 2000* (Qld) does not authorise the carrying out

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<sup>1072</sup> *Guardianship and Administration Act 1995* (Tas) s 41.

<sup>1073</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 381.

<sup>1074</sup> Submissions 54A, 165.

<sup>1075</sup> Submission 164.

<sup>1076</sup> Submission 151.

of minor and uncontroversial health care if the adult objects to the health care. The Commission agrees with the comment made by the Adult Guardian that the adult's objection changes the context of the health care. This does not necessarily mean that the health care cannot be carried out at all; it simply means that it cannot be carried out without consent under the authority of section 64.

## PRESENT AND PREVIOUS OBJECTIONS

### The law in Queensland

12.148 The *Guardianship and Administration Act 2000* (Qld) defines 'object, by an adult, to health care' as follows:<sup>1077</sup>

**object**, by an adult, to health care means—

- (a) the adult indicates the adult does not wish to have the health care; or
- (b) the adult previously indicated, in similar circumstances, the adult did not then wish to have the health care and since then the adult has not indicated otherwise.

*Example—*

An indication may be given in an enduring power of attorney or advance health directive or in another way, including, for example, orally or by conduct.

12.149 This definition includes present and previous objections to the health care. It does not distinguish between an objection made at a time when the adult had capacity for the health matter or special health matter and an objection made at a time when the adult has impaired capacity for the matter.

12.150 A previous objection to health care may well have been made at a time when the adult still had capacity for the health matter or special health matter, although that will not necessarily be the case. Further, if the objection appears in an advance health directive, it will have been made with the intention of being binding in the future. It will have been made subject to the safeguards that apply in relation to the making of advance health directives and is likely to have been an informed decision.

12.151 On the other hand, a present objection to health care, although a strong indication of the adult's current wishes, is necessarily made at a time when the adult has impaired capacity for the health matter or special health matter.

12.152 It is also possible that a person's previously expressed objection about particular health care may be inconsistent with his or her present wishes about that health care. The Law Commission of England and Wales has noted that:<sup>1078</sup>

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<sup>1077</sup> *Guardianship and Administration Act 2000* (Qld) sch 4.

<sup>1078</sup> Law Commission of England and Wales, *Mental Incapacity*, Report No 231 (1995) [3.29]

Realistically, the former views of a person who is without capacity cannot in every case be determinative of the decision which is now to be made. Past wishes and feelings may in any event conflict with feelings the person is still able to express in spite of incapacity. People who cannot make decisions can still experience pleasure and distress. *Present* wishes and feelings must therefore be taken into account, where necessary balanced with past wishes and feelings. (original emphasis; note omitted)

12.153 Although the definition of ‘object’ encompasses present and previous objections (which, in the case of a previous objection could be an objection that was made either with or without capacity), the effect of an adult’s objection to particular health care depends on the type of health care involved and the circumstances in which it is carried out.

12.154 The following table summarises the effect of an adult’s objection to the various types of health care considered earlier in this chapter.

	<b>Objection made in an advance health directive (ie when the adult has capacity)</b>	<b>Objection made other than in an advance health directive (ie when the adult may or may not have capacity)</b>
<b>Health care <u>with</u> consent</b>		
<b>Health care (other than special health care or participation in approved clinical research)<sup>1079</sup></b>	Substitute decision-maker may not exercise power to consent (s 66(2))	Substitute decision-maker’s consent is effective if: <ul style="list-style-type: none"> <li>• the adult has minimal or no understanding of what the health care involves or why the health care is required; and</li> <li>• the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care (s 67(2))</li> </ul>
<b>Removal of tissue for donation</b>	Tribunal may not exercise power to consent (s 65(2))	Tribunal may not consent if the adult objects (s 69(2));  Tribunal’s consent is ineffective if the health provider knows, or ought reasonably to know, that the adult objects (s 67(1), (3)(a)) <sup>1080</sup>

<sup>1079</sup> Special health care (ie removal of tissue for donation, sterilisation, termination of pregnancy and participation in special medical research or experimental health care) and participation in approved clinical research are addressed separately in this table.

<sup>1080</sup> See [12.33]–[12.34] above.

	<b>Objection made in an advance health directive (ie when the adult has capacity)</b>	<b>Objection made other than in an advance health directive (ie when the adult may or may not have capacity)</b>
<b>Participation in special medical research or experimental health care</b>	Tribunal may not exercise power to consent (ss 65(2), 72(3)(b))	Tribunal may not consent if the adult objects (s 72(3)(a));  Tribunal's consent is ineffective if the health provider knows, or ought reasonably to know, that the adult objects (s 67(1), (3)(b)) <sup>1081</sup>
<b>Sterilisation</b> <sup>1082</sup>	Tribunal may not exercise power to consent (s 65(2))	Tribunal's consent is effective if: <ul style="list-style-type: none"> <li>• the adult has minimal or no understanding of what the health care involves or why the health care is required; and</li> <li>• the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care (s 67(2))</li> </ul>
<b>Termination of pregnancy</b>	Tribunal may not exercise power to consent (s 65(2))	Tribunal's consent is effective if: <ul style="list-style-type: none"> <li>• the adult has minimal or no understanding of what the health care involves or why the health care is required; and</li> <li>• the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the proposed health care (s 67(2))</li> </ul>
<b>Participation in approved clinical research</b>	Substitute decision-maker may not exercise power to consent (s 66(2))	Substitute decision-maker's consent is ineffective if the health provider knows, or ought reasonably to know, that the adult objects (s 67(1), (3)(b)) <sup>1083</sup>

1081 Ibid. Participation in special medical research or experimental health care is considered in Chapter 13 of this Report.

1082 Sterilisation is more likely to arise as an issue in relation to an adult who has never had capacity. Accordingly, it will be rare for an adult to have an advance health directive dealing with the matter. Note that under the guardianship legislation, 'sterilisation' does not include health care primarily to treat organic malfunction or disease of the adult: *Guardianship and Administration Act 2000* (Qld) sch 2 s 9; *Powers of Attorney Act 1998* (Qld) sch 2 s 9.

1083 See [12.33], [12.35] above. Participation in approved clinical research is considered in greater detail in Chapter 13 of this Report.

	<b>Objection made in an advance health directive (ie when the adult has capacity)</b>	<b>Objection made other than in an advance health directive (ie when the adult may or may not have capacity)</b>
<b>Health care <u>without</u> consent</b>		
<b>Urgent health care to meet imminent risk to the adult's life or health</b>	Health care may not be carried out without consent if the health provider knows that the adult objects to the health care in an advance health directive (s 63(2))	Health care may be carried out without consent despite the adult's objection (s 63(1))
<b>Urgent health care to prevent significant pain or distress to the adult</b>	Health care may not be carried out without consent if the health provider knows that the adult objects to the health care unless: <ul style="list-style-type: none"> <li>the adult has minimal or no understanding of what the health care involves or why the health care is required; and</li> <li>the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the health care (s 63(3))</li> </ul>	Health care may not be carried out without consent if the health provider knows that the adult objects to the health care unless: <ul style="list-style-type: none"> <li>the adult has minimal or no understanding of what the health care involves or why the health care is required; and</li> <li>the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the health care (s 63(3))</li> </ul>
<b>Withholding or withdrawal of a life-sustaining measure</b> <sup>1084</sup>	A life-sustaining measure may not be withheld or withdrawn without consent if the health provider knows that the adult objects to the withholding or withdrawal of the measure (s 63A(2))	A life-sustaining measure may not be withheld or withdrawn without consent if the health provider knows that the adult objects to the withholding or withdrawal of the measure (s 63A(2))
<b>Minor and uncontroversial health care</b>	Health care may not be carried out without consent if the health provider knows, or could reasonably be expected to know, that the adult objects to the health care (s 64(2))	Health care may not be carried out without consent if the health provider knows, or could reasonably be expected to know, that the adult objects to the health care (s 64(2))

**Table 12.1: Effect of an adult's objection to health care**

12.155 It can be seen from Table 12.1 that an objection made in an advance health directive:

- has the effect, for health care carried out with consent, that neither the adult's substitute decision-maker nor the Tribunal may consent to the health care;<sup>1085</sup> and

<sup>1084</sup>

The effect of an adult's objection to the provision of a life-sustaining measure and the withholding or withdrawal of a life-sustaining measure is considered in Chapter 11 of this Report.

- generally has the effect, for health care that is otherwise authorised to be carried out without consent, that the health care is not authorised.<sup>1086</sup>

12.156 The only type of health care for which an objection made in an advance health directive does not currently operate as an absolute veto is urgent health care, without consent, to prevent significant pain or distress to the adult. Health care of that kind may currently be carried out without consent, despite an objection made in an advance health directive if:<sup>1087</sup>

- the adult has minimal or no understanding of what the health care involves or why the health care is required; and
- the health care is likely to cause the adult no distress or temporary distress that is outweighed by the benefit to the adult of the health care.

12.157 However, the Commission has recommended earlier in this chapter that this type of health care should not be able to be carried out without consent if the health provider knows that the adult objects to the health care in an advance health directive.<sup>1088</sup>

12.158 It can be seen from Table 12.1 that an objection, however made, has the effect that:

- the Tribunal may not consent to the removal of tissue from the adult for donation to another person or to the adult's participation in special medical research or experimental health care;<sup>1089</sup>
- a life-sustaining measure may not be withheld or withdrawn in an acute emergency without consent;<sup>1090</sup> and
- minor and uncontroversial health care may not be carried out without consent.<sup>1091</sup>

12.159 However, an objection to health care generally (being an objection not made in an advance health directive)<sup>1092</sup> will not necessarily be effective to override a substitute decision-maker's consent to the health care. Whether the adult's objection has that effect in a particular case depends on the adult's level of

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1085 *Guardianship and Administration Act 2000* (Qld) ss 65(2), 66(2).

1086 *Guardianship and Administration Act 2000* (Qld) ss 63(2), 63A(2), 64(2).

1087 *Guardianship and Administration Act 2000* (Qld) s 63(3).

1088 See [12.119]–[12.120], Recommendation 12-8.

1089 *Guardianship and Administration Act 2000* (Qld) ss 69(2), 72(3).

1090 *Guardianship and Administration Act 2000* (Qld) s 63A(2).

1091 *Guardianship and Administration Act 2000* (Qld) s 64(2).

