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## **Charting a course through difficult legislative waters: Tribunal decisions on life-sustaining measures**

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*Since the enactment in Queensland of the Powers of Attorney Act 1998 and the Guardianship and Administration Act 2000, a decision can be made to withhold or withdraw life-sustaining medical treatment from an adult who lacks capacity to make such decisions for him or herself. The Guardianship and Administration Tribunal of Queensland has been asked to consider the law in relation to these decisions on a number of occasions since the legislation was passed. This article explores the relevant provisions of these statutes and some of the difficulties that arise from how they are currently drafted. It also examines how the Guardianship and Administration Tribunal has dealt with applications to withhold or withdraw life-sustaining measures, and suggests a course that might avoid some of the difficulties that are inherent in Queensland's legislative regime.*

### **INTRODUCTION**

Decisions to withhold or withdraw medical treatment that a person needs in order to continue living have nearly always been made without recourse to the courts. Through discussion, negotiation and reflection, a person's family and medical team can usually reach agreement as to whether or not treatment should be given. On occasions, however, the issue has found its way into the judicial system,<sup>1</sup> and in Queensland, the Guardianship and Administration Tribunal (the tribunal) has jurisdiction to hear such matters<sup>2</sup> in relation to adults with impaired capacity.<sup>3</sup> Since the tribunal was

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<sup>1</sup> For a recent example, see *Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061.

<sup>2</sup> It also has jurisdiction in relation to a wide range of personal (including health) and financial matters for adults with impaired capacity: *Guardianship and Administration Act 2000* (Qld), s 82. Note also that the Supreme Court's inherent jurisdiction, including its *parens patriae* jurisdiction, is specifically preserved: *Powers of Attorney Act 1998* (Qld), s 109, and *Guardianship and Administration Act 2000* (Qld), s 240.

established in 2000, it has considered issues concerning withholding and withdrawing life-sustaining treatment on four occasions.<sup>4</sup>

These kinds of matters are likely to be brought before the tribunal where there is disagreement about the proposed treatment, either between the adult's medical team and the family,<sup>5</sup> or between the adult's family.<sup>6</sup> If the decision to withhold or withdraw treatment is being made by the adult herself or himself, depending on the circumstances, there may also be some concern regarding the adult's capacity to make the decision.<sup>7</sup> Finally, even if the family and medical team agree that treatment should be withheld or withdrawn, a health provider may be reluctant to take such action because of concerns about possible legal ramifications.<sup>8</sup>

This article considers how the tribunal makes these decisions in Queensland, starting with an examination of the relevant (and complex) legislative regime: the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld).<sup>9</sup> It then identifies anomalies in some of these provisions that may make the tribunal's task more difficult and, finally, it suggests how the tribunal might be able to chart a course through these difficult legislative waters.

To assist in examining this legislation, a recent decision of the tribunal, *Re MC* [2003] QGAAT 13, is also considered. In this case, on the application of her sons, the tribunal consented to the withholding of artificial nutrition and hydration from an 80-year-old woman, Mrs C, who was in a permanent vegetative state.<sup>10</sup>

## RELEVANT STATUTORY PROVISIONS: AN OVERVIEW

The *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld) regulate how decisions about "financial matters" and "personal matters" are made on behalf of someone with impaired capacity (referred to in this article as the "adult").<sup>11</sup> A "personal matter" includes the provision of "health care".<sup>12</sup> "Health care" is defined to include:

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>13</sup>

A "life-sustaining measure" is also defined in the legislation:

- (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.

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<sup>3</sup> This article will only consider decisions to withhold or withdraw life-sustaining measures from adults (that is, persons who are aged 18 or over: *Acts Interpretation Act 1954* (Qld), s 36) because the tribunal's jurisdiction over such decisions does not extend to children.

<sup>4</sup> *Re MC* [2003] QGAAT 13; *Re TM* [2002] QGAAT 1; *Re PVM* [2000] QGAAT 1; *Re RWG* [2000] QGAAT 2.

<sup>5</sup> Although a decision of the New South Wales Supreme Court rather than the tribunal, such a disagreement was the basis of an application by the adult's sister in *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549.

<sup>6</sup> See eg *Re TM* [2002] QGAAT 1.

<sup>7</sup> See eg *Re PVM* [2000] QGAAT 1.

<sup>8</sup> In *Re MC* [2003] QGAAT 13 the application was brought by Mrs C's sons because the treating doctor was reluctant to withdraw or withhold treatment without the express consent of the tribunal.

<sup>9</sup> This legislation also governs other people (such as statutory health attorneys or guardians) who are authorised to make decisions on behalf of an adult.

<sup>10</sup> The artificial nutrition and hydration was provided to Mrs C through a percutaneous endoscopic gastrostomy (PEG), which is a tube that goes directly into the stomach.

<sup>11</sup> *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), Sch 2, ss 1-2.

<sup>12</sup> *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), Sch 2, s 2(g).

<sup>13</sup> *Guardianship and Administration Act 2000* (Qld), Sch 2, s 5(2). This definition raises a number of difficulties that are addressed later in the article. The *Powers of Attorney Act 1998* (Qld) contains a virtually identical definition (except the word "adult" is replaced by "principal"): Sch 2, s 5(2).

(3) A blood transfusion is not a “life-sustaining measure”.<sup>14</sup>

A decision to withhold or withdraw a life-sustaining measure, therefore, may constitute a decision about health care. The legislation then establishes a decision-making regime in cases where the decision is one relating to health care. Putting aside the situation where an advance health directive has been executed,<sup>15</sup> the *Guardianship and Administration Act 2000* (Qld) sets out a list of potential decision-makers and the first person or entity in this list that applies to the particular situation will be the decision-maker:<sup>16</sup>

- a guardian appointed by the tribunal for the health matter or an order made by the tribunal about the matter;
- an attorney who has been appointed by the adult to make a decision about the matter under either an advance health directive or an enduring power of attorney;
- a statutory health attorney.

