

**UNCOMFORTABLE BEDFELLOWS:
QUEENSLAND CRIMINAL LAW AND PATIENTS'
RIGHTS TO REFUSE LIFE-SUSTAINING
TREATMENT**

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Abstract

The publicity given to the request by a Western Australian man with quadriplegia to have artificial nutrition and hydration withdrawn so he could end his life, highlights the moral and legal dilemmas inherent in end-of-life decision making. In ruling that the withdrawal of the life-sustaining measures by the health provider would be lawful, the Supreme Court of Western Australia carefully analysed the potential application of the Criminal Code 1913 (WA). The relevant provisions include recent amendments aimed at addressing the question of a medical professional's criminal responsibility for withholding or withdrawing life-sustaining treatment. To date the Queensland legislature has not followed the Western Australian lead, despite suggestions by the Queensland Guardianship and Administration Tribunal that the intersection between the criminal law and the Guardianship and Administration Act 2000 (Qld) requires clarification. This paper considers whether, pursuant to Queensland criminal law, health professionals could be held criminally responsible for complying with a patient's request to withdraw life-sustaining measures, and accordingly whether amendments should be made to the Criminal Code 1899 (Qld).

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I INTRODUCTION

Once viewed as a fiction of the sci-fi film, the prolongation of life by the use of mechanical life-sustaining devices is now a reality of modern medical science. In many circumstances the timing of a person's death can be controlled by the use of medical technology to an extent not considered fifty years ago. The advent of life-sustaining technology has raised a number of ethical, moral and legal dilemmas regarding end-of-life decision making. Society has been required to consider the preservation and sanctity of life and balance it against the right to self-determination, personal autonomy, and the right to dignity.² Social and moral arguments regarding the intrinsic worth and quality of life have come before the courts and have engaged the minds of academic commentators.³ As is often the case in the technological age, the law has been required to play catch-up, endeavouring to find legal justification for medical practices that are viewed as desirable and socially acceptable.⁴

Sixteen years on from the seminal English case of *Airedale NHS Trust v Bland (Bland)*,⁵ which declared lawful the withdrawal of artificial nutrition and hydration from a patient who was in a persistent vegetative state, questions still remain as to the criminal responsibility of those entrusted with withdrawing or withholding life-sustaining treatment.⁶

² *Airedale NHS Trust v Bland (Bland)* [1993] AC 789, 859, 864, 891.

³ See, eg, J Keown, 'Restoring Moral and Intellectual Shape to the Law after Bland' (1997) 113 *Law Quarterly Review* 481; J.M Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 *Law Quarterly Review* 329; Andrew McGee, 'Finding a way through the ethical and Legal Maze: Withdrawal of Medical Treatment and Euthanasia' (2005) 13 *Medical Law Review* 357; Kristin Savell, 'Human Rights in the Age of Technology: Can Law Rein in the Medical Juggernaut?' (2001) 23 *Sydney Law Review* 423.

⁴ In *Airedale NHS Trust v Bland (Bland)* [1993] AC 789, 891, 877–878 both Lord Mustill and Lord Wilkinson-Browne expressed concern about the legal justification the court was developing in order to deal with the ethically difficult question of withdrawal of nutrition to an 'alive' patient. Both called for legislative intervention.

⁵ [1993] AC 789.

⁶ In the English case of *R (Burke) v The General Medical Council* [2005] EWHC Civ 1003 issues surrounding the circumstances in which a patient has a right to demand provision of life-sustaining measures was discussed, primarily in relation to the *Human Rights Act 1998* (UK). In relation to the withholding and withdrawing of life-sustaining measures in the UK,

Unlike the situation in the majority of common law countries, Australian law remains devoid of a definitive superior court decision from which guidance can be drawn as to when and in what circumstances such actions will be lawful.⁷ While this to some extent confirms that generally, in Australia, these decisions are being made by consensus with medical practitioners, patients and/or families,⁸ the interaction of the criminal law with end-of-life decision making for withholding or withdrawing life-sustaining measures is still not clearly defined.

The uncertainty in Australia has led to a number of matters recently being brought to the attention of the lower courts. In the month of August 2009 alone, three health care providers sought declarations before courts of first instance as to the lawfulness of proposed conduct to terminate life-sustaining treatment. In the first case the court was asked to consider whether it was lawful to comply with an advanced health directive that the patient not be given kidney dialysis.⁹ The second required the court to consider whether medical staff would be criminally responsible for complying with a request by a competent patient who was not terminally ill that the life-sustaining supply of hydration and nutrition be discontinued.¹⁰ The third questioned whether a health provider could cease the forced provision of hydration and nutrition to an elderly patient

Canada and New Zealand, a 'best interests' test is applied, whereas in the USA a substituted judgment test is applied. For a discussion and comparison of the two tests see Lindy Willmott and Ben White, 'A Model for Decision Making at the End of Life: Queensland and Beyond' (Paper presented at the 15th World Congress on Medical Law, Sydney, 2004).

⁷ See, eg, in the UK *Airedale NHS Trust v Bland (Bland)* [1993] AC 789; USA *Cruzan v Director of Missouri Department of Health*, 497 US 261 (1990); Canada, *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR 4th 385; New Zealand, *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235. It should be noted, however, that the legal validity of a pre-emptive declaration from a civil court as to the lawfulness or otherwise of potentially criminal conduct is doubtful, particularly in relation to Criminal Code states. See Chris Corns, 'Withdrawal of Life-Support: Some Criminal Prosecution Aspects' in Ian Freckleton and Kerry Petersen (eds), *Controversies in Health Law* (1999), 44, 54.

⁸ Lindy Willmott and Ben White, 'Charting a course through difficult legislative waters: Tribunal decisions on life-sustaining measures' (2005) 12 *Journal of Law and Medicine* 441, 441.

⁹ *Hunter and New England Area Health Services v A* [2009] NSWSC 761.

¹⁰ *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229.

who was chronically psychotic, suffering from paranoid schizophrenia and whose religious obsessions had compelled him to extreme fasting.¹¹ These cases demonstrate that medical professionals are still uncertain as to the legality of withholding or withdrawing life-sustaining treatment.

Uncertainty as to the potential criminal responsibility of health professionals has been recognised as a potential problem for some time. The problem is of greater significance in the code jurisdictions, where, in the absence of legislative intervention, the courts are more restricted in interpreting the criminal law. In 1988 the Western Australian Law Reform Commission highlighted these uncertainties as they relate to the Griffith Code.¹²

Doctors ... may face substantial legal problems in relation to the provision of medical treatment of terminally ill people.... These problems arise because the legal duties [set out in the Criminal Code] have been developed to meet problems other than the bona fide treatment of patients suffering from terminal conditions, and the application of the Code provisions to such treatment is uncertain. This uncertainty arises because the provisions of the Criminal Code which might be relevant are of general application and there have been no reported cases in which their operation in the present area of concern has been specifically examined. The spectre of criminal liability raised by provisions of general application is undesirable where doctors are endeavouring to practise medicine with a humane concern for the terminally ill.¹³

It is surprising that 20 years passed before the Western Australian Parliament took action to address these concerns. The *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) not only establishes a regime to address medical treatment decisions for patients lacking

¹¹ *Australian Capital Territory v JT* [2009] ACTSC 105.