1092 See [12.22] above.

understanding and on the level of distress that the proposed health care is likely to cause the adult.<sup>1093</sup>

### Discussion Paper

12.160 In the Discussion Paper, the Commission sought submissions on whether, given the effect under the *Guardianship and Administration Act 2000* (Qld) of an adult's objection to particular types of health care, the definition of 'object, by an adult, to health care' is appropriate.<sup>1094</sup>

### Submissions

12.161 The Adult Guardian considered it important for the definition of 'object' to retain the reference to previous objections.<sup>1095</sup>

### The Commission's view

12.162 In view of the way in which the various provisions of the *Guardianship and Administration Act 2000* (Qld) deal with the effect of an adult's objection to health care (especially an objection made in an advance health directive), and the fact that the Commission has recommended that section 63 of the Act be amended to deal with the effect of an objection in an advance health directive to health care mentioned in section 63(1)(b)(ii),<sup>1096</sup> the Commission is satisfied that the definition of 'object' operates satisfactorily in the context of those provisions.

## RECOMMENDATIONS

### ***Objection to health care generally***

**12-1 The *Guardianship and Administration Act 2000* (Qld) should be amended by inserting a provision, based generally on section 46A(1)–(3) of the *Guardianship Act 1987* (NSW), to the effect that:**

- (1) The Tribunal may confer on an adult's guardian or attorney the authority to exercise power for a health matter for the adult, despite the adult's objection to the health care.

<sup>1093</sup> *Guardianship and Administration Act 2000* (Qld) s 67(1)–(2).

<sup>1094</sup> Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 386.

<sup>1095</sup> Submission 164.

<sup>1096</sup> See [12.118]–[12.120] above.

- (2) The Tribunal may confer that authority only at the request, or with the consent of, the guardian or attorney and only if it is satisfied that the adult's objection is, or will be made, because of the adult's lack of understanding of the nature of, or reason for, the treatment.
- (3) The Tribunal may at any time—
  - (a) impose conditions or give directions about the exercise of the guardian's or attorney's power; or
  - (b) revoke such power.
- (4) In this section—
 

*attorney* means an attorney under an enduring document or a statutory health attorney.

**12-2** Section 67 of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that, in addition to and without limiting subsection (2):

- (a) if an adult's guardian or attorney exercises power for a health matter in accordance with the authority conferred by the Tribunal under the provision that gives effect to Recommendation 12-1, the exercise of power is effective to give consent to the health care despite an objection by the adult to the health care; and
- (b) the exercise of power by the Tribunal for the sterilisation of an adult or the termination of an adult's pregnancy is effective to give consent to the health care, despite an objection by the adult to the health care, if the Tribunal was constituted by, or included, a judicial member<sup>1097</sup> for the proceeding in which it consented to the health care.

***Objection to sterilisation or a termination of pregnancy***

**12-3** Sections 70 (Sterilisation) and 71 (Termination of pregnancy) of the *Guardianship and Administration Act 2000* (Qld) should be amended to provide that, in deciding whether to consent to the health care, the Tribunal must take into account any objection by the adult and any other matter relevant to the decision.

<sup>1097</sup>

For the meaning of 'judicial member' for a proceeding for the Tribunal's consent to the sterilisation of an adult or the termination of an adult's pregnancy, see [12.69] above.

**12-4** The Tribunal should develop a Practice Direction to facilitate the identification of those applications for the Tribunal's consent to the sterilisation of an adult or the termination of an adult's pregnancy that should be heard by a Tribunal panel that is constituted by, or includes, a judicial member.

**12-5** The *Guardianship and Administration Act 2000* (Qld) should be amended to provide that:

- (a) in the hearing of an application for the Tribunal's consent to the sterilisation of an adult or the termination of an adult's pregnancy, the Tribunal may adjourn the hearing and direct that, for the further hearing of the application, the Tribunal is to be constituted by, or is to include, a judicial member; and
- (b) if the Tribunal, as constituted by or including a judicial member, decides the application, that decision is taken to be the Tribunal's decision.

***Objection to urgent health care***

**12-6** Section 63(1)(b)(i) of the *Guardianship and Administration Act 2000* (Qld) should be amended by adding the words 'and it is not reasonably practicable to get consent from a person who may give it under this Act or the *Powers of Attorney Act 1998* (Qld)'.

**12-7** Section 63(2) of the *Powers of Attorney Act 1998* (Qld) should be amended to add, as a further limitation on carrying out the health care mentioned in section 63(1)(b)(i), that the health care may not be carried out without consent if the health provider knows that, at a time when the adult had capacity to make decisions about the health care, he or she refused the health care.

**12-8** Section 63(3) of the *Guardianship and Administration Act 2000* (Qld) should be amended to add, as further limitations on carrying out the health care mentioned in section 63(1)(b)(ii), that the health care may not be carried out without consent if the health provider knows that:

- (a) the adult objects to the health care in an advance health directive; or
- (b) at a time when the adult had capacity to make decisions about the health care, he or she refused the health care.

# Chapter 13

## Consent to participation in medical research

INTRODUCTION .....	331
BACKGROUND.....	332
THE LAW IN QUEENSLAND .....	332
Terminology.....	332
Participation in special medical research or experimental health care .....	333
Participation in approved clinical research.....	338
THE LAW IN OTHER JURISDICTIONS .....	342
Jurisdictions with specific consent mechanisms for medical research .....	342
Other Australian jurisdictions .....	350
THE CURRENT REQUIREMENT FOR TRIBUNAL CONSENT OR APPROVAL.....	350
Issues for consideration .....	350
Discussion Paper .....	352
Submissions.....	353
The Commission's view .....	356
THE SCOPE OF THE DEFINITIONS OF 'HEALTH CARE' AND 'SPECIAL HEALTH CARE' .....	360
Issue for consideration .....	360
The law in other jurisdictions.....	362
Discussion Paper .....	362
Submissions.....	363
The Commission's view .....	363
RECOMMENDATIONS .....	363

### INTRODUCTION

13.1 The Commission's terms of reference direct it to review the law in relation to the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld), including 'consent to special medical research or experimental health care'.<sup>1098</sup> The terms of reference also direct the Commission to have regard, among other things, to:

- the need to ensure that adults are not deprived of necessary health care because they have impaired capacity; and
- the need to ensure that adults with impaired capacity receive only treatment that is necessary and appropriate to maintain or promote their health or wellbeing, or that is in their best interests.

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1098

The terms of reference are set out in Appendix 1.

## BACKGROUND

13.2 Medical research encompasses a range of procedures that vary in their potential for therapeutic benefit for, and in their risk and inconvenience to, the research participant.

13.3 Some medical research is conducted by way of clinical trials, where new drugs or medical devices are tested on participants to determine their efficacy and safety.<sup>1099</sup> Other medical research does not involve the trialling of a drug or device, but may depend on obtaining from the research participants a blood or tissue sample, which is then used in the research. In the latter case, the research is unlikely to be of direct therapeutic benefit to the participants.

13.4 The participation of all people in medical research requires safeguards to ensure that they are not exploited or put at risk. In the case of adults with impaired capacity, who are especially vulnerable, the need for safeguards against exploitation is even greater. However, if adults with impaired capacity are not able to participate in medical research at all, they may be denied what could be potentially beneficial health care.

## THE LAW IN QUEENSLAND

### Terminology

13.5 The *Guardianship and Administration Act 2000* (Qld) deals with the consent mechanisms for the participation by an adult in medical research in two contexts:

- special medical research or experimental health care; and
- approved clinical research.

13.6 The guardianship legislation defines 'special medical research or experimental health care' as follows:<sup>1100</sup>

#### **12 Special medical research or experimental health care**

- (1) Special medical research or experimental health care, for an adult, means—
- (a) medical research or experimental health care relating to a condition the adult has or to which the adult has a significant risk of being exposed; or

<sup>1099</sup> See Department of Health and Ageing, Therapeutic Goods Administration, *Access to Unapproved Therapeutic Goods — Clinical Trials in Australia* (October 2004) 9 <[www.tga.gov.au/docs/pdf/unapproved/clintrials.pdf](http://www.tga.gov.au/docs/pdf/unapproved/clintrials.pdf)> at 8 March 2010.

<sup>1100</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 12; *Powers of Attorney Act 1998* (Qld) sch 2 s 12.

- (b) medical research or experimental health care intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition the adult has or has had.
- (2) Special medical research or experimental health care does not include—
  - (a) psychological research; or
  - (b) approved clinical research.

13.7 The guardianship legislation defines ‘clinical research’ and ‘approved clinical research’ as follows:<sup>1101</sup>

**13 Approved clinical research**

- (1) **Clinical research** is—
  - (a) medical research intended to diagnose, maintain or treat a condition affecting the participants in the research; or
  - (b) a trial of drugs or techniques involving the carrying out of health care that may include the giving of placebos to some of the participants in the trial.
- (1A) However, a comparative assessment of health care already proven to be beneficial is not medical research.

*Examples—*

- a comparative assessment of the effects of different forms of administration of a drug proven to be beneficial in the treatment of a condition, for example, a continuous infusion, as opposed to a once-a-day administration, of the drug
- a comparative assessment of the angle at which to set a tilt-bed to best assist an adult’s breathing

- (2) **Approved clinical research** is clinical research approved by the tribunal.

## Participation in special medical research or experimental health care

### **Requirements for the Tribunal’s consent**

13.8 Under the guardianship legislation, the participation by an adult in special medical research or experimental health care is a category of special health care.<sup>1102</sup> Accordingly, the adult’s participation is regulated by sections 65 and 72 of the *Guardianship and Administration Act 2000* (Qld).

13.9 Section 65 of the *Guardianship and Administration Act 2000* (Qld) sets out an order of priority for dealing with special health matters. It provides:

<sup>1101</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 13(1); *Powers of Attorney Act 1998* (Qld) sch 2 s 13(1).

<sup>1102</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 7(d); *Powers of Attorney Act 1998* (Qld) sch 2 s 7(d).

**65 Adult with impaired capacity—order of priority in dealing with special health matter**

- (1) If an adult has impaired capacity for a special health matter, the matter may only be dealt with under the first of the following subsections to apply.
- (2) If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.
- (3) If subsection (2) does not apply and an entity other than the tribunal is authorised to deal with the matter, the matter may only be dealt with by the entity.
- (4) If subsections (2) and (3) do not apply and the tribunal has made an order about the matter, the matter may only be dealt with under the order.

*Editor's note—*

However, the tribunal may not consent to electroconvulsive therapy or psychosurgery—section 68(1).

13.10 The effect of section 65(2) is that, if an adult has made an advance health directive giving a direction about participation in special medical research or experimental health care, the matter may only be dealt with under that direction.

