WILL YOU DO AS I ASK? COMPLIANCE WITH INSTRUCTIONS ABOUT HEALTH CARE IN QUEENSLAND

BEN WHITE AND LINDY WILLMOTT*

I INTRODUCTION

At common law, a competent patient is entitled to refuse medical treatment, even if doing so will result in ending his or her life.[1] This entitlement is underpinned by the right to self determination. Accordingly, there is no requirement to show that the reasons for refusing the treatment are rational or reasonable. A patient's body is his or her own and he or she may refuse or accept treatment as desired. This right to refuse medical treatment extends to the situation where a patient loses capacity but has previously stated very clearly that they wish not to have certain treatment.[2]

In Queensland, decisions about the health care[3] of those with impaired capacity are governed by a legislative scheme comprised of the *Powers of Attorney Act 1998* (Qld) (*PAA*) and the *Guardianship and Administration Act 2000* (Qld) (*GAA*). Although the scheme establishes a comprehensive process for this sort of decision making, it specifically provides for some recognition of the common law as just outlined. Section 39 of the *PAA* states: "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." An advance health directive is one of the decision making mechanisms established under the *PAA.*

However, despite the clear attempt to retain this aspect of the common law, it is suggested that s 66 of the *GAA* may preclude its recognition. Section 66(1) of the *GAA* states: "If an adult has impaired capacity for a health matter, the matter *may only be*

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* Ben White LLB (Hons) (QUT) is an Associate Lecturer, Faculty of Law, Queensland University of Technology; Lindy Willmott BCom (Qld), LLB (Hons) (Qld), LLM (Cantab) is an Associate Professor, Faculty of Law, Queensland University of Technology. The authors wish to thank Ms Colleen Cartwright, Senior Research Fellow, Australasian Centre on Ageing, University of Queensland for her suggestions and advice on aspects of this article. The authors also wish to thank Ms Paula Scully, the Adult Guardian, for her input. All views expressed, of course, are the authors.

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

2 *Re C (adult: refusal of medial treatment)* [1994] 1 All ER 819; *Airedale NHS Trust v Bland* [1993] AC 789 at 860, 866 and 892; *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649 at 653, 662-663, 665-666 and 669; *Malette v Shulman (*1990) 67 DLR (4th) 321.

3 The legislation also governs decisions about other matters such as financial matters.

dealt with under the first of the following subsections to apply" (emphasis added). The subsections that follow do not include directives that are recognised at common law.

It seems therefore that rather than an individual's previously expressed wishes governing the situation, the decision making process established by the statutory scheme would apply. This could result in a different outcome than at common law because although those common law instructions are evidence of a person's wishes and must be considered by a decision maker under the statutory scheme, they are only one of a number of factors considered.

A case study that compares the position under the common law and the Queensland legislation will be used to illustrate these concerns.

> Patricia is a strongly committed Jehovah's Witness and thus holds firmly to the religious belief that she should abstain from blood, including blood transfusions. So that others, including health professionals who may treat her in the future, are aware of her decision, she carries a "No Blood" card. Her husband, Michael, shares her religious beliefs and is also opposed to this sort of treatment.
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> Patricia is involved in a serious car accident and is unconscious when she is found. She is transferred to a local hospital where it becomes clear that she will require a blood transfusion to stay alive. Michael is torn between his and Patricia's religious beliefs and his concern that his wife will die. Faced with the reality of his wife's death, he now argues with hospital staff that the transfusion be given. The hospital staff are uncertain of their legal position given Patricia's "No Blood" card and Michael's insistence that she receive the transfusion.

II COMMON LAW

The right to self determination is a central tenet of our law. In the medical context, this means that a competent adult patient has the right to refuse medical treatment for whatever reasons, rational or irrational. A patient's body is his or her own and he or she may refuse or accept treatment as desired.[4] This includes refusing medical treatment that is needed to keep a person alive.[5]

A person's right to self determination is starkly illustrated by a recent English decision involving a 41 year old woman who suffered a haemorrhage of her spinal column in her neck which resulted in tetraplegia. The woman was able to move her head and articulate words, but needed an artificial ventilator to breathe. The court held that the woman had the right to refuse artificial ventilation even though that refusal would result in her death.[6]

Although the right to refuse treatment clearly exists, where the refusal relates to life-sustaining treatment, the health professionals involved must be certain that the patient

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4 The High Court has described this as "a right in each person to bodily integrity": *Secretary, Department of Health and Community Services v JWB and SMB* (1991) 175 CLR 218, 233.