¹² The Law Reform Commission was concerned with the provisions of the *Criminal Code 1913* (WA); however, at that time, the relevant provisions were the same as those found in the *Criminal Code 1899* (Qld).

¹³ Law Reform Commission of Western Australia, *Medical Treatment for the Dying*, Discussion Paper Project No. 84, (June 1988). For more recent statements concerning the uncertainty, see Attorney General/Minister for Health Western Australia, *Medical Treatment for the Dying*, Discussion Paper (2005) 8.

capacity, but also provides some protection for health professionals whose conduct falls within the requirements of the *Act*. Amongst other things the *Act* amends the *Criminal Code 1913* (WA) so as to provide protection for those responsible for the withholding or withdrawal of medical treatment even in circumstances where death ensues.¹⁴

It is even more surprising that Queensland, the only other Griffith Code jurisdiction, is yet to clarify the criminal responsibility of those responsible for withholding or withdrawing life-sustaining treatment. This is particularly so as Parliament has enacted the *Guardianship and Administration Act 2000* (Qld) (*GAA*) which provides a regime of decision makers who are able to consent to or refuse medical treatment on behalf of an incompetent patient. The ongoing uncertainty has been the subject of comment by the Queensland Guardianship and Administration Tribunal (the Tribunal) in its statement that:

the intersection of the Criminal Code 1899 with the Guardianship and Administration Act 2000 in the context of consent to withholding and withdrawing life-sustaining measures is a matter that should be clarified by the legislature.¹⁵

In considering how to address these concerns, this paper seeks to explore and explain the intersection between Queensland criminal laws and the common law and statutory rights of patients. The paper is divided into four parts. Part two considers the issue of consent to medical treatment for both competent patients and those with impaired capacity. Part three of the paper examines the provisions of the *Criminal Code 1899* (Qld) (the *Code*) that may be applied in circumstances where a patient dies as a result of a health professional withholding or withdrawing life-sustaining treatment in accordance with the patient's common law and/or statutory rights. In this context, s 285 of the *Code* is of particular importance as it imposes a duty on a person to provide the necessities of life to those under that person's charge. Part four examines how the *Code* may be interpreted so as to avoid conflict between a patient's rights to refuse treatment and a health professional's duty to provide it.

¹⁴ *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) s 18. See also Hon Sue Ellery (Parliamentary Secretary) Second Reading Speech, *Acts Amendment (Consent to Medical Treatment) Bill 2006*, 6 December 2006, 9244–9245.

¹⁵ *Re HG* [2006] QGAAT 26, [107].

In the final part the paper addresses the need for reform and includes an evaluation of the recent reforms to the *Criminal Code 1913* (WA). It concludes by suggesting the need for legislative intervention in Queensland to ensure that health professionals can be confident in complying with a patient's request for refusal of treatment.

II A PATIENT'S RIGHT TO HAVE LIFE-SUSTAINING TREATMENT WITHHELD OR WITHDRAWN

A *The Rights of Competent Patients*

The common law clearly and unambiguously gives affect to a competent¹⁶ adult patient's right to refuse medical treatment, even though the refusal will lead to the person's death.¹⁷ The right, which gives expression to the basic principles of patient autonomy and self-determination, 'may be seen as a basic human right protected by the common law'.¹⁸ This basic human right effectively trumps a 'doctor's right (*and his or her*

¹⁶ The term competence is defined consistently with the common law definition of the term, and it tends to be used interchangeably with the term capacity. See, eg, *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819, 824; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229. See also Glenys Williams, *Intention and Causation in Medical Non-Killing* (2007) 121 where it is argued that the preferable term is competence rather than capacity.

¹⁷ See, eg, *RE T (adult: refusal of treatment)* [1993] AC 789; *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218. In Victoria, South Australia and the ACT, statutory force has been given to this principle. See *Medical Treatment Act 1994* (ACT); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Medical Treatment Act 1998* (VIC). See also Lindy Willmott, Ben White and Michelle Howard, 'Refusing Advance Refusals: Advance Directives and Life-sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211; Cameron Stewart, 'Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions' (1999) 23 *University of Melbourne Law Review* 6.

¹⁸ *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871, 882 (Lord Scarman). See also *Airedale National Health Service Trust v Bland* [1993] AC 789, 826 (Lord Hoffmann).

duty) to invade the patient's bodily integrity so as to treat the patient'.¹⁹ It is a right that has been clearly enshrined in the GAA.²⁰

A health professional's obligation to respect a competent patient's wishes is paramount and accordingly must be complied with even though the professional is of the view that compliance is not in the patient's best interests.²¹ In the words of Lord Donaldson in *Re T*,²² 'it matters not whether the [patient's] reasons for the refusal were rational or irrational, unknown or even non-existent'.²³ To do otherwise would offend the principle of bodily inviolability amounting to a trespass to the person.²⁴ A vivid illustration of the law can be found in the English decision of *Re B*.²⁵ In that case a 42 year old woman with tetraplegia refused consent to the continuation of artificial ventilation against the express advice of her treating doctors who were concerned that she had not exhausted all rehabilitation options. After the doctors refused to

¹⁹ Mark Stauch, Kay Wheat, and John Tingle, *Text, Cases and Materials on Medical Law* (2002), 96. Emphasis added. The reason for this will become apparent in part three of the paper.

²⁰ Section 5(b) states that 'the right to make decisions includes the right to make decisions with which others may not agree', and in reference to Health Care Principle Schedule 1, s 12(4) states that 'the health care principle does not affect any right an adult has to refuse health care'. See *RE RWG* [2000] QGAAT 49, [55].

²¹ *Airedale NHS Trust v Bland (Bland)* [1993] AC 789; *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449. There is perhaps one exception to the patient's paramount right to refuse treatment. The exception arises where the treatment is necessary to preserve a viable foetus. For a discussion of the principle and the possible exception see *Hunter and New England Area Health Services v A* [2009] NSWSC 761 [9]–[21] [McDougall J].

²² [1992] 3 WLR 782.

²³ *Ibid*, 799. See also *Ms B v An NHS Hospital Trust* [2002] 2 FCR (UK) 1 [18]; *Hunter and New England Health Service v A* [2009] NSWSC 761, [15]; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [27].