13.11 If an adult does not have a relevant advance health directive, and the Tribunal has made an order about the matter, the matter may only be dealt with under that order.<sup>1103</sup> Section 72 of the *Guardianship and Administration Act 2000* (Qld) prescribes the circumstances in which the Tribunal may consent to an adult's participation in special medical research or experimental health care:

**72 Special medical research or experimental health care**

- (1) The tribunal may consent, for an adult with impaired capacity for the special health matter concerned, to the adult's participation in special medical research or experimental health care relating to a condition the adult has or to which the adult has a significant risk of being exposed only if the tribunal is satisfied about the following matters—
  - (a) the special medical research or experimental health care is approved by an ethics committee;
  - (b) the risk and inconvenience to the adult and the adult's quality of life is small;
  - (c) the special medical research or experimental health care may result in significant benefit to the adult;
  - (d) the potential benefit can not be achieved in another way.

<sup>1103</sup>

*Guardianship and Administration Act 2000* (Qld) s 65(4).

*Editor's note—*

**Special medical research or experimental health care** does not include—

- (a) psychological research; or
  - (b) approved clinical research—see schedule 2, section 12(2).
- (2) The tribunal may consent, for an adult with impaired capacity for the matter, to the adult's participation in special medical research or experimental health care intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition the adult has or has had only if the tribunal is satisfied about the following matters—
- (a) the special medical research or experimental health care is approved by an ethics committee;
  - (b) the risk and inconvenience to the adult and the adult's quality of life is small;
  - (c) the special medical research or experimental health care may result in significant benefit to the adult or other persons with the condition;
  - (d) the special medical research or experimental health care can not reasonably be carried out without a person who has or has had the condition taking part;
  - (e) the special medical research or experimental health care will not unduly interfere with the adult's privacy.
- (3) The tribunal may not consent to the adult's participation in special medical research or experimental health care if—
- (a) the adult objects to the special medical research or experimental health care; or

*Editor's note—*

Section 67, which effectively enables an adult's objection to be overridden in some cases, does not apply.<sup>1104</sup>

- (b) the adult, in an enduring document, indicated unwillingness to participate in the special medical research or experimental health care. (note added)

13.12 Section 72 deals with the giving of consent in relation to two types of special medical research or experimental health care:

- section 72(1) applies where the special medical research or experimental health care relates to a condition that the adult has or to which the adult has a significant risk of being exposed; and

<sup>1104</sup>

This Editor's note is not entirely accurate. It should state that s 67(2) does not apply. See the discussion of the application of s 67(1) of the *Guardianship and Administration Act 2000* (Qld) at [13.19] below.

- section 72(2) applies where the special medical research or experimental health care is intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition that the adult has or has had.

13.13 There is a degree of commonality in the matters about which the Tribunal must be satisfied before giving its consent under section 72(1) or (2). In both cases, the Tribunal must be satisfied that:<sup>1105</sup>

- (a) the special medical research or experimental health care is approved by an ethics committee;<sup>1106</sup> [and]
- (b) the risk and inconvenience to the adult and the adult's quality of life is small. (note added)

13.14 The differences in the remaining matters about which the Tribunal must be satisfied reflect the different purposes of the research to which section 72(1) and (2) applies.

13.15 Although section 72(1) does not refer expressly to medical research or experimental health care that has a potentially therapeutic effect, it is implicit in the matters referred to in section 72(1)(c) and (d) that this is the intended purpose of the section; hence the requirement that the Tribunal must, in addition to the matters referred to at [13.13] above, be satisfied that:

- (c) the special medical research or experimental health care may result in significant benefit to the adult; [and]
- (d) the potential benefit can not be achieved in another way.

13.16 In contrast, section 72(2), which deals with 'special medical research or experimental health care intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition the adult has or has had', does not require the Tribunal to be satisfied that the special medical research or experimental health care may result in significant benefit to the adult personally. Instead, the Tribunal must, in addition to the matters referred to at [13.13] above, be satisfied that:<sup>1107</sup>

<sup>1105</sup> *Guardianship and Administration Act 2000* (Qld) s 72(1)(a)–(b), (2)(a)–(b).

<sup>1106</sup> *Guardianship and Administration Act 2000* (Qld) sch 4 defines 'ethics committee' to mean:

- (a) a Human Research Ethics Committee registered by the Australian Health Ethics Committee established under the *National Health and Medical Research Council Act 1992* (Cwlth); or
- (b) if there is no committee mentioned in paragraph (a)—
  - (i) an ethics committee established by a public sector hospital under the *Health Services Act 1991*, section 2; or
  - (ii) an ethics committee established by a university and concerned, wholly or partly, with medical research; or
  - (iii) an ethics committee established by the National Health and Medical Research Council.

<sup>1107</sup> *Guardianship and Administration Act 2000* (Qld) s 72(2)(c)–(e).

- (c) the special medical research or experimental health care may result in significant benefit to the adult or other persons with the condition;
- (d) the special medical research or experimental health care can not reasonably be carried out without a person who has or has had the condition taking part; [and]
- (e) the special medical research or experimental health care will not unduly interfere with the adult's privacy. (emphasis added)

### **The effect of an adult's objection**

13.17 Section 72(3) of the *Guardianship and Administration Act 2000* (Qld) provides that the Tribunal may not consent to the adult's participation in special medical research or experimental health care if:

- the adult objects to the special medical research or experimental health care; or
- the adult, in an enduring document, indicated unwillingness to participate in the special medical research or experimental health care.

13.18 The guardianship legislation provides for two kinds of enduring documents: enduring powers of attorney and advance health directives.<sup>1108</sup> Under section 65(2) of the Act, if the adult has impaired capacity for a special health matter and has made an advance health directive giving a direction about the matter (which could include an objection to particular special health care), the matter must be dealt with under the direction. In so far as section 72(3)(b) refers to an expression of unwillingness in an advance health directive, it is presumably intended to capture an expression of the adult's views that falls short of amounting to a direction or objection about the matter. In so far as that section refers to an expression of unwillingness in an enduring power of attorney, it is presumably intended to capture information given by the adult in an enduring power of attorney.<sup>1109</sup>

13.19 If the Tribunal consents to an adult's participation in special medical research or experimental health care and the adult later objects, the effect of the adult's objection is governed by section 67 of the Act. In that situation, the Tribunal's consent will be ineffective if the health provider knows, or ought reasonably to know, that the adult objects to the health care.<sup>1110</sup> Because section 67(2) of the Act does not apply to participation in special medical research or

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<sup>1108</sup> *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of 'enduring document'); *Powers of Attorney Act 1998* (Qld) s 28.

<sup>1109</sup> Section 32(1) of the *Powers of Attorney Act 1998* (Qld) provides that an adult may, by an enduring power of attorney, appoint an attorney for one or more personal matters and may provide terms or information about exercising the power. However, a 'personal matter' does not include a special health matter: *Powers of Attorney Act 1998* (Qld) sch 2 s 2. Accordingly, an adult may not, by an enduring power of attorney, appoint an attorney to exercise a power in relation to the adult's participation in special medical research or experimental health care.

<sup>1110</sup> *Guardianship and Administration Act 2000* (Qld) s 67(1).

experimental health care,<sup>1111</sup> the adult's objection amounts to an absolute veto and does not depend, for its effectiveness, on the adult's level of understanding of what the health care involves or why it is required or on the level of distress that the health care is likely to cause the adult.<sup>1112</sup>

### **Data about Tribunal consents**

13.20 Consent for an adult's participation in special medical research or experimental health care is given by the Tribunal on a case-by-case basis. If the particular research involves a number of adults with impaired capacity, it will be necessary for an application for the Tribunal's consent to be made in relation to each adult.

13.21 Information published in the Tribunal's Annual Reports for the financial years 2004–05 to 2008–09 reveals that applications for consent for an adult's participation in special medical research or experimental health care are extremely rare:

	Applications made	Applications approved	Applications dismissed	Applications withdrawn
2008–09 <sup>1113</sup>	0	0	0	0
2007–08 <sup>1114</sup>	0	0	0	0
2006–07 <sup>1115</sup>	1	0	1	0
2005–06 <sup>1116</sup>	0	0	0	0
2004–05 <sup>1117</sup>	1	1	0	0

**Table 13.1: Applications for consent to an adult's participation in special medical research or experimental health care**

### **Participation in approved clinical research**

13.22 The *Guardianship and Administration Act 2000* (Qld) establishes a different framework for obtaining consent for the participation of an adult with impaired capacity in approved clinical research.

<sup>1111</sup> *Guardianship and Administration Act 2000* (Qld) s 67(3)(b).

<sup>1112</sup> *Guardianship and Administration Act 2000* (Qld) s 67 is considered in Chapter 12 of this Report.

<sup>1113</sup> Guardianship and Administration Tribunal, *Annual Report 2008–2009* (2009) 47.

<sup>1114</sup> Guardianship and Administration Tribunal, *Annual Report 2007–2008* (2008) 48.

<sup>1115</sup> Guardianship and Administration Tribunal, *Annual Report 2006–2007* (2007) 46. The application was refused, as the Tribunal was of the view that the health care in question was not experimental health care: see *Re MP* [2006] QGAAT 86.

<sup>1116</sup> Guardianship and Administration Tribunal, *Annual Report 2005–2006* (2006) 44.

<sup>1117</sup> Guardianship and Administration Tribunal, *Annual Report 2004–2005* (2005) 31.

### **Requirements for the Tribunal's approval of clinical research**

13.23 Section 13 of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) provides that the Tribunal may approve clinical research in specified circumstances, and deals with the effect of that approval:

#### **13 Approved clinical research**

...

- (3) The tribunal may approve clinical research only if the tribunal is satisfied about the following matters—
  - (a) the clinical research is approved by an ethics committee;
  - (b) any drugs or techniques on trial in the clinical research are intended to diagnose, maintain or treat a condition affecting the participants in the research;
  - (c) the research will not involve any known substantial risk to the participants or, if there is existing health care for the particular condition, the research will not involve known material risk to the participants greater than the risk associated with the existing health care;
  - (d) the development of any drugs or techniques on trial has reached a stage at which safety and ethical considerations make it appropriate for the drugs or techniques to be made available to the participants despite the participants being unable to consent to participation;
  - (e) having regard to the potential benefits and risks of participation, on balance it is not adverse to the interests of the participants to participate.
- (4) The fact that a trial of drugs or techniques will or may involve the giving of placebos to some of the participants does not prevent the tribunal from being satisfied it is, on balance, not adverse to the interests of the participants to participate.
- (5) The tribunal's approval of clinical research does not operate as a consent to the participation in the clinical research of any particular person.

13.24 The matters about which the Tribunal must be satisfied in order to approve clinical research provide a safeguard for the interests of adults with impaired capacity.<sup>1118</sup> The requirement for approval by an ethics committee<sup>1119</sup> ensures that the proposed research has been scrutinised by a multi-disciplinary committee. Further, the requirement that the Tribunal must be satisfied that 'any drugs or

<sup>1118</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 13(3).