5 *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449; *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649; *Airedale NHS Trust v Bland* [1993] AC 789; *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385.

6 *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449. The hospital had refused to accede to the woman's request and Dame Butler-Sloss P held that hospital had acted unlawfully by not turning off the artificial respirator.

has sufficient capacity to make the decision to refuse treatment. Where the decision is particularly grave (as is any decision to refuse life-sustaining treatment), the patient's competence must be correspondingly high.[7]

As part of their deliberation regarding the patient's competence, the health professionals must also consider whether the decision is that of the patient's alone or whether the decision was made as a result of outside influence. In *Re T*, [8] for example, the English Court of Appeal held that a woman who was 34 weeks pregnant and refused a blood transfusion had been subject to the undue influence of her mother, who was a Jehovah's Witness.[9] The doctors therefore had been justified in ignoring the patient's refusal and administering the transfusion.

The right to refuse life-sustaining treatment may also operate even if the refusal is given in advance of a medical situation arising.[10] In other words, before a patient loses capacity to make a decision about treatment, he or she may give a direction about their future medical treatment which will be binding on health professionals. In addition to the issue of capacity already discussed, directives given in advance must also be clearly intended by the patient to cover the situation which subsequently arises.

In assessing the scope of the directive, the context in which the refusal was given will be relevant. One of the critical issues here will be whether the patient had all relevant information available when refusing the treatment. In *Re T*, for example, at the time the woman signed a form refusing a blood transfusion, it was not contemplated by the medical staff or the patient that a blood transfusion may be necessary to save her life. Rather there was evidence that the woman's understanding at this time was that non-blood products would be sufficient should a transfusion become necessary. As a result of this lack of information, the advance refusal was not regarded by the court as covering the situation that ultimately arose. It was therefore lawful for the doctors to provide the patient with treatment that the doctors considered to be in her best interests.[11]

However, provided there is sufficient information and provided that the refusal is drafted in sufficiently unequivocal terms, it should be treated as a lawful refusal of medical treatment. For example, the Ontario Court of Appeal held that the completion of a Jehovah's Witness card which clearly stated that, for religious reasons, no blood products were to be administered under any circumstances, and then set out the particular non blood products that may be used as alternatives, constituted a valid refusal of treatment.[12]

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7 *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449, 472. In this case, it was held that the woman had sufficient capacity to make the decision to withdraw artificial ventilation.

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

9 Although the patient had been raised by her mother as a Jehovah's Witness and adhered to some of their beliefs, she was not herself a Jehovah's Witness.

10 See above n 2.

11 Compare *Re C (adult: refusal of medial treatment)* [1994] 1 All ER 819 where a 68 year old patient who suffered from paranoid schizophrenia developed gangrene in his foot. He refused amputation despite the prognosis that he had only a 15% chance of survival without amputation. The Family Division granted an injunction preventing surgery to amputate without the written consent of the patient.

12 *Malette v Shulman (*1990) 67 DLR (4^{th}) 321. In that case, the patient was admitted to hospital after a serious car accident. Her doctor administered a blood transfusion despite the existence of the

Although the Australian courts have not yet considered the validity of a common law advance directive, it is likely that the position as outlined would be accepted as law.[13]

In our case study, Patricia has refused medical treatment needed to save her life through her "No Blood" card. Provided the card is sufficiently unambiguous in its terms, this refusal of treatment will be effective. At common law, this remains the case even though Patricia has now lost capacity due to the accident. If medical staff were to provide treatment contrary to those wishes, they would be guilty of an assault exposing them to both criminal[14] and civil[15] liability.

III QUEENSLAND'S LEGISLATIVE SCHEME

A *Who Decides?*

The case study of Patricia would be handled differently under Queensland's legislative scheme. The treatment that is proposed to be given is a blood transfusion. This is "health care" because it is part of the care that may be given to Patricia to treat her physical condition and it is carried out under medical supervision.[16] The issue of whether the blood transfusion should be administered or not is therefore a "health matter".[17]

Decisions about health matters for adults with impaired capacity (as Patricia currently has in our case study) are addressed in s 66 of the *GAA*. That provision sets out a list of potential decision making sources in order of priority.