The legislation also defines who is a “statutory health attorney”. The *Powers of Attorney Act 1998* (Qld) sets out a priority list, with the statutory health attorney being the first person in the list who is “readily available and culturally appropriate” to make the decision.<sup>17</sup> The order of priority is as follows:

- a spouse of the adult if the relationship between the adult and spouse is close and continuing;<sup>18</sup>
- 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;<sup>19</sup>
- 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;
- the adult guardian.<sup>20</sup>

As well as establishing the appropriate person to provide consent for a health matter, the legislation also guides the decision-maker as to how he or she should reach a decision on behalf of the adult. Schedule 1 of both Acts sets out a number of principles that must inform these sorts of decisions. They are separated into “General Principles” and the “Health Care Principle”. The general principles apply to all decisions made under the legislation, of which withholding and withdrawing life-sustaining medical treatment is just one, and so are necessarily broad. The health care principle is used for health-related decisions only.

A final matter to note is the additional protection provided by the legislation regarding decisions to withhold or withdraw life-sustaining measures. Because of the gravity of the decision, a consent to withholding or withdrawal of a life-sustaining measure cannot operate unless the adult’s health provider “reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice”.<sup>21</sup>

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<sup>14</sup> *Powers of Attorney Act 1998* (Qld), Sch 2, s 5A; *Guardianship and Administration Act 2000* (Qld), Sch 2, s 5A. This definition specifically includes the provision of artificial nutrition and hydration to a person in a persistent vegetative state, although it is not clear whether it would extend to the hand-feeding of a patient who is in the same condition but has not lost the swallowing reflex.

<sup>15</sup> The first way in which a matter may be decided is by an advance health directive executed by the adult. This takes priority over the three potential decision-makers set out below. However, it is omitted from this list because different considerations apply when a matter is determined by an advance health directive and they are not considered further in this article.

<sup>16</sup> *Guardianship and Administration Act 2000* (Qld), s 66.

<sup>17</sup> *Powers of Attorney Act 1998* (Qld), s 63.

<sup>18</sup> “Spouse” will include de facto partners (both heterosexual and same-sex partners): *Acts Interpretation Act 1954* (Qld), s 32DA.

<sup>19</sup> The definition of “paid carer” excludes those who receive a State or Commonwealth carer payment or other similar benefit, or who are funded from compensation awarded due to the adult with impaired capacity being injured through negligence: *Powers of Attorney Act 1998* (Qld), Sch 3; *Guardianship and Administration Act 2000* (Qld), Sch 4.

<sup>20</sup> The “adult guardian” is a position that was established by the *Powers of Attorney Act 1998* (Qld) and that person is charged with the responsibility of protecting the rights and interests of adults with impaired capacity: *Guardianship and Administration Act 2000* (Qld), s 174.

<sup>21</sup> *Guardianship and Administration Act 2000* (Qld), s 66A(2).

## ROLE OF THE TRIBUNAL

As has already been discussed, it is rare for the tribunal to be involved in a decision to withhold or withdraw life-sustaining measures from an adult. Most decisions of this kind are made by someone who is close to the adult in accordance with the regime described in the previous section. The decision-maker may be a guardian appointed by the tribunal, an attorney appointed under an advance health directive or enduring power of attorney or may be a statutory health attorney. The tribunal is likely to be involved only if there is some disagreement about the proposed treatment, or if the doctor (even if agreeing with the decision to withhold or withdraw treatment) is not prepared to take such action without tribunal endorsement.

The role of the tribunal in any particular matter will depend upon why the application was brought. The applicant may be requesting that the tribunal itself consent to the withholding or withdrawal of life-sustaining measures. Alternatively (or in addition), the applicant may be seeking some kind of declaratory relief.

### Tribunal consent

If there is more than one attorney or guardian for a matter and they cannot agree on a course of treatment, one or more of them may attempt to resolve the impasse by seeking tribunal consent to withhold or withdraw the life-sustaining measure. The advantage of this course of action is that the decision is made by a statutory body after hearing all material facts and, as such, the decision is more likely to be accepted by the attorneys or guardians, family and friends. To date, the tribunal has consented to the withholding or withdrawal of life-sustaining measures in only three cases.<sup>22</sup>

### Declaratory and other relief

Another potential avenue for relief is to apply to the tribunal for a “declaration, order, direction, recommendation or advice in relation to an adult”.<sup>23</sup> This may provide assistance in a variety of cases where some uncertainty surrounds the decision to withhold or withdraw a life-sustaining measure. For example, declaratory relief may be of assistance in the following situations:

- a dispute arises between family members about who the appropriate decision-maker is in relation to a decision to withhold or withdraw life-sustaining measures;
- there is more than one decision-maker and each decision-maker arrives at a different decision when applying the General Principles and the Health Care Principle;<sup>24</sup>
- the decision-maker has consented to the withholding or withdrawal of a life-sustaining measure, but the treating health provider is not satisfied that the requirement of the legislation – that commencement or continuation of the measure would be inconsistent with good medical practice – has been satisfied.<sup>25</sup>

*Re MC* [2003] QGAAT 13 is illustrative of this last point. In that case, the application for tribunal consent was made by Mrs C’s sons because the health provider was reluctant to withhold or withdraw artificial hydration and nutrition without such consent (at [9]).<sup>26</sup> As mentioned, a consent to the withholding or withdrawal of a life-sustaining measure cannot operate “unless the adult’s health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice”.<sup>27</sup> A declaration by the tribunal that, in the circumstances

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<sup>22</sup> *Re MC* [2003] QGAAT 13; *Re TM* [2002] QGAAT 1; and *Re RWG* [2000] QGAAT 2.

<sup>23</sup> *Guardianship and Administration Act 2000* (Qld), s 115.