<sup>1119</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 13(2); *Powers of Attorney Act 1998* (Qld) sch 2 s 13(2). Approval by an ethics committee is also a requirement for the Tribunal's consent to special medical research or experimental health care: see *Guardianship and Administration Act 2000* (Qld) s 72(1)(a), (2)(a).

techniques on trial in the clinical research are intended to diagnose, maintain or treat a condition affecting the participants in the research'<sup>1120</sup> limits the types of clinical trials that may be approved by the Tribunal. For example, a study on participants to determine whether a proposed new generic drug is bioequivalent to an existing approved drug would not be a study that could be undertaken using adults with impaired capacity.

13.25 Because 'special medical research or experimental health care', as defined in the guardianship legislation, does not include 'approved clinical research',<sup>1121</sup> the effect of the Tribunal's approval of clinical research is that the research, which would otherwise fall within the definition of 'special medical research or experimental health care', is no longer special health care. Instead, a decision about an adult's participation in the approved clinical research is a health matter.

13.26 The significance of being a health matter, rather than a special health matter, is that the Tribunal's consent is not required in order for an individual adult to participate in the approved clinical research. If the adult has an advance health directive dealing with this particular health matter, the matter must be dealt with under the directive. If the adult does not have a relevant advance health directive, the matter may be dealt with according to the hierarchy established by section 66 of the *Guardianship and Administration Act 2000* (Qld) — that is, by:<sup>1122</sup>

- the guardian or guardians appointed by the Tribunal, if any;
- if the Tribunal has not appointed a guardian or guardians — by the attorney or attorneys appointed by the adult in an enduring power of attorney or advance health directive; or
- if there are no guardians or attorneys — by the statutory health attorney.

### ***The effect of an adult's objection***

13.27 Because participation in approved clinical research is a health matter, the effect of an adult's objection to the health care is governed by sections 66 and 67 of the *Guardianship and Administration Act 2000* (Qld).<sup>1123</sup>

13.28 If an adult has impaired capacity for a health matter and has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.<sup>1124</sup>

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<sup>1120</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 13(3)(b).

<sup>1121</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 12(2)(b); *Powers of Attorney Act 1998* (Qld) sch 2 s 12(2)(b). Section 12 of sch 2 is set out at [13.6] above.

<sup>1122</sup> *Guardianship and Administration Act 2000* (Qld) s 66(3)–(5).

<sup>1123</sup> The effect of an adult's objection to health care is considered in Chapter 19 of this Report.

<sup>1124</sup> *Guardianship and Administration Act 2000* (Qld) s 66(1)–(2).

13.29 If the adult does not have an advance health directive dealing with the matter, the effect of the adult's objection is governed by section 67 of the Act. In that situation, the Tribunal's consent will be ineffective if the health provider knows, or ought reasonably to know, that the adult objects to the health care.<sup>1125</sup> Because section 67(2) of the Act does not apply to participation in approved clinical research,<sup>1126</sup> the adult's objection amounts to an absolute veto; it does not depend, for its effectiveness, on the adult's level of understanding of what the health care involves or why it is required or on the level of distress that the health care is likely to cause the adult.

### **Data about Tribunal approvals**

13.30 Although the number of applications made to the Tribunal for the approval of clinical research is relatively small, such applications are much more common than applications for consent for an adult's participation in special medical research or experimental health care. Information published in the Tribunal's Annual Reports for the financial years 2002–03 to 2008–09 reveals that the following numbers of applications have been made for the approval of clinical research:

	<b>Applications made</b>	<b>Applications approved</b>	<b>Applications dismissed</b>	<b>Applications withdrawn</b>
<b>2008–09</b> <sup>1127</sup>	33	17	1	4
<b>2007–08</b> <sup>1128</sup>	19	15	2	1
<b>2006–07</b> <sup>1129</sup>	9	10	1	0
<b>2005–06</b> <sup>1130</sup>	29	25	4	0
<b>2004–05</b> <sup>1131</sup>	28	20	4	0

1125 *Guardianship and Administration Act 2000* (Qld) s 67(1).

1126 *Guardianship and Administration Act 2000* (Qld) s 67(3)(b).

1127 Guardianship and Administration Tribunal, *Annual Report 2008–2009* (2009) 47. At the end of the 2008–09 financial year, 14 applications were pending: at 47.

1128 Guardianship and Administration Tribunal, *Annual Report 2007–2008* (2008) 48. At the end of the 2007–08 financial year, four applications were pending (including two from the previous financial year): at 48.

1129 The Tribunal's 2006–07 Annual Report records that four applications were still pending at the end of 2005–06. The application that was dismissed did not constitute research within the meaning of the *Guardianship and Administration Act 2000* (Qld): Guardianship and Administration Tribunal, *Annual Report 2006–2007* (2007) 47.

1130 Guardianship and Administration Tribunal, *Annual Report 2005–2006* (2006) 45. The Annual Report notes (at 45) that the four applications were dismissed because they did not constitute research within the meaning of the *Guardianship and Administration Act 2000* (Qld).

1131 The Tribunal's 2004–05 Annual Report records that two applications had been set down for hearing, but had not been determined, and a further three applications were finalised before hearing as investigation and evaluation determined that they did not require the approval of the Tribunal: Guardianship and Administration Tribunal, *Annual Report 2004–2005* (2005) 32.

2003–04 <sup>1132</sup>	19	13	0	1
2002–03 <sup>1133</sup>	22	13	1	1

**Table 13.2: Applications for approval of clinical research**

## THE LAW IN OTHER JURISDICTIONS

### Jurisdictions with specific consent mechanisms for medical research

13.31 Two other Australian jurisdictions — New South Wales and Victoria — include specific consent mechanisms in their guardianship legislation for the participation of adults with impaired capacity in medical research.

13.32 The New South Wales provisions are similar in some respects to the Queensland provisions discussed above. The Victorian provisions are quite different, in that they do not require the consent of the Victorian Civil and Administrative Tribunal.

#### *New South Wales*

13.33 The *Guardianship Act 1987* (NSW) provides separate mechanisms for consent to ‘special treatment’ and participation in ‘clinical trials’. These terms are defined in the legislation as follows:<sup>1134</sup>

***clinical trial*** means a trial of drugs or techniques that necessarily involves the carrying out of medical or dental treatment on the participants in the trial.

***special treatment*** means:

- (a) any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, or
- (b) any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned, or
- (c) any other kind of treatment declared by the regulations to be special treatment for the purposes of this Part,

but does not include treatment in the course of a clinical trial.

<sup>1132</sup> The Tribunal’s 2003–04 Annual Report records that it was awaiting further information before another application was approved, that one other matter had been set down for hearing, and that three other clinical trials were finalised before hearing as investigation and evaluation determined that they did not require the approval of the Tribunal: Guardianship and Administration Tribunal, *Annual Report 2003–2004* (2004) 26.

<sup>1133</sup> The Tribunal’s 2002–03 Annual Report records that the other seven clinical trials were finalised before hearing as investigation and evaluation determined that they did not require the approval of the Tribunal: Guardianship and Administration Tribunal, *Annual Report 2002–2003* (2003) 25.

<sup>1134</sup> *Guardianship Act 1987* (NSW) s 33(1).

13.34 The *Guardianship Act 1987* (NSW) provides that consent to the carrying out of 'medical or dental treatment'<sup>1135</sup> on a relevant patient may be given:<sup>1136</sup>

- in the case of minor or major treatment — by the 'person responsible' for the patient;<sup>1137</sup> and
- in any case — by the NSW Guardianship Tribunal.

13.35 Because 'major treatment'<sup>1138</sup> and 'minor treatment'<sup>1139</sup> are defined to exclude 'special treatment' and treatment in the course of a 'clinical trial', the person responsible cannot consent to 'special treatment' for the patient and cannot, without an order of the NSW Guardianship Tribunal, consent to the patient's participation in a clinical trial.

### *Special treatment*

13.36 As noted above, the *Guardianship Act 1987* (NSW) provides generally that the NSW Guardianship Tribunal may consent to the carrying out of medical or dental treatment on a relevant patient.<sup>1140</sup> The Act provides that any person may apply to the Tribunal for consent to the carrying out of medical or dental treatment on a relevant patient,<sup>1141</sup> and that the Tribunal may consent to the carrying out of the treatment if it is satisfied that it is appropriate for the treatment to be carried out.<sup>1142</sup>

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1135 The term 'medical or dental treatment' is defined broadly in s 33(1) of the *Guardianship Act 1987* (NSW), which is set out at [13.99] below.

1136 *Guardianship Act 1987* (NSW) s 36(1).

1137 For a person other than a child or a person in the care of the Director-General under s 13 of the *Guardianship Act 1987* (NSW), the 'person responsible' is determined according to the hierarchy in s 33A(4) of the Act. The hierarchy is, in descending order:

- the person's guardian if the instrument appointing the guardian provides for the guardian to give consent to the carrying out of medical or dental treatment on the person;
- the spouse of the person if the relationship between the person and the spouse is close and continuing and the spouse is not a person under guardianship;
- a person who has the care of the person;
- a close friend or relative of the person.

1138 *Guardianship Act 1987* (NSW) s 33(1) defines 'major treatment' as follows:

**major treatment** means treatment (other than special treatment or treatment in the course of a clinical trial) that is declared by the regulations to be major treatment for the purposes of this Part.

1139 *Guardianship Act 1987* (NSW) s 33(1) defines 'minor treatment' as follows:

**minor treatment** means treatment that is not special treatment, major treatment or treatment in the course of a clinical trial.

1140 *Guardianship Act 1987* (NSW) s 36(1).

1141 *Guardianship Act 1987* (NSW) s 42(1).

1142 *Guardianship Act 1987* (NSW) s 44(1). Section 44(2) specifies the matters to which the Tribunal must have regard.

13.37 The Act also imposes a number of restrictions on the Tribunal's power to give consent, including, in particular, restrictions on its power to consent to special treatment for a patient. Section 45 provides:

**45 Restrictions on Tribunal's power to give consent**

- (1) The Tribunal must not give consent to the carrying out of medical or dental treatment on a patient to whom this Part applies unless the Tribunal is satisfied that the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being.
- (2) However, the Tribunal must not give consent to the carrying out of special treatment unless it is satisfied that the treatment is necessary:
  - (a) to save the patient's life, or
  - (b) to prevent serious damage to the patient's health,
 or unless the Tribunal is authorised to give that consent under subsection (3).
- (3) In the case of:
  - (a) special treatment of a kind specified in paragraph (b) of the definition of that expression in section 33(1), or
  - (b) prescribed special treatment (other than special treatment of a kind specified in paragraph (a) of that definition),
 the Tribunal may give consent to the carrying out of the treatment if it is satisfied that:
  - (c) the treatment is the only or most appropriate way of treating the patient and is manifestly in the best interests of the patient, and
  - (d) in so far as the National Health and Medical Research Council has prescribed guidelines that are relevant to the carrying out of that treatment—those guidelines have been or will be complied with as regards the patient.