The first source, if it addresses the relevant health matter to be decided, is an "advance health directive" which is defined to mean a directive under the *PAA*.[18] That Act imposes some requirements of form that must be fulfilled before a document will be considered to be an advance health directive. In general terms, these requirements are that the directive must:[19]

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card. Compare *Werth v Taylor* (1991) 475 NW 2d 426 where an American court held that despite documents refusing blood transfusion being signed two months prior to admission of a pregnant woman as well as verbal statements to the same effect at the time of admission, the refusal was not effective to cover the later situation where a blood transfusion became necessary to save the woman's life. This decision has been criticised on the basis that it construed the scope of the patient's refusal too narrowly: Ian Kennedy and Andrew Grubb, *Medical Law* (Butterworths, 3rd ed, 2000) 2040.

13 Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report 49 (1996) Vol 1, 357.

14 Assault is an offence under the *Criminal Code 1899* (Qld), s 245.

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

16 *PAA* and *GAA*, Sch 2 s 5.

17 *PAA* and *GAA*, Sch 2 s 4.

18 *GAA*, Sch 4.

19 Some of these requirements apply generally to "enduring documents" of which an advance health directive is one: *PAA*, s 28 and *GAA*, Sch 4.

- Be in writing;[20]
- Be signed by the person making the document, who is called the "principal"[21] (or his or her "eligible signer");[22]
- Be signed and dated by an "eligible witness"[23] who must be present during the signing by the principal and must be satisfied that the principal appeared to have capacity;[24]
- Include a certificate signed and dated by a doctor that states that the principal appeared to have the capacity necessary to execute the document.[25]

There is no evidence of Patricia's "No Blood" card meeting these formal requirements so in the absence of another appropriately completed and executed advance health directive, this source of decision making within s 66 *GAA* cannot be relied upon.

The second potential source of decision making is a guardian or guardians who have been appointed by the Guardianship and Administration Tribunal or the Tribunal itself.[26]

A third is an attorney appointed by the principal, under either an advance health directive or an enduring power of attorney, to make such a decision.[27] The formal requirements for an enduring power of attorney are similar to those already discussed in relation to an advance health directive.[28] In our case study, there is no evidence of either of these potential decision makers being appointed in this way, or of a decision being made by the Tribunal.

The fourth and final source of decision making under s 66 is a "statutory health attorney".[29] Section 63 of the *PAA* determines who is to be an adult's "statutory health attorney". Again, a priority list is created starting with an adult's spouse if the relationship is one that is close and continuing.[30] In the absence of such a relationship, others who participate in the adult's life (other than those who provide paid care) such as a carer over the age of 18 or a close friend or relation may become the adult's statutory health attorney.[31] If there is no one who meets these criteria, then the Adult Guardian is the adult's statutory health attorney.[32] In our case study, Patricia's statutory health attorney is Michael. He is her spouse and, assuming the relationship is still close and continuing, will make the decision.[33]

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20 *PAA*, s 44(2). Although it need not be in the approved form: *PAA*, s 44(2).
21 *PAA*, Sch 3.
22 *PAA*, s 44(3)(a). An eligible signer is defined in s 30.
23 *PAA*, s 44(3)(b). An eligible witness is defined in s 31.
24 *PAA*, s 44(4) and (5).
25 *PAA*, s 44(6) and (7).
26 G*AA*, s 66(3).
27 *GAA*, s 66(4).
28 See *PAA*, s 44. One difference is that an enduring power of attorney must be in an approved form: s 44(1).
29 GAA, s 66(5).
30 *PAA*, s 63(1)(a).
31 *PAA*, s 63(1)(b) and (c).
32 *PAA*, s 63(2).
33 One qualification that may complicate the case study is that the statutory health attorney must be not only readily available to make the decision, but they must also be "culturally appropriate": *PAA*, s 63(1). Although Michael is a Jehovah's Witness as well, there may be some questions as to whether he is culturally appropriate to make such a decision given his intention to depart from the

B *How Does He Decide?*

Having identified Michael as the appropriate decision maker, the question then becomes how he is to make that decision.