<sup>24</sup> This could occur if two relatives are statutory health attorneys under s 63(1) of the *Powers of Attorney Act 1998* (Qld), or the adult has appointed two attorneys under an advance health directive or enduring power of attorney.

<sup>25</sup> The health provider may not act upon a consent unless he or she is satisfied of this requirement: *Guardianship and Administration Act 2000* (Qld), s 66A.

<sup>26</sup> In that case, one of Mrs C’s sons had been appointed her attorney for health matters so he was authorised to consent to the withdrawal, but the health provider was not prepared to act on that consent.

<sup>27</sup> *Guardianship and Administration Act 2000* (Qld), s 66A(2).

of that case, continuing treatment would be inconsistent with good medical practice would have provided appropriate relief.<sup>28</sup>

## TRIBUNAL CONSENT: THE DECISION-MAKING PROCESS

If the application is for the tribunal, as a potential decision-maker under the legislation,<sup>29</sup> to give its consent to withholding or withdrawing a life-sustaining measure, there is a range of issues that must be considered before providing that consent. These issues, which will be examined in turn, may also be relevant to a tribunal providing declaratory relief, if the declaration sought requires a determination of some or all of these issues.

### Adult lacks capacity

A decision about a health matter can only be made on behalf of an adult if the adult no longer has capacity to make that decision for herself or himself. The starting point is a presumption that an adult has capacity to decide a matter.<sup>30</sup> “Capacity” is defined in the legislation in the following terms:

“Capacity”, for a person for a matter, means the person is capable of –

- (a) understanding the nature and effect of decisions about the matter; and
- (b) freely and voluntarily making decisions about the matter; and
- (c) communicating the decisions in some way.<sup>31</sup>

A crucial issue for the tribunal in every case is whether the presumption of capacity has been rebutted. When considering General Principle 1, which provides that an adult is presumed to have capacity for a matter, Ambrose J in *Re Bridges* [2001] 1 Qd R 574 at 583 commented in the following terms:

That does not mean it is an irrebuttable presumption that she has capacity. In my view, on a proper construction of the Act, that presumption is rebuttable.<sup>32</sup>

It is frequently the case that the issue of the adult’s (lack of) capacity is not in dispute. In *Re MC* [2003] QGAAT 13, for example, Mrs C was in a permanent vegetative state and her condition would not improve (at [37]), so it was clear that she lacked capacity to make decisions about her health care.

By contrast, the issue of capacity was squarely before the tribunal in *Re PVM* [2000] QGAAT 1. In that case, Mr M’s wife applied to the tribunal seeking, amongst other things, the tribunal’s consent to remove Mr M’s ventilation. Mr M had sustained traumatic brain injury and spinal chord injury after a severe fall. As a result of his injuries, he had difficulty communicating. His wife claimed that, on a previous occasion, her husband had given her clear instructions that he did not wish to be put on a ventilator, and that he still did not want this course of action.<sup>33</sup> However, there was conflicting evidence before the tribunal as to whether or not Mr M had capacity to make a decision about withholding his ventilation.

The intensive care specialists (one of whom was the director of the unit in which Mr M was being treated) were of the view that Mr M had capacity to decide about treatment, while the

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<sup>28</sup> The actual order of the tribunal was to consent to the withholding of a life-sustaining measure to Mrs C, as sought by the application of her sons. In its reasons, the tribunal noted the existence of various guidelines which suggested that discontinuing treatment in Mrs C’s case would be consistent with good medical practice.

<sup>29</sup> *Guardianship and Administration Act 2000* (Qld), s 66A.

<sup>30</sup> *Guardianship and Administration Act 2000* (Qld), s 7(a). General Principle 1 (*Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), Sch 1) has also been cited as authority for this point (eg, *Re Bridges* [2001] 1 Qd R 574) although reliance on this section may be problematic because the General Principles only apply to decisions where there is “an adult with impaired capacity” for a matter: *Guardianship and Administration Act 2000* (Qld), s 11. The difficulty that this raises is that this presumption of capacity in the General Principles could only operate once the adult has been found to have impaired capacity for the relevant decision. Section 7(a) of the *Guardianship and Administration Act 2000* (Qld) avoids this problem, however, as the presumption of capacity in that provision is not connected with an assessment of impaired capacity.

<sup>31</sup> *Powers of Attorney Act 1998* (Qld), Sch 3; *Guardianship and Administration Act 2000* (Qld), Sch 4.

<sup>32</sup> Cited in *Re PVM* [2000] QGAAT 1 at [37].

<sup>33</sup> As the applicant was of the view that the adult, Mr M, had capacity to consent to the withdrawal of ventilation, perhaps the more appropriate relief to seek would have been a declaration about the adult’s capacity, rather than an application for the tribunal’s consent to withdraw the ventilation.

psychiatrists who assessed Mr M concluded that he lacked capacity. The tribunal was more persuaded by the evidence of the intensive care specialists because they were experienced in dealing with patients who had difficulties in communication. On the other hand, the psychiatrists had more limited contact with Mr M and were not specialised in communicating with people in Mr M's condition. It was also relevant to the tribunal that the intensive care specialists were more certain of their diagnosis of capacity than were the psychiatrists.

Differing views concerning Mr M's capacity were also held by his family. Mr M's mother, wife and two of his sisters felt that he had capacity, while some other family members did not. The tribunal was more persuaded by the evidence of those closest to Mr M, namely his mother and wife, both of whom were confident of Mr M's capacity to make the decision. In finding that Mr M was capable of making a decision about whether his ventilation should continue or not, the tribunal held that the presumption of capacity had not been rebutted.