*Clinical trials*

13.38 The *Guardianship Act 1987* (NSW) also provides that the NSW Guardianship Tribunal may, in specified circumstances, approve a clinical trial as a trial in which relevant patients may participate. Section 45AA provides:

**45AA Tribunal may approve clinical trials**

- (1) The Tribunal may approve, in accordance with this section, a clinical trial as a trial in which patients to whom this Part applies may participate.
- (2) The Tribunal may give an approval under this section only if it is satisfied that:

- (a) the drugs or techniques being tested in the clinical trial are intended to cure or alleviate a particular condition from which the patients suffer, and
  - (b) the trial will not involve any known substantial risk to the patients (or, if there are existing treatments for the condition concerned, will not involve material risks greater than the risks associated with those treatments), and
  - (c) the development of the drugs or techniques has reached a stage at which safety and ethical considerations make it appropriate that the drugs or techniques be available to patients who suffer from that condition even if those patients are not able to consent to taking part in the trial, and
  - (d) having regard to the potential benefits (as well as the potential risks) of participation in the trial, it is in the best interests of patients who suffer from that condition that they take part in the trial, and
  - (e) the trial has been approved by a relevant ethics committee and complies with any relevant guidelines issued by the National Health and Medical Research Council.
- (3) The fact that a clinical trial will or may involve the giving of placebos to some of the participants in the trial does not prevent the Tribunal from being satisfied that it is in the best interests of patients that they take part in the trial.
- (4) The Tribunal's approval of a clinical trial under this section does not operate as a consent to the participation in the trial of any particular patient to whom this Part applies. The appropriate consent must be obtained under Division 3 or 4 before any medical or dental treatment in the course of the trial is carried out on the patient.
- (5) In this section:

**ethics committee** means:

- (a) for so long as there is any relevant Institutional Ethics Committee registered by the Australian Health Ethics Committee established under the *National Health and Medical Research Council Act 1992* of the Commonwealth—an Institutional Ethics Committee so registered, or
- (b) in the absence of such a committee, an ethics committee established by:
  - (i) an area health service or a public hospital, or
  - (ii) a university, being an ethics committee concerned, wholly or partly, with medical research, or
  - (iii) the National Health and Medical Research Council.

13.39 Section 45AB of the Act further provides for who may consent to a patient's participation in a clinical trial that has been approved by the Tribunal. It provides:

**45AB Consent for participation in clinical trials in individual cases**

- (1) If the Tribunal is satisfied as to the matters specified in section 45AA(2) in relation to a clinical trial, it may, by order, determine:
  - (a) that the function of giving or withholding consent for the carrying out of medical or dental treatment on patients in the course of the trial is to be exercised by the persons responsible for the patients (in which case Division 3 applies), or
  - (b) that the Tribunal is to exercise that function itself (in which case Division 4 applies).
- (2) Before making a determination referred to in subsection (1)(a), the Tribunal must be satisfied that the form for granting consent and the information available about the trial provide sufficient information to enable the persons responsible to decide whether or not it is appropriate that the patients should take part in the trial.

13.40 Section 45AB(1) provides two avenues for consent. The Tribunal may determine that the function of giving or withholding consent for the treatment involved in the clinical trial may be given by the persons responsible for the patients. Alternatively, the Tribunal may determine that it will exercise that function itself.

13.41 Section 45(2) provides a safeguard where the Tribunal proposes to determine that consent may be given by the persons responsible for the patients. Before making such a determination, the Tribunal must be satisfied that the form for granting consent and the information available about the trial provide sufficient information to enable the persons responsible to decide whether or not it is appropriate that the patients should take part in the trial.

13.42 The New South Wales provisions in relation to clinical trials differ from the Queensland provisions in relation to clinical research in that they enable the NSW Guardianship Tribunal to reserve to itself the power to consent to an adult's participation in a clinical trial. In addition, there is no similar requirement under the Queensland legislation for the Tribunal to be satisfied about the sufficiency of the information contained in the consent form and of the information available about the trial.

**Victoria**

13.43 In Victoria, as a result of amendments made to the *Guardianship and Administration Act 1986* (Vic) in 2006, it is no longer necessary to obtain the approval of the Victorian Civil and Administrative Tribunal ('VCAT') in order to carry out a medical research procedure on an adult with impaired capacity (referred to in the legislation as a 'patient').

13.44 The *Guardianship and Administration Act 1986* (Vic) now provides a four step process for authorising a ‘medical research procedure’, other than in an emergency, on a patient.<sup>1143</sup> The Act defines ‘medical research procedure’ to mean:<sup>1144</sup>

- (a) a procedure carried out for the purposes of medical research, including, as part of a clinical trial, the administration of medication or the use of equipment or a device; or
- (b) a procedure that is prescribed by the regulations to be a medical research procedure for the purposes of this Act—

but does not include—

- (c) any non-intrusive examination (including a visual examination of the mouth, throat, nasal cavity, eyes or ears or the measuring of a person’s height, weight or vision); or
- (d) observing a person’s activities; or
- (e) undertaking a survey; or
- (f) collecting or using information, including personal information (within the meaning of the *Information Privacy Act 2000*) or health information (within the meaning of the *Health Records Act 2001*); or
- (g) any other procedure that is prescribed by the regulations not to be a medical research procedure for the purposes of this Act.

13.45 The first step is to determine whether the relevant research project has been approved by the relevant human research ethics committee (‘HREC’).<sup>1145</sup> A medical research procedure must not be carried out on a patient if the research project has not been approved by the relevant HREC.<sup>1146</sup> Further, the medical research procedure must be carried out in accordance with the approval of the HREC, including any conditions of the approval.<sup>1147</sup>

13.46 The second step is to determine whether the patient is likely to be capable, within a reasonable period of time, of consenting to the carrying out of a medical research procedure.<sup>1148</sup> If the patient is not likely to be capable, within a reasonable period of time, of giving consent, the medical research procedure may be carried out under the authority of a consent given under section 42S by the ‘person responsible’ for the patient or under the authority of what is described in the

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1143 *Guardianship and Administration Act 1986* (Vic) s 42P(3).

1144 *Guardianship and Administration Act 1986* (Vic) s 3(1).

1145 *Guardianship and Administration Act 1986* (Vic) s 42Q(1).

1146 *Guardianship and Administration Act 1986* (Vic) s 42Q(2).

1147 *Guardianship and Administration Act 1986* (Vic) s 42Q(3).

1148 *Guardianship and Administration Act 1986* (Vic) s 42R(1).

legislation as ‘procedural authorisation’ under section 42T.<sup>1149</sup> If the patient is likely to be capable, within a reasonable period of time, of giving consent, the medical research procedure may not be carried out under the authority of section 42S or 42T.<sup>1150</sup>

13.47 The third step is to seek the consent of the person responsible for the patient.<sup>1151</sup> The person responsible may consent to the carrying out of a medical research procedure on the patient, but only if he or she believes that the carrying out of the procedure would not be contrary to the best interests<sup>1152</sup> of the patient.<sup>1153</sup> The consent must be consistent with any requirements for consent specified in the HREC approval for the relevant research project or the conditions of that approval.<sup>1154</sup>

13.48 The fourth step of procedural authorisation applies only if the person responsible for the patient cannot be ascertained or contacted.<sup>1155</sup> In specified circumstances, a registered practitioner may carry out, or supervise the carrying out of, a medical research procedure without the consent under section 42S of the person responsible for the patient. The specified circumstances, which are set out in section 42T(2) of the Act, are:

- (a) the patient is not likely to be capable, within a reasonable time as determined in accordance with section 42R(2), of giving consent to the carrying out of the procedure; and
- (b) steps that are reasonable in the circumstances have been taken—
  - (i) to ascertain whether there is a person responsible and, if so, who that person is; and
  - (ii) if the person responsible is ascertained, to contact that person to seek his or her consent to the proposed procedure under section 42S—

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<sup>1149</sup> *Guardianship and Administration Act 1986* (Vic) s 42R(4).

<sup>1150</sup> *Guardianship and Administration Act 1986* (Vic) s 42R(3).

<sup>1151</sup> *Guardianship and Administration Act 1986* (Vic) s 42S(1).

<sup>1152</sup> *Guardianship and Administration Act 1986* (Vic) s 42U(1) provides that, for the purposes of determining whether a medical research procedure would or would not be contrary to the best interests of a patient, the following matters must be taken into account:

- (a) the wishes of the patient, so far as they can be ascertained; and
- (b) the wishes of any nearest relative or any other family members of the patient; and
- (c) the nature and degree of any benefits, discomforts and risks for the patient in having or not having the procedure; and
- (d) any other consequences to the patient if the procedure is or is not carried out; and
- (e) any other prescribed matters.

<sup>1153</sup> *Guardianship and Administration Act 1986* (Vic) s 42S(2)–(3).

<sup>1154</sup> *Guardianship and Administration Act 1986* (Vic) s 42S(4).

<sup>1155</sup> *Guardianship and Administration Act 1986* (Vic) s 42T(1).

- but it has not been possible to ascertain whether there is a person responsible or who that person is or to contact that person; and
- (c) the practitioner believes on reasonable grounds that inclusion of the patient in the relevant research project, and being the subject of the proposed procedure, would not be contrary to the best interests of the patient;<sup>1156</sup> and
  - (d) the practitioner does not have any reason to believe that the carrying out of the procedure would be against the patient's wishes; and
  - (e) the practitioner believes on reasonable grounds that the relevant human research ethics committee has approved the relevant research project in the knowledge that a patient may participate in the project without the prior consent of the patient or the person responsible; and
  - (f) the practitioner believes on reasonable grounds that—
    - (i) one of the purposes of the relevant research project is to assess the effectiveness of the therapy being researched; and
    - (ii) the medical research procedure poses no more of a risk to the patient than the risk that is inherent in the patient's condition and alternative treatment; and
  - (g) the practitioner believes on reasonable grounds that the relevant research project is based on valid scientific hypotheses that support a reasonable possibility of benefit for the patient as compared with standard treatment. (note added)

13.49 Before, or as soon as practicable after the medical research procedure is carried out, the registered practitioner supervising the carrying out of the medical research procedure (or, if there is no such person, the practitioner carrying out the procedure) must sign a certificate certifying as to each of the matters set out in section 42T(2) of the Act and stating that the person responsible (if any) or the patient (if the patient gains or regains capacity) will be informed as required by the legislation.<sup>1157</sup> The practitioner must forward a copy of the certificate to the Public Advocate and the relevant HREC as soon as practicable and, in any event, within two working days after supervising the carrying out of, or carrying out, the procedure.<sup>1158</sup>

13.50 A registered practitioner involved in the research project must inform the person responsible (if any) or the patient (if the patient gains or regains capacity), as soon as reasonably practicable, of the patient's inclusion in the research project and of the option to refuse consent for the patient for the procedure and withdraw

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1156 See n 1152 above for the matters that must be taken into account in deciding whether a medical research procedure would or would not be contrary to the best interests of a patient.