²⁴ *Airedale NHS Trust v Bland (Bland)* [1993] AC 789, 864, 891; *RE T (adult: refusal of treatment)* [1993] AC 789; *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218, 232, 233, 264, 309, 310. Section 245 of the *Criminal Code 1899* (Qld) defines assault as inclusive of the common law tort of battery; however, a civil action in Queensland is still one of battery, although *Criminal Code* excuses and defences may be applicable to the civil action. See *White v Connolly* [1927] St R Qd 75.

²⁵ [2002] 2 All ER 449.

accede to her request, she sought a declaration from the court as to her capacity, and she sought damages for trespass for the continued and unwanted treatment by the hospital. The court granted her declaration, holding that the hospital was in fact trespassing against her and awarded nominal damages.

The criminal law augments a patient's right to refuse treatment by way of the offence of assault.²⁶ In this respect the *Criminal Code* of Queensland is no exception. It is unlawful to strike, touch, move or to apply force of any kind without consent.²⁷

It must be noted that there are situations including medical emergency or necessity where a health professional who treats without consent will be protected from civil liability.²⁸ Until recently, the protection from criminal responsibility in such circumstances was less certain.²⁹ However, in September 2009, the Queensland Parliament enacted a new s 282 excuse of surgical operations and medical treatment.³⁰ The

²⁶ *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218, 232, 233, 264. Although the Court's comments are in the context of the *Criminal Code 1983* (NT), they are of general application.

²⁷ *Criminal Code 1899* (Qld) ss 245, 246. Although it is interesting to note that failure to comply with a request to cease lawful treatment may not amount to assault, where the failure does not involve application of force to 'such a degree as to cause injury or personal discomfort' (*Criminal Code* s 285).

²⁸ See, eg, Lord Goff's discussion of necessity in *In Re F (mental patient: sterilisation)* [1990] 2 AC 1, 74–76; *Airedale NHS Trust v Bland (Bland)* [1993] AC 789, 867. Loane Skene refers to the defence of necessity being wider than one of medical emergency. For a full discussion of the situations where an exception to the general rule of consent to medical treatment, see, Loane Skene, *Law and Medical Practice: Rights Duties, Claims and Defences* (2nd ed, 2004), 93–97, 169.

²⁹ The wording of the excuse of extraordinary emergency made it difficult to apply to activities of health professionals. Section 25 of the *Code* states that a 'person is not criminally responsible for an act or omission done or made under such circumstances of a sudden or extraordinary emergency that an ordinary person possessing ordinary powers of self-control could not reasonably be expected to act otherwise'. It is difficult to contemplate the application of the ordinary person requirement within the context of provisions of health services.

³⁰ *Criminal Code (Medical Treatment) Amendment Act 2009* (Qld) s 3. The

excuse provides, amongst other things, that a person is not criminally responsible for conducting a surgical operation or medical treatment provided that: it was conducted in good faith and with reasonable skill; it was for the patient's benefit; and the treatment was reasonable 'having regard to the patient's state at the time and to all the circumstances of the case'.³¹ The section is sufficiently broad to apply in most situations where a health professional provides life-sustaining treatment in circumstances of an emergency.³²

B *The Rights of Incompetent Patients*

The right to refuse medical treatment, including life-sustaining treatment, extends at common law to situations where the patient has expressed his or her desire in advance of losing capacity to consent.³³ In Queensland the *GAA* and the *Powers of Attorney Act 1998 (Qld) (PAA)* give restricted legislative effect to this right through the recognition of an advance health directive.³⁴ Such a directive will only operate where the patient has a terminal illness or condition that is incurable or irreversible and which is expected to kill the patient within one year; the patient is in a persistent vegetative state; the patient is permanently unconscious and there is no reasonable prospects that the patient will regain consciousness; and the patient has an illness or injury and there is

Act repealed the existing s 282 excuse and replaced it with a similar more broadly applicable excuse.

³¹ *Criminal Code 1899 (Qld)* s 282(1).

³² The section also has the potential to impact on a patient's right to refuse treatment. See, eg, the discussion of *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 in Part 3 below.

³³ This common law right has been given statutory force in most jurisdictions in Australia. See *Medical Treatment Act 1988 (Vic)*; *Powers of Attorney Act 1998 (Qld)*; *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*; *Medical Treatment Act 1994 (ACT)*; *Natural Death Act 1988 (NT)*; *Guardianship and Administration Act 1990 (WA)*. For a discussion as to the nature of the right to make advance health directives see Ben White and Lindy Willmott, 'Will you do as I ask? Compliance with instructions about health care in Queensland' (2004) 4 *Queensland University of Technology Law and Justice Journal* 77; Lindy Willmott, Ben White and Michelle Howard, 'Refusing Advance Refusals: Advance Directives and Life-Sustaining Medical Treatment' (2006) 30 *Melbourne University Law Review* 211.

³⁴ *Guardianship and Administration Act 2000 (Qld)* s 66A; *Powers of Attorney Act 1998 (Qld)* ss 35, 36.

no reasonable prospect that the patient will recover to the extent that he or she can be sustained without continued life-sustaining measures.³⁵

For the majority of patients who have not expressed their views by way of an advance health directive, power of attorney, or living will prior to losing capacity, medical decisions are, of necessity, made by others. In furtherance of the principle of self-determination and patient autonomy, the *GAA* provides a regime of potential persons (the first applicable in the list becomes the decision-maker) to make certain decisions on behalf of the incompetent patient.³⁶ Where there is an inability to reach consensus about the proposed treatment,³⁷ the Tribunal is empowered to provide guidance, declaratory relief and, where required, consent on behalf of the impaired patient. The decision-making ability applies to 'health care' matters, which 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.³⁸

The legislation provides a complex set of guidelines in the form of 'General Principles' and the 'Health Care Principle' which are used to inform the substitute decision maker and assist appropriate decision making.³⁹ The intention of the legislature is to provide a consent mechanism that allows the patient a degree of autonomy,⁴⁰ while at

³⁵ *Powers of Attorney Act 1998* (Qld) s 36(2).

³⁶ *Guardianship and Administration Act 2000* (Qld), s 66 provides for substitute decision makers as follows: Tribunal appointed guardian, attorney appointed by the incompetent adult by virtue of advance health directive or enduring power of attorney, statutory health attorney (this is defined and a list again in order of priority is provided including spouse, carer (not paid), close friend or relation, adult guardian).

³⁷ Often because of disagreement between the health provider and family or different members of the family as to the appropriate form of treatment. See, eg, *RE MC* [2003] QGAAT 13; *RE TM* [2002] QGAAT 1; *Northridge v Central Sydney Area Health Service* [2000] NSWSC 1241.

³⁸ *Guardianship and Administration Act 2000* (Qld) Schedule 2, s 5 (2).

³⁹ *Guardianship and Administration Act 2000* (Qld), s 11.