The definition of "capacity" in the *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld) is consistent with how this issue has been treated at common law so it may be appropriate, in some circumstances, for the tribunal to obtain guidance from some of the common law cases. A first similarity is that, as is the case under the legislation, at common law a person is presumed to have capacity to make a decision about a matter.<sup>34</sup>

Second, the capacity that is required at common law varies with the nature of the decision to be made. The graver the consequences of the decision, the higher the adult's capacity must be.<sup>35</sup> This is illustrated well by the case of *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449. B was a 41-year-old woman who was a tetraplegic and suffered complete paralysis from the neck down. She wanted to be taken off life-sustaining measures but the hospital would not agree. B was forced to apply for declaratory relief that the hospital's actions constituted an assault because they were treating her without consent. Before it could grant the relief sought, the Family Division had to assess whether B had capacity to make this decision and concluded that she did. However, as her decision to withdraw treatment had grave consequences, the capacity needed to make this decision was correspondingly high.

This same approach is likely to be taken under the legislation. Paragraph (a) of the definition of "capacity" requires that a person be capable of understanding the nature and effect of decisions about the matter. Where the consequence of the decision is particularly serious, the tribunal is likely to require convincing evidence that the adult understands the nature and effect of the decision. In *Re PVM* [2000] QGAAT 1, for example, the tribunal received evidence from many health providers and family members about the adult's capacity. This evidence was assessed very carefully before the tribunal was prepared to find that the adult had sufficient capacity to make the decision.

A third similarity is that a person is only regarded as having capacity at common law if he or she is able to make a decision about a health matter freely and voluntarily. This is not satisfied if the will of the adult is overborne. In *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, for example, T was a young woman who had been in an accident. Her condition deteriorated and she needed a blood transfusion. After a meeting with her mother, a Jehovah's Witness, T declined any treatment that involved blood products. The English Court of Appeal held that T's decision was not her own, but one reached because her will was overborne by that of her mother. In effect, the court held that the undue influence of her mother meant that T lacked capacity to decide to refuse blood products. This common law approach is reflected in para (b) of the definition of "capacity" in Queensland's legislation.

A fourth similarity with the common law is that the legislative definition of capacity for a matter is contingent upon the ability to communicate the decision. At common law, a similar view prevails although a distinction has been made between capacity and competence. In the recent decision of *R (on application of Burke) v General Medical Council* [2004] EWHC 1879 (Admin), Munby J explained that a patient may have mental capacity to make a decision but may still be regarded as incompetent because the patient lacks the ability to communicate her or his views (at [41]-[45]). Accordingly, at common law a "patient suffering the mental torture of Guillain-Barré syndrome,

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<sup>34</sup> *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 at 457.

<sup>35</sup> *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 at 472.

rational but trapped and mute in an unresponsive body” (at [45]), would be considered *incompetent* to make a decision about their health care. Under the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld), such a person would be regarded as having *impaired capacity* for a matter. Although different terms are used, the result is, of course, the same, with a person who is unable to communicate a decision being incapable of making it.

### **Whether the matter constitutes “health care”**

The tribunal has been given the power to consent to the withholding or withdrawal of a life-sustaining measure for adults with impaired capacity.<sup>36</sup> The scope of this power is constrained, however, by a series of rather awkward definitions in the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld), which require the tribunal to consider certain issues.

The part of the definition of “life-sustaining measures” that is relevant here is that it must be “health care”.<sup>37</sup> However, the meaning of that term presents difficulties because its definition states that withholding or withdrawing a life-sustaining measure constitutes health care under the legislation “if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice”.<sup>38</sup> The logical corollary of this is that withholding or withdrawing a life-sustaining measure where the commencement or continuation is consistent with good medical practice would *not* constitute “health care” under the legislation. The outcome of this is that, if treatment is not health care, it cannot be a “life-sustaining measure” for which the tribunal is empowered to consent to withhold or withdraw.<sup>39</sup>

Accordingly, for the tribunal to consent to withholding or withdrawing the life-sustaining measure, it would have to satisfy itself that such a decision was about health care, which, because of the definition discussed, means that it must conclude that continuing or commencing the measure for the adult would be inconsistent with good medical practice. Therefore, the tribunal would need to hear medical evidence about what constitutes good medical practice in the circumstances of the case before it.

In *Re MC* [2003] QGAAT 13 the tribunal received both verbal and written evidence about what constituted appropriate treatment for Mrs C. This included evidence from medical practitioners as well as empirical research and academic literature about appropriate medical treatment for patients in a permanent vegetative state. The tribunal also considered the guidelines in New Zealand and the United Kingdom that assist health providers in making decisions about treatment.<sup>40</sup> Although the tribunal was of the view that it did not need to determine whether continuing artificial hydration and nutrition was inconsistent with good medical practice (at [51]), it spent some time considering this issue and concluded that, on the facts of the case, it was in accordance with good medical practice to discontinue treatment that was burdensome and futile (at [65]).

If the tribunal is asked to consent to the withholding or withdrawal of life-sustaining measures, it must satisfy itself that such a decision is one about “health care”. As the definition of “health care” is currently drafted, this would require the tribunal to determine whether commencing or continuing the treatment is inconsistent with good medical practice. Only if this is answered in the affirmative will a decision to withhold or withdraw constitute “health care”, and the tribunal then is able to consider whether it should consent to its withholding or withdrawal.

### **Consideration of General Principles and Health Care Principle**

In deciding whether to consent to withhold or withdraw a life-sustaining measure, the tribunal must consider both the General Principles and Health Care Principle that are set out in Sch 1.<sup>41</sup>

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<sup>36</sup> *Guardianship and Administration Act 2000* (Qld), s 82(1)(f).

<sup>37</sup> *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), Sch 2, s 5A.

<sup>38</sup> *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), Sch 2, s 5(2).

<sup>39</sup> *Guardianship and Administration Act 2000* (Qld), s 82(1)(f).

<sup>40</sup> At the conclusion of its reasons for decision, the tribunal observed that it would be of assistance to those who had to make decisions about withholding and withdrawing life-sustaining measures for the Australian Medical Association to produce a comprehensive set of guidelines to assist the decision-making process: *Re MC* [2003] QGAAT 13 at [71].