A preliminary point to address is the issue of whether a blood transfusion is a "life-sustaining measure" as defined in the scheme.[34] The circumstances in which this sort of treatment can be withdrawn or withheld are more limited as there are specific additional criteria that must be met before such a decision can be made. However, these criteria are not relevant to Michael's decision because, although a blood transfusion might be regarded as falling with the ordinary meaning of a "life-sustaining measure", in the *PAA* and the *GAA* it is specifically excluded from that definition.[35]

Accordingly, the relevant principles that must be applied in making a decision like this[36] are the General Principles and the Health Care Principle.[37] These principles are central to the exercise of functions and powers under the Acts.[38] At common law, subject to the requirements discussed above that the advance directive actually covered the medical situation that arises and that the person had sufficient capacity to make that decision, the only relevant consideration is what the person who is now incapacitated wanted. This factor is still very relevant under Queensland's legislative scheme as the Health Care Principle 12(2) specifically provides for the adult's views and wishes to be taken into account.[39] General Principle 7(4) also requires a decision maker to take into account the adult's views and wishes, although this is subject to Principle 7(5) which requires that a decision maker ensure that an adult receives proper care and protection. General Principle 9 also requires that an adult's values (including their religious beliefs) be taken into account. This may be particularly important given that Patricia's objections to the blood transfusion are based on religious grounds.

However, the General Principles and the Health Care Principle also compel a decision maker to have regard to wider considerations. There is no specific priority stated in the legislation as to which principles should be given more weight. Some guidance is found though in the most recent decision of the Guardianship and Administration Tribunal on withdrawal of medical treatment, *Re MC*.[40] In that case, the Tribunal stated that the crucial tests in the Health Care Principle were whether the treatment is the option which is the least restrictive of the adult's rights and whether it is their best interests.[41] Clearly

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views of the faith to which she so firmly adheres. However, as Michael is himself a Jehovah's Witness, it would be difficult to argue that he is not culturally appropriate to make the decision. The concern that may arise, however, is whether his decision was arrived at in accordance with the statutory guidelines which are discussed below.

34 *PAA* and *GAA*, Sch 2 s 5A.

35 *PAA* and *GAA*, Sch 2 s 5A(3).

36 Although one might wonder whether in practice, a statutory health attorney would be aware of these principles and what they require.

37 Section 11 of the *GAA* directs those performing a function or exercising a power under the *GAA* to apply these principles. They are extracted in Schedule 1 of both the *PAA* and the *GAA.*

38 *PAA*, s 76 and *GAA*, s 11.

39 *PAA* and *GAA*, Sch 1 Health Care Principle 12(2)(a) and (3). Note, however, that if the decision maker relies on Health Care Principle 12(1)(b)(ii) that the exercise of the power is "in the circumstances, in the adult's best interests", it is arguable that the Health Care Principle does not require the decision maker to consider the adult's views and wishes.

40 *Re MC* [2003] QGAAT 13.

41 *PAA* and *GAA*, Sch 1 Health Care Principle 12(1).

these factors go well beyond considering what the adult would have wanted, and indeed, it may be that these considerations conflict with that person's desires. For example, in a situation where a person will certainly die without receiving a blood transfusion, some would argue that it is in the person's best interests to receive that treatment despite their religious objections and despite the enormous distress that such action might cause the adult.

Given that criteria that are quite different from the common law must be applied, a decision maker acting under the scheme may reach a different conclusion. Under the statutory regime, Michael may be justified in consenting to Patricia receiving a blood transfusion, despite her objections, because he regards this treatment as being in her best interests.

C *Can Section 39 of the* PAA *Operate?*

It is clear that the position under the common law is different from that under the legislative scheme. The different criteria may mean, at least in some circumstances, that a different decision is made. This inconsistency need not be problematic if s 39 of the *PAA* provides for the continued recognition of the common law position in relation to instructions about health care. However, it is suggested that the operation of s 39 has been excluded by s 66 of the *GAA*.

Section 66(1) of the *GAA* states: "If an adult has impaired capacity for a health matter, the matter *may only be dealt with* under the first of the following subsections to apply" (emphasis added). It is suggested that these words "may only be dealt with" are absolutely clear: the sources of decision making in relation to health care are to be found *only* in this section. Instructions about health care that would be recognised as binding at common law are not mentioned in s 66, so while they may be relevant in guiding decision makers, they cannot compel a particular outcome.

Section 66 of the *GAA* is clearly inconsistent with s 39 of the *PAA* and it seems would exclude its operation. A contrary argument could be mounted that s 39 should prevail because although it is an earlier provision, it is the more specific: *generalia specialibus non derogant*.[42] However, this rule of statutory interpretation can be rebutted and it is suggested that in this case it is. Section 8 of the *GAA* and s 6A(4) of the *PAA* specifically provide that the *GAA* should prevail in the case of inconsistency between it and the *PAA*. Accordingly, s 66 of the *GAA* would apply and, in our case study, Michael would be able to consent to the provision of the blood transfusion despite Patricia's specific refusal.[43]

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42 *Goodwin v Phillips* (1908) 7 CLR 1.