⁴⁰ *Guardianship and Administration Act 2000* (Qld), Health Care Principle 12(2) (a) and (3) require the taking into account of the patient's wishes if known. Note however the suggestion that if Health Care Principle 12(1) (b)(ii) referring to the exercise of the power in accordance with adult's

the same time ensuring the grave decision regarding withholding or withdrawing of life-sustaining measures⁴¹ accords with good medical practice.⁴²

An incompetent patient's right of autonomy, as with those of a competent patient, are protected by the common law civil action of battery and the *Criminal Code* offence of assault. Furthermore, the rights of patients without capacity are reinforced by s 79 of the *GAA*, which makes it an offence for a doctor to carry out health care on a patient with impaired capacity without consent. The legislation does, however, provide health professionals with some protection from both civil and criminal action.⁴³ Importantly, the legislation provides that a person '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'.⁴⁴ Therefore, the responsibility of a health professional for the consequences of withholding or withdrawing life-sustaining treatment, with consent, does not differ according to whether the patient was or was not competent.

The question thus remains as to the circumstances in which a health professional will be liable for withholding or withdrawing life-sustaining treatment? Or more precisely for the purpose of this paper: in what circumstances could a health professional be held criminally responsible?

Unfortunately the *PAA* and the *GAA* fail to clarify the question. Instead the Acts tend to fuel the uncertainty as both clearly state that nothing contained within them authorises, justifies or excuses the killing of another.⁴⁵ Furthermore, both Acts provide that s 284 (consent by a person

'best interests' is applied, the patient's views may not be relevant. See Ben White and Lindy Willmott above n 33, 82.

⁴¹ *Guardianship and Administration Act 2000* (Qld) Sch 2, s 5A–(1).

⁴² *Guardianship and Administration Act 2000* (Qld) Sch 2, s 5(2). Unlike the application of an advance health directive, the only limitation on a substitute decision maker when deciding to withhold or withdraw life-sustaining measures is that the decision not to commence or continue with treatment must be in accordance with good medical practice

⁴³ *Guardianship and Administration Act 2000* (Qld) ss 63, 63A, 64.

⁴⁴ *Guardianship and Administration Act 2000* (Qld) ss 80, 77.

⁴⁵ *Power of Attorney Act 1998* (Qld) s 37; *Guardianship and Administration Act 2000* (Qld) s 238.

to his or her own death does not relieve the person who caused the death of criminal responsibility) and Chapter 28 (the homicide and suicide provisions) of the *Criminal Code* are unaffected by the provisions of the PAA and GAA.⁴⁶

III POSSIBLE OFFENCE IN QUEENSLAND FOR THE WITHDRAWAL AND WITHHOLDING OF LIFE-SUSTAINING TREATMENT

A *Homicide Offences under the Criminal Code 1899 (Qld)*

The *Code* defines the offence of homicide as causing the death of another either directly or indirectly in circumstances where the killing is unlawful in that it is not authorised, justified or excused.⁴⁷ The homicide will be murder if the Crown is able to prove that the accused intended to kill or to cause grievous bodily harm and manslaughter if the Crown is unable to prove such intent.⁴⁸ However, the *Code* provides for two alternative routes or ‘streams’ by which an accused can be held criminally responsible for the death of another. Where there is evidence of a positive act resulting in death, the prosecution will be through one or other of the ‘two streams’.⁴⁹ The first is referred to as the Chapter 27 ‘stream’ or negligence route. The second is the Chapter 28 ‘stream’ or direct route. However, a case based on an omission can only be brought

⁴⁶ *Power of Attorney Act 1998* (Qld) s 37; *Guardianship and Administration Act 2000* (Qld) s 238. These provisions, amongst others, have caused commentators to question the relationship between the homicide provisions of the *Criminal Code* and a patient’s right to refuse life-sustaining treatment or have it refused or withdrawn on his or her behalf. See, eg, Ben White and Lindy Willmott, ‘Re-thinking Life-Sustaining Measures: Questions for Queensland’ (An Issues Paper reviewing the legislation governing withholding and withdrawing life-sustaining measures, Queensland University of Technology, 2005) Issue 14, 82.

⁴⁷ *Criminal Code 1899* (Qld) ss 291, 293.

⁴⁸ *Criminal Code 1899* (Qld) ss 300, 302(1)(a) and 310. Discussion of the constructive murder provisions set out in s 302 (1)(b)–(e) of the *Criminal Code* is beyond the scope of this article as is the excuse and the defence of provocation, s 304 and diminished responsibility, s 304A.

⁴⁹ *R v Morgan* [1999] QCA 348 [Thomas J]. See also B White, A Garwood-Gowers and L Willmott, ‘Manslaughter under the Griffith Code: Rowing not so gently down two streams of law’ (2005) 29 *Criminal Law Journal* 217. Although the two stream analysis has only ever been applied by the courts to the offence of manslaughter the rationale for its application applies equally to the offence of murder.

via the first ‘stream’. This is because an omission to act does not attract liability except where it is established that there was a duty imposed by law upon the person to act or perform a duty, and that the duty was breached. The provisions in Chapter 27 of the *Code* have a dual function. Not only do they provide the bases for establishing responsibility for negligent acts, but they also create duties. Breach of the duty does not in itself create an offence; it merely provides the quality of conduct whereby, if death results, it will lead to the offence of either murder or manslaughter.⁵⁰ Therefore, before determining which ‘stream’ would apply to a health professional, who withholds or withdraws life-sustaining treatment, it is necessary to determine whether such conduct is either an act or an omission.

B *The Omission / Act Distinction*

Both at common law and under the *Code*, the law distinguishes between positive acts and omissions to act. While there is no authority from a superior Australian court classifying the withholding or withdrawing of life-sustaining treatment as either an act or omission, there is a body of persuasive international authority that has defined such conduct as an omission. In *Bland*,⁵¹ the House of Lords held that the withdrawal by doctors of nutrition and hydration from a patient who had remained in a persistent vegetative state (PVS) for three years would not be unlawful. Their Lordships’ justification for the decision lay in the acceptance that the withdrawal of life-sustaining treatment was an omission, thereby distinguishing it from a positive act that causes the death of the patient. By analogy the withholding of medical treatment is also readily conceived as an omission.⁵² Lord Goff referred to the fine distinction between the act by the medical professional and those of an ‘interloper’, the former’s conduct amounting to an omission, the latter’s conduct a positive act. His Lordship reasoned that by failing to treat or by discontinuing treatment, the medical professionals would be merely allowing the patient to die by natural causes, thus the conduct can be seen as amounting to an omission, whereas an ‘interloper’ who

⁵⁰ R G Kenny, *An Introduction to Criminal Law in Queensland and Western Australia* (7th ed, 2008), [8.38]. See also *R v Hodgetts and Jackson* [1990] 1 Qd R 456.