<sup>41</sup> *Guardianship and Administration Act 2000* (Qld), s 11(1).

### General Principles

A number of the 11 General Principles (GP) may be relevant to a decision to withhold or withdraw life-sustaining measures, depending on the facts of the particular case. The following principles, in particular, may be relevant to this kind of health decision:

- GP2(1): “The right of all adults to the same basic human rights regardless of a particular adult’s capacity must be recognised and taken into account.”

It is beyond question that a competent adult is entitled to decide to withhold or withdraw life-sustaining measures<sup>42</sup> and it could be argued that GP2(1) supports the view that an adult who lacks capacity should be entitled to the same choices.

- GP3: “An adult’s right to respect for his or her human worth and dignity as an individual must be recognised and taken into account.”
- GP7(4): “Also, the principle of substituted judgment must be used so that if, from the adult’s previous actions, it is reasonably practicable to work out what the adult’s views and wishes would be, a person ... must take into account what the person ... considers would be the adult’s views and wishes.”<sup>43</sup>
- GP9: “The importance of maintaining an adult’s cultural and linguistic environment, and set of values (including any religious beliefs), must be taken into account.”

This principle may be relevant if, for example, the adult has particular religious beliefs which prohibit certain treatment being given.

- GP10: “Power for a matter should be exercised by a guardian or administrator for an adult in a way that is appropriate to the adult’s characteristics and needs.”

It is foreseeable that this principle could be relevant in a decision about life-sustaining measures. Indeed, if the decision is to be made by a guardian appointed by the tribunal for the purpose, the guardian must take these factors into consideration. However, the wording of the provision would suggest that it will only apply if the consent is given by a guardian rather than the tribunal.<sup>44</sup> Although the tribunal is not directed to consider the adult’s characteristics and needs under GP10, it is submitted that these kinds of issues will nevertheless be relevant in an assessment of substituted judgment (GP7(4)) and what is “necessary and appropriate” to maintain or promote the adult’s health or wellbeing (HCP12(1)(b)(i)).

Some of these principles were considered by the tribunal in *Re MC* [2003] QGAAT 13. It placed particular weight (at [67]-[68]) on considerations of Mrs C’s human worth and dignity in the context of being provided with futile treatment (GP3) and the principle of substituted judgment (GP7(4)).

### Health Care Principle

The legislation also requires the Health Care Principle (HCP) to be considered in any decision about a health matter.<sup>45</sup> It will therefore be considered by the tribunal in determining whether to consent to withdraw or withhold a life-sustaining measure. The HCP is as follows:<sup>46</sup>

#### 12 Health Care Principle

- (1) The “health care principle” means that power for a health matter for an adult should be exercised by an attorney –
  - (a) in the way least restrictive of the adult’s rights; and
  - (b) only if the exercise of power –

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<sup>42</sup> *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 at 472.

<sup>43</sup> Note, however, that a person must exercise a power under the legislation in a way consistent with the adult’s proper care and protection: GP7(5).

<sup>44</sup> See also the equivalent wording in GP10 in Sch 1 of the *Powers of Attorney Act 1998* (Qld) where reference is made only to “attorney”, not to the tribunal.

<sup>45</sup> *Guardianship and Administration Act 2000* (Qld), s 11.

<sup>46</sup> *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld), Sch 1, Pt 2. The Health Care Principle in Sch 1 of the *Guardianship and Administration Act* includes a further provision that relates to special health care. This has not been reproduced as is not relevant for the purposes of this article.

- (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.

Example of exercising power in the way least restrictive of the adult's rights –

If there is a choice between a more or less intrusive way of meeting an identified need, the less intrusive way should be adopted.

- (2) In deciding whether the exercise of a power is appropriate, the ... Tribunal... must, to the extent practicable –
  - (a) seek the adult's views and wishes and take them into account; and
  - (b) take the information given by the adult's health provider into account.
- (3) The adult's views and wishes may be expressed –
  - (a) orally; or
  - (b) in writing, for example, in an advance health directive; or
  - (c) in another way, including, for example, by conduct.
- (4) The health care principle does not affect any right an adult has to refuse health care.

A number of comments can be made about HCP12. First, the power to make a decision must be exercised in the way least restrictive of the adult's rights. This principle was applied by the tribunal in *Re MC* [2003] QGAAT 13 in the context of the provision of artificial hydration and nutrition through a PEG.<sup>47</sup> The tribunal held (at [64]) that treatment of this kind was not the least restrictive option, because it was intrusive, futile and burdensome.<sup>48</sup> This was the conclusion even though the only alternative treatment option, the cessation of the PEG feeding, would result in Mrs C's death.<sup>49</sup>

Second, the tribunal must exercise the power only if it is satisfied that one of the conditions in HCP(1)(b) is met. The exercise of the power must *either* be necessary and appropriate to maintain or promote the adult's health or wellbeing *or*, in all the circumstances, in the adult's best interests.<sup>50</sup>

Third, the drafting of HCP12 raises an interesting point concerning the extent to which the tribunal is required to consider the adult's views and wishes and the information provided by the health provider as referred to in HCP12(2). This provision requires the tribunal to consider these factors in "deciding whether the exercise of a power is *appropriate*". The term "appropriate" is used in HCP12(1)(b)(i) but not in HCP12(1)(b)(ii) which refers to the adult's "best interests". This raises the question of whether the matters referred to in HCP12(2) are relevant only where the tribunal exercises its power under HCP12(1)(b)(i) (necessary and appropriate), or are also relevant when it exercises its power under HCP12(1)(b)(ii) (in the adult's best interests).