43 Of course, the Adult Guardian may intervene if he or she is not satisfied that decisions are being made in accordance with the appropriate principles: *GAA*, s 43. However, as has already been discussed, it may be that the application of these principles supports the giving of a blood transfusion.

IV THE QUEENSLAND LAW REFORM COMMISSION REPORT

A *The Draft Bill*

The *PAA* and the *GAA* are based on a 1996 report of the Queensland Law Reform Commission (the QLRC) entitled *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability.*[44] The report consisted of three volumes, the second of which included a draft Bill called the *Assisted and Substituted Decision Making Bill*. The report is worth considering in some detail because it is suggested that the reason for this difficulty in the law lies in a gap between what was recommended by the Commission and what was eventually enacted.

The QLRC specifically addressed both the issue of instructions given about health care that would be recognised by the common law and also the different ways in which decisions could be made about health care for those who have lost capacity. In relation to the latter issue, clause 153 of the *Assisted and Substituted Decision Making Bill* provided as follows:

> "If an adult has impaired decision-making capacity for a health care decision, the decision is to be made –
> (a) as required by the adult's most recent decision document (if any) dealing with the decision; or
> (b) if the decision is not dealt with in a decision document of the adult and there is an appointed decision maker authorised to make the decision or a relevant tribunal order – by the appointed decision maker or under the tribunal order; or
> (c) if the decision is not dealt with in a decision document of the adult and there is no appointed decision maker authorised to make the decision or a relevant tribunal order – by a statutorily authorised health care decision maker."

Although some of the terms used are different, it is clear there are strong similarities between s 66 of the *GAA* and clause 153. The term "decision document" included an advance health directive[45] and such a directive was also required to comply with formalities similar to those now required under the *PAA*.[46]

The QLRC Bill also included a clause addressing common law instructions in terms that are virtually identical to s 39 of the *PAA*. Clause 78 provided:

> 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 made under this Act.

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44 Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability,* Report 49 (1996). Other publications produced in the course of this reference included the following: Queensland Law Reform Commission, *Steering Your Own Ship?,* Issues Paper MP1 (1991); Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making for People Who Need Assistance Because of Mental or Intellectual Disability,* Discussion Paper WP38 (1992); Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability,* Draft Report WP43 (1995).

45 *Assisted and Substituted Decision Making Bill,* Sch 2.

46 *Assisted and Substituted Decision Making Bill,* cl 82. The requirements for eligibility as a witness were set out in cl 84. It seems overall that these formal requirements were less onerous than under the current legislation. For example, s 44 of the *PAA* requires a doctor's involvement which was not a formal requirement under the draft Bill.

It therefore seems clear that the clauses of the QLRC Bill that address these two issues were substantially enacted in the *PAA* and the *GAA*.[47] There was, however, one critical difference – instead of a single Act as recommended, the enactment occurred through two pieces of legislation[48] and the relevant clauses were separated.

Section 39 of the *PAA*, which recognises these common law instructions, provides this protection only in relation to the *PAA*, and s 8 of the *GAA* and s 6A(4) of the *PAA* provides that the later legislation prevails over the *PAA* in the case of inconsistency. As the language of s 66 *GAA* and s 39 *PAA* is inconsistent, s 66 will prevail. By contrast, the Bill drafted by the QLRC had the effect that cl 78 (now s 39 of the *PAA*) applied to the entire Bill, including cl 153 (now s 66 of the *GAA*) which dealt with how decisions about health care were to be made.

B *The QLRC's Reasoning*

The Bill was deliberately drafted in this way based on the Commission's consideration of the relationship between these common law instructions and the Commission's proposed statutory decision making regime.[49] The relevant issue to be resolved was whether common law instructions should be allowed to continue to operate given that the QLRC was proposing to include statutory advance health directives as part of its decision making regime. These directives, under the proposed reforms, needed to comply with certain formal requirements that were not necessary for recognition at common law.

The Commission noted the argument that continued recognition of common law instructions "might lead to unnecessary uncertainty and could undermine any restrictions which the legislation attempted to impose."[50] The concern was that the legislation could be circumvented if, for example, the formality requirements concerning execution of an advance health directive were not met. In that case, the document could still be enforceable at common law despite not complying with the formality requirements imposed for policy reasons.