⁵¹ [1993] AC 789.

⁵² As Lord Butler-Sloss noted in the Court of Appeal in *Bland*, ‘Medical ethics draw no distinction between the withholding of treatment and the withdrawing of treatment’, 818.

turns off the life-sustaining measures, is actively interrupting attempts to prolong life.⁵³

In *Bland* the Court concluded that it was no longer in the patient's 'best interests' for the life-sustaining treatment to be continued. Therefore, the medical professionals no longer owed a duty to provide such treatment and accordingly could not be criminally responsible for any omission to treat. This included the withdrawal of the artificial nutrition and hydration. Integral to this argument was the conclusion that the provision of artificial hydration and nutrition amounted to medical treatment.⁵⁴

In coming to their decision a number of their Lordships grappled with the moral dilemma that their decision sanctioned the intentional termination of a patient's life. The legal sanctioning of any form of killing, whether by an omission or a positive act, offends the entrenched doctrine of the sanctity of life.⁵⁵ Adherence to the doctrine protects the vulnerable from the 'slippery slope' that is argued may result from the legalisation of euthanasia.⁵⁶ The House of Lords recognised, however, that the doctrine of sanctity of life is not absolute; it yields in certain circumstances to the right to self-determination or autonomy.⁵⁷ By

⁵³ [1993] AC 789, 866.

⁵⁴ *Airedale NHS Trust v Bland (Bland)* [1993] AC 789, 870 (Lord Goff), 858 (Lord Keith), 878 (Lord Lowry).

⁵⁵ The right to life is a fundamental principle of international human rights. The right to life is recognised in many conventions and declarations including the International Covenant on Civil and Political Rights. Article 6 of that Convention provides that 'Every human being has the inherent right to life, the right shall be protected by law and no one shall be arbitrarily deprived of his or her right to life'.

⁵⁶ John Keown, 'Restoring Moral and Intellectual Shape to the Law after Bland' (1997) 113 *Law Quarterly Review* 481, 483. Keown notes that the principle does allow justifiable lethal force in self-defence, prosecution of just war, and execution in accordance with law. Cf Peter Singer, *Rethinking Life and Death* (1994) who advocates for the sanctioning of intentional killings in some circumstances (i.e. euthanasia).

⁵⁷ *Airedale NHS Trust v Bland (Bland)* [1993] AC 789, 864 (Lord Goff), 819–23 (Butler-Sloss), 826–8 (Hoffman), 859 (Lord Keith). Cf Keown, above n 3, where he argues that in *Bland* the Court misunderstood the doctrine of sanctity of life with one of quality of life. Keown refers to the doctrine as not 'requiring the preservation of life at all costs'; however, the doctrine can never sanction intentional killing or 'life-shortening' in

applying the act/omission distinction, the Court was able to maintain the fine line that distinguishes between the unlawful lethal injection and the lawful withdrawal of life-sustaining treatment. This distinction is maintained notwithstanding that the unlawful acts would lead to a swift and painless death whilst the lawful omission may entail a prolonged and sometimes painful death.⁵⁸

While there is yet to be any superior Australian or, more specifically, Queensland court decision that accepts the authority of *Bland*, there have been a number of lower court and tribunal decisions that either expressly or by implication endorsed the *Bland* determination.⁵⁹ Most recently in *Brightwater Care Group (Inc) v Rossiter*,⁶⁰ although the Court did not expressly address the question as to whether the withdrawal of life-sustaining treatment was an omission or an act, the decision is based on the assumption that the withdrawal of such treatment by health professionals is an omission. The Court only considered the plaintiff's potential criminal responsibility as a possible breach of the first 'stream' of homicide and only then as a possible breach of a duty and not as a negligent act. It is therefore submitted that, given the strength of international authority and acceptance by leading criminal text writers and commentators, notwithstanding the limited domestic authority, the law as expressed in *Bland* also applies to the *Code*.⁶¹

Accordingly, to be found criminally responsible for the death of a patient where a medical professional withholds or withdraws treatment, it must first be established that he or she was under a legal duty to act. The applicable duty is found in s 285 of the *Code*.⁶² Although other duty

any form. He therefore argues that *Bland* should have been argued not as intentionally causing death, but as withdrawing futile treatment with the foresight that the side-effect would be the death of the patient. But note the cogent criticism of this argument by Andrew McGee, above n 3.

⁵⁸ This is so at least for the family and carers. See *RE MC* [2003] QGAAT 13. See also Edward Grant and Clarke Forsythe, 'The Plight of the Last Friend: Legal Issues for Physicians and Nurses in Providing Nutrition and Hydration' (1987) 2 *Issues in Law and Medicine* 277.

⁵⁹ *Re RWG* [2000] QGAAT 49, [56].

⁶⁰ [2009] WASC 229 ('*Rossiter*').

⁶¹ See, eg, Kenny [12.6] above n 50. See also Eric Colvin and Justice John McKechnie, 'Criminal Law in Queensland and Western Australia: Cases and Commentary' (5th ed 2008) [3.12].

⁶² Section 285 requires a person having charge of another to provide that

provisions are also potentially relevant to the circumstances where a medical professional withdraws or withholds life-sustaining treatment, their application is less certain, and to date the Tribunal and courts have focused on the relevance of s 285 in such circumstances.⁶³

*C The Medical Professional's Duty under
s 285 of the Criminal Code*

There has been only limited judicial consideration of the s 285 duty. In *R v Young*,⁶⁴ Lucas J, with whom Hoare J agreed, stated that duty 'imposed by s 285 is for practical purposes in the same terms as that imposed by the common law'.⁶⁵ Lucas J cited with approval the common law decision *R v Charlotte Smith*⁶⁶ where Erle CJ stated '[t]he law is undisputed that if a person having the care and custody of another who is helpless neglects to supply him with the necessaries of life and thereby causes or accelerates his death it is a criminal offence'.⁶⁷

Section 285 gives effect to the duty in the following terms:

Duty to provide necessaries

It is the duty of every person having charge of another who is unable by reason of age, sickness, unsoundness of mind, detention, or any other cause, to withdraw himself or herself from such charge, and who is unable to provide himself or herself with the necessaries of life, whether the charge

person with the necessaries of life where that person is unable to do so themselves because of sickness, age, detention or unsoundness of mind. Section 288 states that every person who undertakes to provide medical treatment to another has a duty to do so with reasonable skill and reasonable care. Section 290 requires a person who has undertaken to do an act, the omission of which would be injurious to life or health, to perform the act. In effect the duty imposed on the doctor in relation to the withholding or withdrawing of life-sustaining measures would be the same under these provisions.