There is a strong case to suggest that the factors in HCP12(2) are relevant only where the exercise of the power is "necessary and appropriate" in HCP12(1)(b)(i). From a statutory interpretation perspective, if a section uses a word twice in the one provision, it is presumed to have the same meaning at both places.<sup>51</sup> The effect of this presumption would be that the use of the word "appropriate" in HCP12(2) is a reference to the same word in HCP12(1)(b)(i). This would mean that the factors listed under HCP12(2) are not specifically required to be considered when deciding upon the exercise of power in an adult's best interests under HCP12(1)(b)(ii). This interpretation is given additional weight when the original drafting of HCP12 is considered. Originally, HCP12(1)(b) referred only to the exercise of power that was "necessary and appropriate", the term "appropriate" being defined in HCP12(2). The provision referring to an "adult's best interests" was inserted later,<sup>52</sup>

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<sup>47</sup> See above n 10.

<sup>48</sup> The tribunal also cited the decision of the New South Wales Supreme Court in *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 to support this view.

<sup>49</sup> See also *Re TM* [2002] QGAAT 1 at [164]-[165].

<sup>50</sup> Compare *Re MC* [2003] QGAAT 13 at [55] where the tribunal considered the best interests test to be a test that had to be satisfied in deciding on a health matter.

<sup>51</sup> See eg *Wilson v Commissioner of Stamp Duties* (1986) 6 NSWLR 410 at 418-419.

<sup>52</sup> By the *Guardianship and Administration and Other Acts Amendment Act 2001* (Qld), s 16.

which suggests that the reference to “appropriate” in HCP12(2) was not designed to apply to HCP12(1)(b)(ii).

It is conceded, however, that despite these interpretation difficulties, the current drafting of HCP12 may not cause many difficulties in practice. This is because it may already be the case, as the law is currently drafted, that both an adult’s views and wishes and information from the adult’s health provider should be considered when assessing best interests under HCP12(1)(b)(ii). At common law, the determination of best interests is strongly driven by the views of the treating doctor and also includes considering what an adult wants (or would have wanted).<sup>53</sup> Further, an adult’s views and wishes must be considered under GP7(4), already discussed.

A related fourth comment is that the reference to “best interests”, which is not defined in the legislation, is likely to import the meaning developed by a body of cases at common law.<sup>54</sup> Indeed, in *Re MC* [2003] QGAAT 13, after noting the best interests test under the legislation, the tribunal then referred to relevant common law cases (at [56]-[62]). It is beyond the scope of this article to consider the meaning of “best interests” at common law, but it has developed beyond factors such as medical issues regarding prognosis and treatment to include other factors such as the views and wishes of the adult and possibly the adult’s relatives.<sup>55</sup>

#### *A conflict of Principles*

Finally, the difficulties that may be encountered by the tribunal if some of the Principles suggest one course of action while others suggest a different approach. For example, there may be clear and undisputed evidence that an adult would not have wanted to be kept alive by artificial means but, in the circumstances of the case, continued treatment was regarded as being in the adult’s best interests. A conflict of principles can arise because GP7(4) requires the tribunal to consider the principle of substituted judgment while HCP12(1)(b)(ii) refers to the adult’s best interests. The legislation does not provide guidance as to which of the Principles should have priority in determining the appropriate decision. This may raise difficulties because it means that the tribunal must make a value judgment about which Principle to give priority to in a particular situation.

#### **Relevance of good medical practice**

If an adult has impaired capacity, as discussed above, the tribunal (or another person or entity) may give consent for withholding or withdrawing life-sustaining measures from that adult. Under s 66A of the *Guardianship and Administration Act 2000* (Qld), however, that consent is subject to the constraint that it cannot “operate unless the adult’s health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice”.<sup>56</sup> This safeguard was designed to prevent inappropriate decisions by empowering the treating health care professional to prevent that consent from taking effect unless the decision is also medically appropriate.

If an application is made to the tribunal to obtain its consent to the withholding or withdrawal of a life-sustaining measure, technically the tribunal would not have to make a determination about good medical practice pursuant to s 66A(2). This is a matter for determination by the health provider, not by the person or entity providing consent. Indeed, this was the view taken by the tribunal in *Re MC* [2003] QGAAT 13 at [51]-[52].

However, it is submitted that there are two reasons that it may be desirable (or possibly necessary) for a tribunal to make a determination about whether commencing or continuing the life-sustaining measure would be inconsistent with good medical practice. The first reason is a practical rather than a legal one. If the application to the tribunal is because the health provider is reluctant to withhold or withdraw the measure without tribunal consent, then the provision of that consent of itself may not solve the difficulty encountered by the health provider. This is because, notwithstanding

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<sup>53</sup> See eg *Airedale NHS Trust v Bland* [1993] AC 789; *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235; *Re G* [1997] 2 NZLR 201.

<sup>54</sup> *Ibid.*

<sup>55</sup> See eg the often-quoted statement by Butler-Sloss P in *Re A (Male Sterilisation)* [2000] 1 FLR 549 at 555: “best interests encompasses medical, emotional and all other welfare issues.”

<sup>56</sup> *Guardianship and Administration Act 2000* (Qld), s 66A(2).

tribunal consent, the health provider must still be satisfied in relation to good medical practice under s 66A(2). The health provider's concerns will only be addressed if the tribunal makes a declaration in relation to good medical practice.<sup>57</sup>

The second reason why the tribunal may need to consider good medical practice is the definition of "health care" in the context of withholding or withdrawing life-sustaining measures. As discussed, such a decision only constitutes health care if the commencement or continuation of the measure would be inconsistent with good medical practice. Before the tribunal can consent, it must satisfy itself that the proposed treatment is health care which requires a finding to be made in relation to good medical practice.