1157 *Guardianship and Administration Act 1986* (Vic) s 42T(3).

1158 *Guardianship and Administration Act 1986* (Vic) s 42T(5).

the patient from future participation in the project without compromising the patient's ability to receive any available alternative treatment or care.<sup>1159</sup>

### Other Australian jurisdictions

13.51 In the Australian jurisdictions that do not have specific provisions in their guardianship legislation dealing with medical research, the issue of whether adults with impaired capacity may participate in medical research and the circumstances in which they do so depends on the breadth of the definitions in the relevant legislation of medical treatment or health care and on the factors in the legislation that govern the exercise of the power to consent to medical treatment or health care.

## THE CURRENT REQUIREMENT FOR TRIBUNAL CONSENT OR APPROVAL

### Issues for consideration

#### *Participation in special medical research or experimental health care*

13.52 As explained above, in Queensland, only the Tribunal may consent to the participation of an adult with impaired capacity in special medical research or experimental health care.<sup>1160</sup> That is similar to the position in New South Wales where only the NSW Guardianship Tribunal may consent to medical or dental treatment that constitutes special treatment.<sup>1161</sup>

13.53 In contrast, the *Guardianship and Administration Act 1986* (Vic) does not require VCAT consent for an adult with impaired capacity to participate in medical research; nor does it require VCAT approval of clinical trials. Instead, consent to a special medical procedure for an adult with impaired capacity may be given by the person responsible for the adult and, in some circumstances, the special medical procedure is authorised to be carried out without any consent.<sup>1162</sup>

13.54 In Queensland, there is no mechanism for the Tribunal to approve a special medical research project or an experimental health care project and for consent then to be given by an adult's substitute decision-maker.<sup>1163</sup> If the particular research involves a number of adults with impaired capacity, application

1159 *Guardianship and Administration Act 1986* (Vic) s 42T(4).

1160 See [13.11] above. Note, however, that the Tribunal may not exercise power in relation to the matter if the adult has given a relevant direction about the matter in an advance health directive: *Guardianship and Administration Act 2000* (Qld) s 65(1)–(2).

1161 See [13.33]–[13.37] above.

1162 See [13.43]–[13.50] above.

1163 *Guardianship and Administration Act 2000* (Qld) s 74(1) provides that, if the Tribunal consents to special health care for an adult, the Tribunal may appoint one or more persons who are eligible for appointment as a guardian or guardians for the adult and give the guardian or guardians power to consent for the adult to continuation of the special health care or the carrying out on the adult of similar special health care. However, the section still requires that the Tribunal has initially consented to the special health care for an individual adult.

must be made to the Tribunal for consent to the participation of each individual adult.

13.55 As a matter of practicality, if all the potential research participants have been identified, there may be scope for the applications to be heard together. However, for some research, the potential participants are, of necessity, accrued over a considerable period of time — for example, if the research is about a condition or disease that is reasonably rare. This raises the issue of whether, for at least some types of research (such as those that have a very low risk and are minimally invasive), it should be possible for the Tribunal to approve the research project and for the adult's substitute decision-maker to have the power to consent to the adult's participation in the research.

13.56 Such an approach would be similar to the mechanism provided under the *Guardianship and Administration Act 2000* (Qld) for the Tribunal to approve clinical research.<sup>1164</sup>

### ***Participation in an approved clinical research***

13.57 In Queensland and New South Wales, the Tribunal's approval is required in order for an adult with impaired capacity to take part in clinical research (in New South Wales, in a clinical trial). In Queensland, once clinical research has been approved, it becomes a health matter and the power to consent rests with the adult's substitute decision-maker — that is, the guardian, attorney or statutory health attorney.

13.58 The main difference between the two jurisdictions is that, in New South Wales, the Tribunal has the option of itself consenting to the participation of adults in the approved clinical trial or, in the alternative, determining that the function of giving or withholding consent is to be exercised by the persons responsible for the adults.

13.59 Further, as noted earlier, section 45AB(2) of the *Guardianship Act 1987* (NSW) requires the Tribunal, before determining that the function of giving or withholding consent is to be exercised by the persons responsible, to be satisfied that the form for granting consent and the information about the trial provide sufficient information to enable the persons responsible to decide whether or not it is appropriate that the adults should take part in the trial. Although the consent and information forms would ordinarily be considered by the relevant ethics committee in deciding whether to give ethical approval for the clinical trial, the requirement in section 45AB(2) provides a further opportunity for scrutiny of those documents.

13.60 In contrast, the *Guardianship and Administration Act 1986* (Vic) does not require VCAT consent for an adult with impaired capacity to participate in medical research; nor does it require VCAT approval of clinical trials. Instead, consent to a special medical procedure for an adult with impaired capacity may be given by the person responsible for the adult and, in some circumstances, the special medical procedure is authorised to be carried out without any consent.

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1164

See [13.22]–[13.26] above.

## Discussion Paper

13.61 In the Discussion Paper, the Commission sought submissions on the following questions:<sup>1165</sup>

- 13-1 Is it appropriate that, under the *Guardianship and Administration Act 2000* (Qld), only the Tribunal may consent to an adult's participation in special medical research or experimental health care?
- 13-2 Is it appropriate that the *Guardianship and Administration Act 2000* (Qld) provides for the Tribunal to approve clinical research?
- 13-3 Is it appropriate that, under the *Guardianship and Administration Act 2000* (Qld), consent to an adult's participation in approved clinical research may be given by the adult's substitute decision-maker (that is, the guardian, attorney or statutory health attorney)?
- 13-4 If yes to Question 13-2, should the *Guardianship and Administration Act 2000* (Qld) be amended to provide that the Tribunal may either:
  - (a) consent to an adult's participation in approved clinical research; or
  - (b) decide, for particular approved clinical research, that the power to consent to an adult's participation in the research may be exercised by the adult's substitute decision-maker (that is, the adult's guardian, attorney or statutory health attorney)?
- 13-5 If the *Guardianship and Administration Act 2000* (Qld) continues to provide that an adult's substitute decision-maker may consent to the adult's participation in approved clinical research, should the Act be amended to provide that, before approving the clinical research, the Tribunal must be satisfied that the form for granting consent and the information about the trial provide sufficient information to enable the adult's substitute decision-maker to decide whether or not it is appropriate for the adult to take part in the trial?
- 13-6 Should the *Guardianship and Administration Act 2000* (Qld) be amended to enable the Tribunal, in addition to consenting to an adult's participation in special medical research or experimental health care, to have the option to approve certain special medical research or experimental health care, in which case the research would no longer be special health care and consent could be given by an adult's substitute decision-maker?
- 13-7 If yes to Question 13-6, to what types of special medical research or experimental health care should that approval mechanism apply?

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Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 353.

## Submissions

### *Threshold issue*

13.62 Two submissions raised a threshold issue about the participation by an adult in special medical research or experimental health care.

13.63 Family Voice Australia commented that consent to special medical research or experimental health care involves a ‘personal weighing up of risks and benefits, including an altruistic desire to benefit others through such participation’.<sup>1166</sup> It commented that no-one, including a Tribunal, can invoke either a best interests test or substitute decision-making principles to exercise altruism on behalf of an adult with impaired capacity. For that reason, it was of the view that, unless the matter is addressed in an advance health directive, it should not be possible for consent to be given for an adult’s participation in special medical research or experimental health care.<sup>1167</sup>

13.64 A similar comment was made by Right to Life Australia.<sup>1168</sup> It referred to section 72(2) of the *Guardianship and Administration Act 2000* (Qld), which sets out the matters about which the Tribunal must be satisfied in order to consent to an adult’s participation in special medical research or experimental health care that is intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition that the adult has or has had. In relation to section 72(2)(c), Right to Life Australia commented:<sup>1169</sup>

This section allows for adults with impaired capacity to have special medical research or experimental health care done to them which may not be of any benefit to them but which may benefit others. This is unacceptable and should not be allowed. It is only if significant benefit may be achieved for the person themselves that such medical research and experimental health care should be permitted to be done to them.

### ***Tribunal oversight of special medical research or experimental health care and clinical research***

13.65 The Adult Guardian suggested that the ‘current legislative procedure in Queensland may be unnecessarily complex given the other checks and balances in place to deal with potential risks’.<sup>1170</sup> In that regard, she referred to the National Health and Medical Research Council’s *National Statement on Ethical Conduct in*

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1166 Submission 157.

1167 Ibid. This respondent also commented that the participation by an adult in special medical research or experimental health care should be removed from the definition of ‘special health care’ and included in the definition of ‘special personal matter’. That issue is considered in Chapter 8 of this Report.

1168 Submission 149.

1169 *Guardianship and Administration Act 2000* (Qld) s 72 is set out at [13.11] above.

1170 Submission 164.

*Human Research*, which forms the primary guidelines for human research ethics committees and researchers.<sup>1171</sup> The Adult Guardian commented:

Human research ethics committees provide feedback to and in some cases decline to approve research until the form of consent and information available for the provision of consent is sufficient for members of the public to determine whether they should consent to be included in research.

13.66 The Adult Guardian suggested that it would perhaps be sufficient if an adult's guardian, attorney or statutory health attorney could consent to the adult's involvement in the particular research. It was observed that, in making this decision, the risks and benefits of involvement will need to be weighed in the framework of the Health Care Principle and the General Principles.<sup>1172</sup>

13.67 The Mater Health Services Human Research Ethics Committee ('MHS HREC'), although not commenting on the particular consent mechanisms for special medical research or experimental health care and clinical research, emphasised the importance of retaining Tribunal oversight of the participation of adults with impaired capacity in medical research. This respondent anticipated that the Victorian model<sup>1173</sup> was likely to be preferred by researchers, as it did not require the additional step of obtaining Tribunal approval. However, it considered that Tribunal oversight provided an important safeguard for adults with impaired capacity and had a slightly different focus from that of a human research ethics committee:<sup>1174</sup>

While Tribunal approval may take additional time and resources for researchers, it does provide an additional safeguard for participants, which may be especially important when adults lack capacity to give consent for themselves. The Tribunal and HRECs have some crossovers in their focuses and roles — both consider and aim to protect the well-being of adults/participants, and consider how consent may appropriately be given in certain circumstances. However, the Tribunal's special focus is on decision-making, and arrangements for decision-making, for adults with impaired capacity. Research involving adults with impaired capacity can make HRECs uncomfortable, so the additional protection and oversight offered by the Tribunal can add some comfort when approving this sort of research. Also noting that some HRECs are more thorough than others, the addition of Tribunal oversight may be especially important in those cases.