⁶³ *RE RWG* [2000] QGAAT 49; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229. See, also, *Medical Treatment for the Dying: Discussion Paper* (2005 Attorney General/Minister for Health Western Australia), 9–11.

⁶⁴ [1969] Qd R. 417.

⁶⁵ [1969] Qd R. 417, 441.

⁶⁶ (1865) 10 Cox C.C. 82.

⁶⁷ *R v Young* [1969] Qd R. 417, 441.

is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and the person is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.

In order to sustain a successful prosecution, the Crown must firstly establish that the accused had the 'charge' of another and, in the context of withdrawal or withholding of life-sustaining treatment, that that person, through sickness or age, was unable to withdraw from the charge. Secondly, the Crown must establish that the patient was unable to provide for him or herself the 'necessaries of life'. A breach of the duty would be established if the Crown proves that the accused failed to provide the necessaries of life. If it is further established that the accused intended to kill or cause grievous bodily harm, the offence would be one of murder, if not, the offence would be one of manslaughter.⁶⁸

Necessaries of life have been held to amount to such things as medical assessment or treatment,⁶⁹ food, shelter and clothing.⁷⁰ In the Queensland decision of *R v Nielsen*,⁷¹ a step-father and mother were convicted of failing to provide the necessaries of life⁷² to their thirty-one year old daughter who was in their care. The daughter who suffered from schizophrenia had been kept in her bedroom without medication

⁶⁸ *MacDonald and MacDonald* [1904] St R Qd 151. The Crown must prove that the accused was 'grossly negligent' in circumstances where the prosecution is based on a positive act. Arguably it is also necessary to prove 'gross negligence' where the position is based on a non-intentional omission. Whether 'gross negligence' must be established in circumstances where the prosecution is based on an intentional omission is both unresolved and beyond the scope of this paper. See the recent decisions of *R v BBD* [2006] 1 Qd R 478 and *R v Clark* (2007) 171 A Crim R 532 where the Court of Appeal considered the appropriate direction that should be given to a jury in respect to the degree of negligence that must be proved.

⁶⁹ *Smith* [1908] QWN 13.

⁷⁰ *MacDonald and MacDonald* [1904] St R Qd 151; *R v Nielsen* (2001) 121 A Crim R 231, 243–44.

⁷¹ (2001) 121 A Crim R 231.

⁷² *Criminal Code 1899* (Qld) s 325. The charge was one of failing to provide the necessaries of life which in the circumstances required the Crown to prove a breach of s 285 of the *Code*.

or adequate food. At the time the authorities took her into care she weighed 42.5 kg some 12-16 kg below her 'expected weight' and, due to the lack of medication, she was 'grossly disturbed'. The Court of Appeal held that due to her psychotic state the daughter was under the charge of her parents within the meaning of s 285. It also held that the term necessities of life, as set out in s 285, included anti-psychotic drugs and adequate food. Although not raised as a ground of appeal, the Court also stated that the parents' failure to seek medical assessment of their daughter for a period of five years also meant that they had failed to provide the necessities of life.⁷³

It would therefore seem beyond doubt that life-sustaining treatment such as cardiopulmonary resuscitation, mechanical ventilation, kidney dialysis and the provision of artificial hydration and nutrition together with other medications are necessities of life.⁷⁴ Prima facie a medical professional who withholds or withdraws life-sustaining treatment from a patient under his or her charge would seem to be failing to comply with his or her duty under s 285. However, it would seem extremely unlikely that a medical professional who was acting pursuant to a patient's request, an advanced health directive or a directive of a substitute decision maker would be found by a jury to have breached his or her duty. Even so, leaving the criminal responsibility of medical professionals in the hands of the jury is particularly problematic as determinations will invariably be made on a case-by-case basis. Medical professionals could not with certainty withhold or withdraw life-sustaining treatment as the prospect of prosecution and perhaps a remote chance of conviction remain. Furthermore, a court that was requested to provide declaratory relief as to whether withholding or withdrawing of life-sustaining treatment would attract criminal responsibility is perhaps less likely to provide such relief in circumstances where the question to be answered is entirely one for a jury. It is therefore preferable that s 285 of the *Code* be interpreted to exclude its application to these situations or that the *Code* provide a specific excuse applicable in circumstances where a health professional withholds or withdraws life-sustaining treatment. How this may be achieved is considered in the next section.

⁷³ (2001) 121 A Crim R 231, 243, 244.

⁷⁴ See *MacDonald and MacDonald* [1904] St R Qd 151; *R v Nielsen* (2001) 121 A Crim R 231; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229. See also P Mac Farlane, 'What is food-withdrawal of nutrition and hydration and other matters' (2003) 24 *The Queensland Lawyer* 135.

IV AVOIDING CRIMINAL RESPONSIBILITY FOR WITHDRAWING OR WITHHOLDING LIFE-SUSTAINING TREATMENT

A *Circumstances where Medical Treatment is not a Necessary of Life*

Life-sustaining medical treatment may not always be considered a necessary of life. The Tribunal and commentators have argued that health professionals are not criminally responsible in circumstances where medical treatment is merely artificially prolonging the moment of death without any prospect of recovery by the patient. In such circumstances treatment has no therapeutic function and, accordingly, is not a necessary of life.⁷⁵ As the *Code* duty is in the same or similar terms to the common law duty, such an interpretation finds support in the United Kingdom cases and in the decisions of other common law jurisdictions.⁷⁶ In *Auckland Area Health Board v Attorney-General*,⁷⁷ Thomas J held that a ventilator which induced heartbeat and breathing could not be construed as a ‘necessary of life’ in circumstances where it had no therapeutic benefit as the patient was beyond recovery.⁷⁸

Support for Thomas J’s approach can be found in *Re RWG*⁷⁹ where the Tribunal quoted from MacFarlane’s *Queensland Health Handbook* that ‘...the duty is to provide only medical necessities and would not generally extend to the provision of extraordinary measures’.⁸⁰ The distinction between ‘ordinary’ and ‘extraordinary means’ was defined by bioethicist Elizabeth Hepburn as:

⁷⁵ See, eg, *Re RWG*. [2000] QGAAT 49; Peter MacFarlane and Simon Reid, 2004 *Queensland Health Law Handbook* (14th ed, 2004).

⁷⁶ *Airedale NHS Trust v Bland (Bland)* [1993] AC 789; *Cruzan v Director of Missouri Department of Health*, 497 US 261 (1990); *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR 4th 385; *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235. Limiting the definition of necessities of life to those that have a therapeutic purpose or function also has the support of some commentators. See eg, Glanville L. Williams, *Textbook of Criminal Law* (2nd ed., 1983), 379; Peter MacFarlane and Simon Reid, above n 75. See also *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235; *Re RWG*. [2000] QGAAT 49.

⁷⁷ [1993] 1 NZLR 235.