### Potential criminal responsibility

Withholding or withdrawing life-sustaining measures can potentially have criminal law implications. A doctor or other health provider who fails to provide medical treatment needed to stay alive may breach s 285 of the *Criminal Code 1899* (Qld), which imposes a duty on certain individuals to provide the "necessaries of life". A failure to provide such necessaries will result in the health provider being deemed to have caused the consequences of that failure.<sup>58</sup> In this context, that consequence would be the death of the patient, and that killing would be unlawful unless it was authorised, justified or excused by law.<sup>59</sup>

The tribunal (and other decision-makers), in consenting to the withholding or withdrawing of life-sustaining measures, may encounter difficulties as there is tension between the criminal law as discussed and the consent mechanism created by the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld). This tension is made explicit by s 284 of the *Criminal Code*, which provides that consent by a person to their own death does not affect the criminal responsibility of any person by whom such death is caused. Interestingly, the *Powers of Attorney Act* and the *Guardianship and Administration Act* specifically provide that nothing in these Acts authorises, justifies or excuses the killing of a person, or affects s 284 of the *Criminal Code*.<sup>60</sup>

The potential criminal liability that could arise when consenting to withholding or withdrawing life-sustaining measures was recognised by the tribunal in *Re RWG* [2000] QGAAT 2 at [55]:

This issue of whether life-sustaining treatment can be withheld from a patient with impaired capacity is also further complicated by the fact that health care professionals have certain duties under the *Criminal Code* which essentially require that a person having charge of another is required to provide that person with the necessaries of life if the person is unable to do so for himself because of sickness or unsoundness of mind or age.

This relationship between the *Criminal Code* and the *Powers of Attorney Act* and the *Guardianship and Administration Act* is unsatisfactory. However, it is submitted that there are two possible bases upon which it can be argued that withholding or withdrawal of life-sustaining measures pursuant to consent obtained under the *Powers of Attorney Act* or the *Guardianship and Administration Act* will not involve criminal responsibility.

### Consent renders withholding or withdrawal lawful

At common law, a "mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death".<sup>61</sup> This also represents the law in Queensland.<sup>62</sup> The rationale for this is that in such cases, the principle of self-determination prevails over the sanctity of human life.<sup>63</sup>

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<sup>57</sup> As discussed, the tribunal has power to provide a declaration: *Guardianship and Administration Act 2000* (Qld), s 115.

<sup>58</sup> *Criminal Code 1899* (Qld), s 285.

<sup>59</sup> *Criminal Code 1899* (Qld), s 291.

<sup>60</sup> *Powers of Attorney Act 1998* (Qld), s 37; *Guardianship and Administration Act 2000* (Qld), s 238.

<sup>61</sup> *Re MB (Medical Treatment)* [1997] 2 FLR 426 at 432 per Butler-Sloss LJ. See also *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449.

<sup>62</sup> *Re RWG* [2000] QGAAT 2 at [54]-[55]. In this case, the tribunal concluded that this was the common law in Queensland and also drew on the provisions of the *Guardianship and Administration Act 2000* (Qld).

<sup>63</sup> *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449; *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649.

Although that is clearly the law, the issue of how this fits within the criminal law framework remains and this is an issue that some judges have addressed. A good example is Lord Browne-Wilkinson in *Airedale NHS Trust v Bland* [1993] AC 789 at 882-883:

A mentally competent patient can at any time put an end to life support systems by refusing his consent to their continuation. In the ordinary case of murder by positive act of commission, the consent of the victim is no defence. But where the charge is one of murder by omission to do an act and the act omitted could only be done with the consent of the patient, refusal by the patient of consent to the doing of such act does, indirectly, provide a defence to the charge of murder. The doctor cannot owe to the patient any duty to maintain his life where that life can only be sustained by intrusive medical care to which the patient will not consent.

Although *Bland* is a decision on the common law, a similar argument could be made in Queensland. Providing a competent patient with life-sustaining measures even after consent has been withdrawn would mean that the health provider will be committing an assault under s 246 of the *Criminal Code*. The argument would follow that although s 284 provides that criminal responsibility is not affected if a person consents to her or his own death, that provision cannot have application to the case of a competent refusal of life-sustaining measures.<sup>64</sup>

If this argument is correct, then the legal position must be the same for adults with impaired capacity, for whom decisions are made on their behalf under the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld). This is because the legislation specifically provides that if a health provider carries out health care that is authorised under the legislation, he or she 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”.<sup>65</sup> Accordingly, if no criminal liability attaches to a decision to withhold or withdraw life-sustaining measures from a competent patient, consent given by the tribunal under the *Powers of Attorney Act* and the *Guardianship and Administration Act* for an adult with impaired capacity will also absolve health care professionals of criminal responsibility.

### *Not a necessary of life*

A second line of argument as to why withholding or withdrawing life-sustaining measures does not attract criminal responsibility is that it does not breach the duty created by s 285 of the *Criminal Code*.<sup>66</sup> That section imposes a duty on a health provider to provide “necessaries of life” to a patient under her or his control. However, if the treatment (in this case, a life-sustaining measure) is not a necessary of life, the health provider is not under a duty to provide it.

Although there has been some suggestion that whether or not treatment will be regarded as a “necessary of life” will depend on the nature of the treatment,<sup>67</sup> it is suggested that terms such as “extraordinary measures” should be avoided. Rather, a preferred approach is to assess whether the treatment, in the actual circumstances of the particular case (having regard to the patient’s condition and prognosis), can appropriately be called a necessary of life.

This was an issue addressed by Thomas J in *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235.<sup>68</sup> In considering whether a ventilator was a necessary of life for a man who suffered from Guillain-Barré syndrome and who was “beyond recovery”, Thomas J said (at 249-250):

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

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<sup>64</sup> There are problems, however, with such an argument. For example, it could be argued that s 284 is clearly the more specific of the two provisions (and appears later in the Act) and so should take precedence in the case of conflict.