Despite this concern, the QLRC recommended that the recognition of common law instructions should be preserved. It was of the view that reform in this area should not detract from the common law rights that a person already had. Preserving the common law would "maximise the opportunity for people to exercise control over their future medical treatment".[51] The effect of the Commission's recommendations was that a person's common law instructions would be enforced without recourse to the statutory

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47 Neither *Hansard* nor the Explanatory Notes to the Acts states this in relation to the specific sections considered in this article. However, the similar wording used and general statements in the Explanatory Notes to both the *PAA* and the *GAA* about enacting the QLRC's recommendations support this conclusion. For example, in the Explanatory Notes to clause 8 of the *GAA* (which became s 8 as discussed above) states: "Clause 8 provides that the Act is to be read in conjunction with the Powers of Attorney Act 1998 ... *This ensures that the complete scheme of substituted decision-making as recommended by the QLRC is implemented through the operation of these two Acts*": Explanatory Notes, *Guardianship and Administration Bill 1999* (Qld), 8 (emphasis added).

48 Explanatory Notes, *Powers of Attorney Bill 1997* (Qld), 2**.**

49 Queensland Law Reform Commission, *Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*, Report 49 (1996) Volume 1, 357-358.

50 Ibid, 358.

51 Ibid.

decision making regime if there were sufficient evidence that it represented the wishes of the person in the context of the particular health decision. Alternatively, a person had the right to execute an advance health directive under the proposed legislation. In the case of a conflict between the two, cl 78 of the draft Bill made it clear than a common law directive would only operate if the person had not executed an advance health directive under the Act for that matter.

V A NEED FOR REFORM

A *Problems*

It is suggested that the approach taken by the QLRC is a reasonable one. It also appears clear that it was the intention of the Parliament that this should be the law, otherwise there would be no reason for enacting s 39 of the *PAA*.[52] However, it was suggested above that the plain words of the legislation do not permit this conclusion. If it is accepted that the preferred approach is that recommended by the QLRC, the law as it stands raises some significant problems.

An obvious problem is that a person's wishes may not be followed. In our case study, it was argued that a decision under the scheme could result in the blood transfusion being given to Patricia even though she clearly did not want it. If the QLRC's view is accepted, this is clearly undesirable. However, even if the decision making under the scheme did lead to the same outcome as Patricia wanted, the process is more uncertain. Instead of only having to follow a patient's direction made prior to losing capacity, the legislation requires quite a complex balancing of factors which inevitably introduces some uncertainty.

This legal uncertainty can create significant practical problems for health professionals treating a patient like Patricia if the patient has made their wishes known in unequivocal terms. They are placed in the difficult position where they are no longer relying on what a patient decided prior to incapacity but on a statutory health attorney's decision. In such a case, the health professionals know that the patient does not want the treatment but may have to rely on another to make the decision, and in circumstances where there may well be good reasons why a statutory health attorney would disagree with a patient's decision and refuse to honour those wishes.[53]

B *Suggested Reform*

In light of these problems and the likelihood that the current position does not reflect what was intended to be the law, it is suggested that the legislative scheme be amended. This could be achieved in a number of ways but it is suggested that the simplest way would be to amend s 39 of the *PAA*. It currently reads:

> **39** Common law not affected
>
> This Act does not affect common law recognition of instructions about health care given by an adult that are not given in an advance health directive.

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52 See also the arguments advanced in note 47.

53 An illustration of how such a situation can arise is found in *Qumsieh v The Guardianship and Administration Board & Anor* [1998] VSCA 45.

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

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

Such a provision would permit the continued recognition at common law of instructions given about health care despite those instructions not being in an advance health directive that complies with the formal requirements of the legislation. This would mean that Patricia's "No Blood" card in our case study would be effective to refuse treatment. This suggested amendment would therefore give effect to the relevant QLRC recommendations.

VI CONCLUSION

The principle of self determination in the context of medical decision making is an important one. For many years now, the common law has recognised that a person can give a directive about a health matter that may be effective if that person later loses capacity to make the decision. The importance of this autonomy was also recognised by the QLRC when it reviewed the law on substituted decision making. In addition to recommending the introduction of a statutory scheme that included advance health directives as one method of decision making for those with impaired capacity, it also recommended the retention of common law directives. Unfortunately, the way in which these recommendations were implemented seems to have defeated these intentions. To remedy this anomaly, it is suggested that the minor legislative amendment recommended in this article be adopted.