⁷⁸ *Ibid.*

⁷⁹ [2000] QGAAT 49.

⁸⁰ *Ibid* [57]

The term ‘extraordinary means’ should not be construed to mean ‘unusual’, but rather should be understood as “disproportionate”; it reflects the outcome of a process of balancing burdens and benefits by which a particular procedure is judged worthwhile. In this context ‘extraordinary means’ is a moral rather than a medical term. Inherent in this approach is a notion that competing values and goals need to be assessed and the overall benefit of the treatment to the patient considered. This procedure has sometimes been expressed in terms of proportionality that is the likely gain must be proportional to the hardship associated with the treatment’.⁸¹

The Tribunal in *Re RWG* further stated that, although there is a lack of authority from Queensland courts, the decisions from other jurisdictions ‘indicate that a doctor is under no duty to provide medical treatment, which will provide no benefit to the patient and is not in the patient’s best interests’.⁸² Under the ‘best interest’ test, although the presumed wishes of the patient, and those known of the family, are considered, the determination of what is in the best interests of the patient ultimately rests with the medical profession.⁸³

Where the *GAA* applies, decisions made to withdraw or withhold life-sustaining measures can only be taken after consideration of the General Principles and the Health Care Principles as set out in the *Act*.⁸⁴ Under

⁸¹ Ibid [59] quoting from Elizabeth Hepburn, *Of Life and Death* (1996). For an alternative view which posits that there is no distinction between extraordinary and ordinary means either by the nature of the treatment or morally see Ian N Olver, *Is Death Ever Preferable to Life?* (2002), 57.

⁸² *Re RWG* [2000] QGAAT 49, [64]. As stated above, the ‘best interests’ test which originated in *Bland* is the preferred test in the UK and a number of other common law jurisdictions. This can be contrasted with the substituted judgment test which is applied in the US. For a comprehensive discussion of both see Willmott and White above n 6.

⁸³ Reference can be made to the civil jurisdiction where the test applied in the UK in negligence actions is the Bolan test which refers to a body of responsible medical opinion. This is no longer the common law in Australia, although legislative enactments in the various Civil Liability Acts have provided a defence to professionals who act in accordance with medical practice which is widely accepted by peer professional opinion as competent professional practice. See, eg, *Civil Liability Act 2003* (Qld) s 22.

⁸⁴ *Guardianship and Administration Act 2000* (Qld) s 11.

these provisions the decision must be made in a way least restrictive of the adult's rights,⁸⁵ where it is necessary and appropriate to maintain or promote the adult's health or well-being or is in the adult's best interests.⁸⁶ Further, the adult's views and wishes are to be taken into account, as are those of the health providers.⁸⁷ Any decision made by the decision-maker, in order to be effective, 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'.⁸⁸ This then leaves the ultimate decision in the hands of the medical professional.⁸⁹

While not expressed in terms of 'futility' or 'necessaries of life' it is submitted that the requirements of the *GAA* are such that it would be extremely unlikely that any decision made in accordance with the *Act* to withdraw or withhold life-sustaining treatment could be regarded as a 'necessary of life', for the purposes of s 285. Accordingly, no duty would arise and a health professional could not be held criminally responsible for the withholding or withdrawal of life-sustaining measures where the treatment is artificially prolonging the moment of death.

In summary, therefore, the argument that life-sustaining treatment is not a necessary of life applies to an incompetent patient in circumstances

⁸⁵ See *Re MC* [2003] QGAAT 13 where the Tribunal held that provision of artificial hydration and nutrition through a PEG was intrusive, burdensome and futile in the circumstances and was not the least restrictive option. See also *Northbridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549.

⁸⁶ *Power of Attorney Act 1998* (Qld) Health Care Principle 12 and *Guardianship and Administration Act 2000* (Qld) Sch 1, Pt 2. It has been suggested that as 'best interests' is not defined in the *PAA* or *GAA* would import the common law meaning as per *Bland* and *Auckland*. See, eg, Lindy Willmott and Ben White, 'Charting a course through difficult legislative waters: Tribunal decisions on life-sustaining measures' (2005) 12 *Journal of Law and Medicine* 441, 450.

⁸⁷ *Guardianship and Administration Act 2000* (Qld) Health Care Principle 12(2).

⁸⁸ *Guardianship and Administration Act 2000* (Qld) s 66A.

⁸⁹ Note, however, that in *Re RWG*. [2000] QGAAT 49, the Tribunal took the view that this was also a matter that required determination of the Tribunal, in situations where the Tribunal was asked to provide consent. This is due to the definition under the *GAA* of health care matter. See also Willmott and White, above n 86.

where Parliament has prescribed that the decision to refrain from or cease such treatment can be made. It may also apply to a competent patient who is close to death or who is suffering intolerable pain with no chance of relief or recovery.

B *When is a Patient under a Health Professional's Charge?*

As discussed above, a competent patient's common law right to refuse life-sustaining treatment applies notwithstanding that the reasons for the decision are 'irrational, unknown or even non-existent'.⁹⁰ Therefore, medical professionals can be faced with a request by a competent patient to withhold or withdraw life-sustaining treatment in circumstances where to do so may not in their view, be in the 'best interest' of the patient. A patient may, however, refuse life-sustaining treatment in circumstances where treatment would ensure a continuation of life perhaps without or with only limited pain and suffering and perhaps with or without the possibility of a full or partial recovery. In such circumstances the life-sustaining treatment would be a necessary of life. Therefore, it would seem that the obligations of medical professionals as imposed by s 285 are potentially in conflict with a competent patient's right to refuse treatment.

It has been argued therefore that, as the corollary to a patient's right to refuse medical treatment, including life-sustaining measures, a health professional's duty to provide such treatment only arises in certain circumstances. Two approaches have been put forward to limit the circumstances when a patient is under a health professional's charge. The first is based on the argument that patients who have capacity are not under the charge of their health providers. In *Rossiter*⁹¹ Martin CJ of the Supreme Court of Western Australia favoured the view that a patient who requires life-sustaining treatment is not necessarily under the charge of medical staff. In reference to the identical provision to that of s 285 of the *Code* His Honour states:

[T]he reference to a person 'having charge of another' is a reference to a person who, by reason of one or more of the various disabilities identified in the section, lacks the

⁹⁰ *Re T* [1992] 3 WLR 782, 799. See also *Ms B v An NHS Hospital Trust* [2002] 2 FCR (UK) 1 [18]; *Hunter and New England Health Service v A* [2009] NSWSC 761 [15]; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 [27].