<sup>65</sup> *Guardianship and Administration Act 2000* (Qld), s 80. Note also s 79 of the *Guardianship and Administration Act 2000* (Qld) which provides (like *Criminal Code*, s 246) that if a health care professional treats an adult with impaired capacity without consent, then he or she has committed an offence.

<sup>66</sup> This section was discussed in *Re RWG* [2000] QGAAT 2 at [55] (see above).

<sup>67</sup> Some writers have suggested that whether treatment was a necessary of life or not depended on whether it was an “extraordinary measure”: MacFarlane P and Reid S, *Queensland Health Law Handbook* (14th ed, Goprint, Brisbane 2004). This view was also noted by the tribunal in *Re RWG* [2000] QGAAT 2 at [56].

<sup>68</sup> The provision considered was s 151 of New Zealand’s *Crimes Act 1961* (NZ), which imposes a similar duty to s 285 of the *Criminal Code* (Qld).

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.

Thomas J went on to say, however, that artificial ventilation could be construed as a necessary of life in appropriate circumstances (at 250). The example given is where a patient needs this interim support so as to enable her or him to recover from an illness, in which case such treatment would be a necessary of life. Accordingly, the question of whether or not treatment is a necessary of life is best answered not by reference to the treatment itself but to the circumstances in which it is applied. It is suggested that in a case like *Re MC*,<sup>69</sup> it would be open to the tribunal to declare that the artificial hydration and nutrition being provided to Mrs C, who was also “beyond recovery”, was not a necessary of life and therefore there was no duty to provide it.

As discussed, liability arises under s 285 because, by breaching the duty to provide necessities of life, the health care professional is deemed to have caused the consequences of that breach. However, the effect of a declaration by the tribunal that the treatment is not a necessary of life would be that the duty has not been breached. Accordingly, the health provider has not caused the death and would not be criminally responsible.

Although these two alternative bases are available, it is clear that the relationship between the *Criminal Code* and the *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld) is an awkward one. However, it is suggested that the tribunal should be able to navigate these difficulties through one or possibly both of the avenues described above.

## CONCLUSION

When a matter concerning the withholding or withdrawal of life-sustaining measures comes before the tribunal, the relief granted (if any is granted) will depend on the particular reason why the matter came before the tribunal. Depending on the circumstances of the case, the tribunal may consent to the proposed withholding or withdrawal; or alternatively, may give declaratory relief about who is the appropriate decision-maker, whether particular treatment could be regarded as being inconsistent with good medical practice, or whether an adult has capacity to make a decision about a matter.

If the tribunal is being asked to consent to withholding or withdrawing a life-sustaining measure, it needs to consider a number of issues:

1. The tribunal must assess whether the adult herself or himself has capacity to consent to the withholding or withdrawal. Tribunal consent can only be given on an adult's behalf if incapacity has been established.
2. Consent can only be given by the tribunal if the withholding or withdrawal constitutes “health care” as defined in the legislation. It will only be health care if continuing or commencing the life-sustaining measure would be inconsistent with good medical practice. If this is not satisfied, the proposed treatment will not be health care and the tribunal will be unable to provide consent.
3. In exercising its discretion, the tribunal will need to consider the General Principles and the Health Care Principle listed in Sch 1. Of particular importance will be a consideration of the adult's dignity, what the adult's likely views and wishes would be, relevant medical information about the adult's condition and prognosis, what is least restrictive of the adult's rights and, possibly, what would be in the adult's best interests. Because the legislation does not provide guidance as to which of these Principles is more important, in some cases the tribunal may be required to make an assessment of which of them should be given particular emphasis.
4. Depending on the reason for seeking consent of the tribunal, it may be prudent to grant declaratory relief regarding whether commencing or continuing the measure would be inconsistent with good medical practice. A health provider is unable to act on tribunal consent unless satisfied that this is the case. Where the medical evidence is equivocal, the tribunal might be minded to provide declaratory relief in relation to good medical practice, in addition to providing consent to withhold or withdraw the measure. Indeed, as the tribunal is required to

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<sup>69</sup> As noted above, there was some discussion of this issue in *Re RWG* [2000] QGAAT 2 at [55]-[57].

make a determination of this issue in assessing whether the withholding or withdrawal constitutes "health care", the tribunal would not have to undertake any further inquiry to provide such declaratory relief.

5. Finally, the tribunal may wish to comment on the implications of its decision (if consent is granted) in relation to potential criminal responsibility under the *Criminal Code*. Although the issue is not beyond doubt, the authors are of the view that tribunal consent alone is sufficient to ensure criminal responsibility does not attach to a health provider who withholds or withdraws a life-sustaining measure where the adult subsequently dies. To put the matter beyond doubt, the tribunal may be able to comment on whether, in the circumstances of the case, the measure could be regarded as a necessary of life under s 285 of the *Criminal Code*.

The tribunal has, to date, heard only four cases involving withholding or withdrawing life-sustaining measures and it is suggested that the decisions reached in all of those cases were sensible ones. However, it is clear from the foregoing discussion that the task of the tribunal in hearing these matters is a difficult one. In addition to the challenging ethical and medical issues raised by such decisions, there are also a number of legal problems. The *Powers of Attorney Act 1998* (Qld) and the *Guardianship and Administration Act 2000* (Qld) are complex pieces of legislation and their operation sometimes produces results that are perhaps unforeseen and unintended.<sup>70</sup> This article addresses some of those difficulties in the legislation and suggests how the tribunal might wish to proceed when dealing with those statutory problems.

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<sup>70</sup> It is beyond the scope of this article to comment on these difficulties. However, for a detailed examination of some of the problems in the legislative regime as it relates to decisions to withdraw or withhold life-sustaining measures, see the following research issues paper: White B and Willmott L, *Rethinking Life-sustaining Measures: Questions for Queensland*, available at [http://eprints.qut.edu.au/archive/00007093/01/7093\\_1.pdf](http://eprints.qut.edu.au/archive/00007093/01/7093_1.pdf)