For these reasons, the MHS HREC considers the Tribunal has a worthwhile role to play in approving research.

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1171 See National Health and Medical Research Council, *National Statement on Ethical Conduct in Human Research* (2007) <<http://www.nhmrc.gov.au/files/nhmrc/file/publications/synopses/e72-jul09.pdf>> at 7 March 2010. This replaced the NHMRC's earlier statement, *National Statement on Ethical Conduct in Research Involving Humans* (1999) <<http://www.nhmrc.gov.au/files/nhmrc/file/publications/synopses/e35.pdf>> at 7 March 2010.

1172 Submission 164.

1173 See [13.43]–[13.50] above.

1174 Submission 150.

13.68 A member of a human research ethics committee who undertakes research in the field of palliative medicine commented that having Tribunal approval has proved extremely beneficial:<sup>1175</sup>

The patients are by definition very unwell ... It has been very reassuring to be able to tell relatives that we have the approval of the guardianship board when asking for consent.

### ***Consent mechanism for special medical research or experimental health care***

13.69 Several respondents commented on the appropriateness or otherwise of limiting the power to consent to an adult's participation in special medical research or experimental health care to the Tribunal.

13.70 Doctors at a forum of health professionals were of the view that the inability of the Tribunal to approve special medical research or experimental health care as a whole (as it can for clinical research) was a problem when undertaking this type of research as it required an application to be made to the Tribunal for its consent to the participation of each individual adult.<sup>1176</sup>

13.71 However, the Department of Communities commented that there should be no change to the consent requirements for participation in special medical research or experimental health care.<sup>1177</sup>

13.72 Another respondent thought it was appropriate that only the Tribunal may consent to an adult's participation in special medical research or experimental health care.<sup>1178</sup>

### ***Consent mechanism for approved clinical research***

13.73 One respondent was of the view that the Tribunal should have the power to approve clinical research (with consent being given by an adult's substitute decision-maker) and also to consent to the adult's participation in clinical research.<sup>1179</sup> That respondent was also of the view that, before approving clinical research, the Tribunal should have to be satisfied that the form for granting consent and the information about the trial provide sufficient information to enable the adult's substitute decision-maker to decide whether or not it is appropriate for the adult to take part in the trial.

13.74 The Department of Communities commented that there should be no change to the consent requirements for participation in clinical research.<sup>1180</sup>

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1175 Submission 172.

1176 Health forum 6.

1177 Submission 169.

1178 Submission 165.

1179 Ibid.

1180 Submission 169.

### **General comments**

13.75 The Queensland Centre for Intellectual and Development Disability, which is part of the University of Queensland's School of Medicine, referred to the difficulty of making 'blanket statements' about who should be able to consent to an adult's participation in medical research:<sup>1181</sup>

It is very difficult to make blanket statements about who should be able to consent, as it is very dependent on the individual research project, its potential risks and burdens. It is crucial that people with disability are not automatically excluded from research which might potentially be of benefit to them and others, but equally their vulnerability to exploitation must remain an important consideration. Many people with decision making incapacity lack the close, long standing relationships with substitute decision makers who will be able to closely and conscientiously monitor the person's likely preferences about participating in research. Therefore the person, in effect, can lose their right to withdraw from research participation once it is given.

### **The Commission's view**

#### ***Participation of adults in medical research***

13.76 Although two respondents expressed the view that it should not be possible for consent to be given for adults with impaired capacity to participate in special medical research or experimental health care, the Commission is of the view that the *Guardianship and Administration Act 2000* (Qld) should continue to include mechanisms to enable such participation to occur.

13.77 Under section 72 of the *Guardianship and Administration Act 2000* (Qld), the circumstances in which the Tribunal may consent to an adult's participation in special medical research or experimental health care are narrowly defined and include appropriate safeguards not only against the risk of detriment to the adult's health, but also against the risk of exploitation of the adult.

13.78 In particular, for special medical research or experimental health care relating to a condition that the adult has, or to which the adult has a significant risk of being exposed, it is necessary that the research or health care 'may result in significant benefit to the adult'.<sup>1182</sup> Similarly, for special medical research or experimental health care that is intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition that the adult has or has had, it is necessary that the research or health care 'may result in significant benefit to the adult or other persons with the condition'.<sup>1183</sup> Accordingly, there is a requirement that the special medical research or experimental health care is capable of benefiting the adult directly or of directly benefiting other persons with the same condition.

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1181 Submission 153.

1182 *Guardianship and Administration Act 2000* (Qld) s 72(1)(c).

1183 *Guardianship and Administration Act 2000* (Qld) s 72(2)(c).

13.79 If there were no consent mechanism in the legislation for special medical research or experimental health care, adults with impaired capacity would not have the same opportunity as adults with capacity to take part in medical research or experimental health care that could potentially be of direct benefit to them or other people with the same condition. The Commission is therefore of the view that the *Guardianship and Administration Act 2000* (Qld) should continue to include consent mechanisms for special medical research or experimental health care.

### **Consent mechanism for special medical research or experimental health care**

13.80 The Commission is satisfied that section 72 of the *Guardianship and Administration Act 2000* (Qld), which enables the Tribunal to consent to an adult's participation in special medical research or experimental health care, provides appropriate safeguards for the interests of adults with impaired capacity. That section should therefore be retained.

13.81 However, the Commission considers that, in practical terms, there is currently insufficient flexibility in the legislation for consenting to special medical research or experimental health care. Where the research involves a number of adults with impaired capacity, a separate application must be made to the Tribunal for its consent for the participation of each adult. There is no mechanism for the Tribunal to approve the research as a whole, as there is for clinical research. The different approaches for the two types of research cannot be justified on the grounds of risk or the degree of invasiveness, as some medical research that is not clinical research (for example, medical research that involves taking a blood sample from an adult) can pose less risk to the adult and be less invasive than some clinical research.

13.82 Accordingly, the *Guardianship and Administration Act 2000* (Qld) should be amended to provide an additional means for giving consent for an adult's participation in special medical research or experimental health care. The Act should provide that, in specified circumstances, the Tribunal may approve special medical research or experimental health care (as it can for clinical research). The grounds that would need to be satisfied for the Tribunal to approve the special medical research or experimental health care should be based on the grounds currently set out in section 72(1)–(2) of the *Guardianship and Administration Act 2000* (Qld).

13.83 In addition to amending the *Guardianship and Administration Act 2000* (Qld) to give the Tribunal the specific power to approve special medical research or experimental health care, section 7(d) of the definition of 'special health care' in schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended to refer to 'participation by the adult in special medical research or experimental health care *unless the special medical research or experimental health care is approved by the Tribunal under [the proposed new provision]*'. This will take approved special medical research or experimental health care out of the ambit of the definition of special health care.

13.84 The purpose of these amendments is that special medical research or experimental health care that is approved by the Tribunal will no longer constitute 'special health care'. As a result, consent for an adult's participation could be given by the adult's substitute decision-maker. This will avoid the situation where multiple applications must be made to the Tribunal in relation to the various adults participating in the one medical research project.

13.85 Of course, there may be circumstances where the complexity or seriousness of the research makes it more appropriate that consent for an adult's participation be given by the Tribunal rather than by an adult's substitute decision-maker. In that situation, the Tribunal may refuse the application for approval of the special medical research or experimental health care. For the research to proceed, it would be necessary for the Tribunal's consent for the various research participants to be sought under section 72 of the *Guardianship and Administration Act 2000* (Qld).

### ***Participation in approved clinical research***

13.86 The Commission is generally satisfied that section 13(3) of schedule 2 of the *Guardianship and Administration Act 2000* (Qld), which sets out the circumstances in which the Tribunal may approve clinical research, includes appropriate safeguards for the interests of adults with impaired capacity. However, because section 13(3)–(5) of schedule 2 deals with the Tribunal's substantive powers in relation to the approval of clinical research, rather than with matters of definition, those subsections should be omitted from schedule 2 and relocated to the body of the *Guardianship and Administration Act 2000* (Qld).<sup>1184</sup>

13.87 The Commission also considers that there are advantages in the flexibility found in the New South Wales provisions dealing with clinical trials. As discussed above, section 45AB of the *Guardianship Act 1987* (NSW) provides that, if the NSW Guardianship Tribunal is satisfied of the matters specified in section 45AA(2) (of which matters the Tribunal must be satisfied to approve a clinical trial), the Tribunal may, by order, determine that:<sup>1185</sup>

- the function of giving or withholding consent in the course of the trial is to be exercised by the persons responsible for the patients; or
- the Tribunal is to exercise that function itself.

13.88 Depending on the nature of the clinical research, the Commission considers that there may be circumstances where it would be appropriate for consent to be given by the Tribunal rather than by an adult's substitute decision-maker. The *Guardianship and Administration Act 2000* (Qld) should therefore be amended to include a provision to the general effect of section 45AB(1) of the *Guardianship Act 1987* (NSW). This will enable the Tribunal, on approving clinical research, to order that consent for an adult's participation in the research may be

<sup>1184</sup> Note, sch 2 of the *Powers of Attorney Act 1998* (Qld) does not replicate these provisions.

<sup>1185</sup> *Guardianship Act 1987* (NSW) ss 45AA, 45AB are considered at [13.38]–[13.40] above.

given by the adult's substitute decision-maker or, alternatively, for the Tribunal itself to consent to the adult's participation in the research.

13.89 At present, the scheme of the Queensland guardianship legislation is that clinical research is a subcategory of special medical research or experimental health care. However, when clinical research is approved by the Tribunal, it ceases to be special medical research or experimental health care,<sup>1186</sup> which means that it also ceases to be a category of special health care.

13.90 This will change under the Commission's proposals for clinical research. Approved clinical research will cease to be special health care only if the Tribunal orders that consent for an adult's participation in the approved clinical research may be given by the adult's substitute decision-maker. In view of this change, the definition of 'special health care' in section 7 of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended to include, as a further category of special health care, approved clinical research unless the Tribunal has ordered that consent for an adult's participation in the approved clinical research may be given by the adult's substitute decision-maker.<sup>1187</sup>

#### **Information available to substitute decision-maker**

13.91 Under section 45AB(2) of the *Guardianship Act 1987* (NSW), before the Tribunal may determine that the persons responsible for adults may consent to the adults' participation in a clinical trial, the Tribunal must be satisfied that the form for granting consent and the information available about the trial provide sufficient information to enable the persons responsible to decide whether or not it is appropriate that the adults should take part in the trial.<sup>1188</sup>

13.92 This requirement provides an additional safeguard and should be included as a requirement for the Tribunal to approve special medical research or experimental health care or to order that an adult's substitute decision-maker may give consent to the adult's participation in approved clinical research.

#### **The effect of an adult's objection**

13.93 At present, the effect of section 67(1) and (3)(b) of the *Guardianship and Administration Act 2000* (Qld) is that, if an adult objects to participation in special medical research or experimental health care or approved clinical research, the adult's objection is effective regardless of the adult's understanding of what the

<sup>1186</sup> *Guardianship and Administration Act 2000* (Qld) sch 2 s 12(2)(b); *Powers of Attorney Act 1998* (Qld) sch 2 s 12(2)(b).

<sup>1187</sup> As a result of this amendment, it is not necessary to change the reference to 'approved clinical research' in s 12(2)(b) of the definition of 'special medical research or experimental health care' in sch 2 of the *Guardianship and Administration Act 2000* (Qld) or sch 2 of the *Powers of Attorney Act 1998* (Qld).

<sup>1188</sup> *Guardianship Act 1987* (NSW) s 45AB is set out at [13.39] above.

research or health care involves or why it is required.<sup>1189</sup> The Commission agrees with this approach.

13.94 Under the Commission's proposals, special medical research or experimental health care, if approved, will be a health matter and in the absence of approval will remain a special health matter. Similarly, approved clinical research may be a special health matter or a health matter (depending on whether the Tribunal orders that consent may be given by an adult's substitute decision-maker). However, the reference in section 67(3)(b) of the *Guardianship and Administration Act 2000* (Qld) to 'participation in special medical research or experimental health care or approved clinical research' will not need to be changed. Whether, in the circumstances, consent may be given by the Tribunal or by an adult's substitute decision-maker, the approach reflected in the section remains appropriate. Accordingly, it is not necessary to amend section 67(3)(b) as a consequence of the Commission's proposals in relation to special medical research or experimental health care or approved clinical research.

## THE SCOPE OF THE DEFINITIONS OF 'HEALTH CARE' AND 'SPECIAL HEALTH CARE'

### Issue for consideration

13.95 The consent mechanism in the guardianship legislation for participation in approved clinical research is premised on the fact that the clinical research is itself 'health care' and that, when approved by the Tribunal, it does not constitute special health care.

13.96 The legislation defines 'health care' in the following terms:<sup>1190</sup>

#### 5 Health care

- (1) **Health care**, of an adult, is care or treatment of, or a service or a procedure for, the adult—
  - (a) to diagnose, maintain, or treat the adult's physical or mental condition; and
  - (b) carried out by, or under the direction or supervision of, a health provider.
- (2) **Health care**, of an adult, includes withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.

<sup>1189</sup>

*Guardianship and Administration Act 2000* (Qld) s 67(1), (3)(b). In addition, the Tribunal may not consent to an adult's participation in special medical research or experimental health care if the adult objects to the special medical research or experimental health care or the adult has in an enduring document indicated unwillingness to participate: s 72(3).

<sup>1190</sup>

*Guardianship and Administration Act 2000* (Qld) sch 2 s 5; *Powers of Attorney Act 1998* (Qld) sch 2 s 5.

- (3) **Health care**, of an adult, does not include—
- (a) first aid treatment; or
  - (b) a non-intrusive examination made for diagnostic purposes; or
  - (c) the administration of a pharmaceutical drug if—
    - (i) a prescription is not needed to obtain the drug; and
    - (ii) the drug is normally self-administered; and
    - (iii) the administration is for a recommended purpose and at a recommended dosage level.

*Example of paragraph (b)—*

a visual examination of an adult's mouth, throat, nasal cavity, eyes or ears

13.97 The legislation defines 'clinical research' and 'approved clinical research' in the following terms:<sup>1191</sup>

**13 Approved clinical research**

(1) **Clinical research** is—

- (a) medical research intended to diagnose, maintain or treat a condition affecting the participants in the research; or
- (b) a trial of drugs or techniques involving the carrying out of health care that may include the giving of placebos to some of the participants in the trial.

...

(2) **Approved clinical research** is clinical research approved by the tribunal.

13.98 Medical research of the kind referred to in subsection (1)(a) of the definition of 'clinical research' clearly falls within section 5(1)(a) of the definition of 'health care' contained in the legislation. However, although the definition of 'clinical research' includes a trial of drugs that involves the giving of a placebo, the definition of 'health care' does not expressly include either 'approved clinical research' or a trial of drugs or techniques that may include the giving of a placebo. As a result, it is not clear that the giving of a placebo (such as the injection of a saline solution) to a research participant amounts to the health care of the participant. In terms of the definition of health care in schedule 2 of the legislation, it is not strictly 'care or treatment of, or a service or a procedure ... to diagnose, maintain, or treat the adult's physical or mental condition'.

<sup>1191</sup>

*Guardianship and Administration Act 2000* (Qld) sch 2 s 13; *Powers of Attorney Act 1998* (Qld) sch 2 s 13.

## The law in other jurisdictions

13.99 The *Guardianship Act 1987* (NSW), which also provides for the approval by the Tribunal of clinical trials, avoids this problem by expressly including the giving of a placebo in the definition of 'medical or dental treatment or treatment' in section 33(1) of the Act:

***medical or dental treatment or treatment*** means:

- (a) medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by or under the supervision of a medical practitioner, or
- (b) dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a dentist, or
- (c) any other act declared by the regulations to be treatment for the purposes of this Part,

(and, in the case of treatment in the course of a clinical trial, is taken to include the giving of placebos to some of the participants in the trial), but does not include:

- (d) any non-intrusive examination made for diagnostic purposes (including a visual examination of the mouth, throat, nasal cavity, eyes or ears), or
- (e) first-aid medical or dental treatment, or
- (f) the administration of a pharmaceutical drug for the purpose, and in accordance with the dosage level, recommended in the manufacturer's instructions (being a drug for which a prescription is not required and which is normally self-administered), or
- (g) any other kind of treatment that is declared by the regulations not to be treatment for the purposes of this Part. (emphasis added)

## Discussion Paper

13.100 In the Discussion Paper, the Commission sought submissions on whether the definition of 'health care, of an adult' in schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and the *Powers of Attorney Act 1998* (Qld) should be amended to add a further subsection to the effect that 'health care, of an adult, includes participation in approved clinical research'.<sup>1192</sup>

1192

Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Discussion Paper, WP No 68 (2009) vol 1, 356.

## Submissions

13.101 One respondent commented that the definition of ‘health care, of an adult’ should be amended to include participation in approved clinical research.<sup>1193</sup>

## The Commission’s view

13.102 The Commission is of the view that, to avoid doubt, the definition of ‘health care’ in section 5 of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that health care of an adult also includes:

- clinical research; and
- special medical research or experimental health care.

13.103 The reference to ‘clinical research’, rather than to ‘approved clinical research’, is to ensure that clinical research that has not been approved is not, on that basis, beyond the regulation of the Act.<sup>1194</sup> This proposal also ensures that approved clinical research that involves the administration of a placebo will nevertheless fall within the definition of health care.

13.104 In order to avoid any doubt, the definition of ‘health care’ should also be amended to refer specifically to ‘special medical research or experimental health care’. On a literal interpretation of section 5(1) of the definition, as presently drafted, if a blood sample is taken from an adult as part of research ‘intended to gain knowledge that can be used in the diagnosis, maintenance or treatment of a condition that the adult has or has had’,<sup>1195</sup> the procedure is arguably not a procedure ‘to diagnose, maintain, or treat the adult’s physical or mental condition’, in which case it does not fall within section 5(1) of the definition.

## RECOMMENDATIONS

### ***Special medical research or experimental health care***

**13-1 Section 72 of the *Guardianship and Administration Act 2000* (Qld) should be retained.**

**13-2 The *Guardianship and Administration Act 2000* (Qld) should be amended so that the Tribunal may approve special medical research or experimental health care.**

<sup>1193</sup> Submission 165.

<sup>1194</sup> See *Guardianship and Administration Act 2000* (Qld) s 79, which applies where ‘health care’ is carried out without the necessary consent or authorisation.

<sup>1195</sup> See *Guardianship and Administration Act 2000* (Qld) s 72(2).

- 13-3 The grounds on which the Tribunal may approve special medical research or experimental health care should generally be based on the grounds mentioned in section 72(1)–(2) of the *Guardianship and Administration Act 2000* (Qld).

*Approval of clinical research*

- 13-4 Section 13(3)–(5) of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) should be omitted from the schedule and relocated to the body of the *Guardianship and Administration Act 2000* (Qld).
- 13-5 The *Guardianship and Administration Act 2000* (Qld) should be amended to include a provision to the general effect of section 45AB(1) of the *Guardianship Act 1987* (NSW).

*Information available to substitute decision-maker*

- 13-6 The *Guardianship and Administration Act 2000* (Qld) should be amended to include a provision, based generally on section 45AB(2) of the *Guardianship Act 1987* (NSW), so that, as a requirement for the Tribunal:

- (a) to approve special medical research or experimental health care; or
- (b) to order that an adult's substitute decision-maker may give consent to the adult's participation in approved clinical research

the Tribunal must be satisfied that the form for granting consent and the information available about the special medical research or experimental health care or clinical research provide sufficient information to enable the adult's substitute decision-maker to decide whether or not it is appropriate that the adult should take part in the special medical research or experimental health care or clinical research.

*Definition of 'special health care'*

- 13-7 The definition of 'special health care' in section 7 of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended as follows:
- (a) section 7(d) should be amended to refer to 'participation by the adult in special medical research or experimental health care *unless the special medical research or experimental health care is approved by the Tribunal under [the provision that gives effect to Recommendation 13-2];* and

- (b) section 7 should include, as a further category of special health care, approved clinical research unless the Tribunal has ordered that consent for an adult's participation in the approved clinical research may be given by the adult's substitute decision-maker.

***Definition of 'health care'***

**13-8** The definition of 'health care' in section 5 of schedule 2 of the *Guardianship and Administration Act 2000* (Qld) and schedule 2 of the *Powers of Attorney Act 1998* (Qld) should be amended to provide that 'health care' also includes:

- (a) clinical research; and
- (b) special medical research or experimental health care.