⁹¹ [2009] WASC 229.

capacity to direct or control their own destiny and is therefore dependent upon the person ‘having charge’ of them.⁹²

The defendant who suffered from quadriplegia was generally unable to move, he required services including turning in bed, assistance with bowel movement, physiotherapy and he received nutrition and hydration through a PEG.⁹³ He was not terminally ill and he could have continued to live for many years, although his condition would have gradually deteriorated. Mr Rossiter therefore lacked the ‘physical capacity to control his own destiny’.⁹⁴ He was, however, capable of evaluating information and making informed decisions as to his own health care. Mr Rossiter had received advice as to the consequence and effects of discontinuing the provision of nutrition and hydration and he had responded on many occasions, by talking through a tracheotomy, that he wanted that service to cease. Martin CJ concluded that, as Mr Rossiter was competent to make ‘informed and insightful decisions’ as to his own treatment, he was not, in the context of the duty provision, in the charge of the plaintiff health provider.⁹⁵ Although there was insufficient evidence to reach a conclusion, Martin CJ also suggested that Mr Rossiter may have had the financial capacity to control the direction that his future care could take. If his financial situation was such that he could have left Brightwater for the services of another health provider then Mr Rossiter was not ‘unable to withdraw himself’ from the charge of the plaintiff.⁹⁶

The approach adopted by Martin CJ enabled His Honour to reconcile the rights of patients with the duty of health professionals as imposed by the criminal law. However, with due respect to His Honour, it is submitted that the approach adopted does not stand close scrutiny. First the language of the identical provision to s 285 of the *Code* does not support a conclusion that persons with the mental capacity to control their future are not under the care of others. The section refers to those who due to ‘age, sickness, unsoundness of mind, detention, or any other cause’ are unable to withdraw themselves from the care of another. The

⁹² [2009] WASC 229, [39].

⁹³ A percutaneous endoscopic gastrostomy tube (PEG) through which the patient receives nutrition and hydration.

⁹⁴ [2009] WASC 229, [40].

⁹⁵ [2009] WASC 229, [40].

⁹⁶ [2009] WASC 229, [40].

second problem with the approach is that it is not capable of general application. Take for example the hypothetical case of a quadriplegic patient who developed a serious life threatening skin problem because medical staff failed to provide adequate removal of excrement and/or bathing. In such circumstances a member of the medical staff could face charges for an offence such as negligent acts causing harm, which would require that the Crown prove a breach of the duty provision. It seems highly unlikely that, in such circumstances, a court would find that there was no duty owed if the patient was in control of his or her mental capacities and had the financial ability to remove him or herself from the services of the medical staff. Therefore, the principle adopted by Martin CJ would have to constitute some form of exception, the basis for which remains uncertain.

The second approach to limiting the circumstances where a patient is under the charge of a health professional is based on the question of consent. It is argued that if consent to medical treatment were not considered to be a prerequisite to the existence of the medical professional's duty to provide treatment, the principle of self-determination and patient autonomy would be abrogated. The emphatic view of the Western Australian Law Reform Commission in its 1991 report was that valid, informed refusal to provide consent relieves a health professional of his or her duty to a patient to provide that treatment.⁹⁷ Therefore, once competent adults validly refuse to consent to a particular form of treatment, they are no longer under the charge of the treating health professional. As the mechanism by which the patient is under the charge of the health professional is generally contractual,⁹⁸ it is arguable that the competent patient, irrespective of their age or physical incapacities, is always free to withdraw from such charge.⁹⁹ The contract could be

⁹⁷ West Australia Law Reform Commission *Medical Treatment for the Dying* Project No 84 (1991) [1.11] and [1.12].

⁹⁸ A doctor is not generally bound to take on any patient and, in relation to competent adults, the relationship will generally be contractual. There may be instances, however, where a doctor's Hippocratic oath, requires him/her to 'rescue' a stranger; see *Lowns v Woods* [1996] Aust Torts Reports 81–376. The relationship of a patient and a public treatment facility may not be strictly contractual, although a patient's right to withdraw from the care exists.

⁹⁹ See, eg, Zada Lipman, 'The Criminal Liability of Medical Practitioners for Withholding Treatment from Severely Defective Newborn Infants' (1986) 60 *The Australian Law Journal* 286, 292.

interpreted as the provision of medical treatment in accordance with the instructions and informed consent of the patient, where this can be obtained. In fact there is no reason why it could not be argued that a patient can withdraw from a health professional's charge in relation to a particular form of treatment, while still remaining in the health professional's charge in relation to other treatments and care including the provision of the 'necessaries of life'. Such an interpretation of the duty provision would uphold the entrenched notion of patient autonomy by ensuring the wishes of the patient determined his or her own fate, but at the same time ensuring that treating practitioners are not held criminally responsible for complying with a patient's request.

This second approach, however, also suffers from a fundamental flaw. In the context of the withdrawal or withholding of life-sustaining treatment, the crux of this approach is that a patient's consent to die relieves the health provider of any criminal responsibility. So expressed, the approach is at odds with s 284 of the *Code* which states that '[c]onsent by a person to the causing of the person's own death does not affect the criminal responsibility of any person by whom such death is caused.'¹⁰⁰ That section is one of general application and there is no reason to suggest that it does not apply where a homicide offence is based on the failure to perform a duty as set out in the *Code*. In fact, its position within the *Code* would suggest otherwise.

C *Relevant Excuses under the Code*

As s 285 may apply in circumstances where a medical professional withholds or withdraws life-sustaining treatment at the request of a competent patient, it is therefore necessary to consider whether any of the exculpatory provisions of the *Code* are of possible application. The excuse that is most likely to apply is that contained in s 282 of the *Code*. As stated above, this section was the subject to significant change when the Queensland Parliament passed the *Criminal Code (Medical Treatment) Amendment Act 2009* (Qld). The amended section reads:

282 Surgical operations and medical treatment

'(1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—

(a) a person or an unborn child for the patient's benefit; or

¹⁰⁰ The provision can also be found in the *Criminal Code 1913* (WA) s 261.

(b) a person or an unborn child to preserve the mother's life;

if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

The most significant amendment to the section was the expansion of its application, not only to the adverse consequences of a surgical operation, but also to the adverse consequences of 'medical treatment'. The term 'medical treatment' is not defined; however, the term could encompass not only positive acts but also decisions not to administer treatment. Take for example the case of *Burke v The General Medical Council*¹⁰¹ where the Court was presented with evidence that the provision of artificial nutrition and hydration may increase the pain and suffering of patients with certain forms of cancer and severe and deteriorating dementia.¹⁰² In such circumstances the appropriate medical treatment to relieve pain and suffering would be the withdrawal or failure to provide nutrition and hydration.

If it is accepted that medical treatment includes withholding or withdrawal of treatment, then s 282 substantially alleviates the conflict between a patient's common law rights and the duty imposed on a health professional under s 285. A medical professional who withheld or withdrew life-sustaining treatment would not be criminally responsible, provided he or she acted in good faith, with reasonable care and skill, and the decision was 'reasonable, having regard to the patient's state at the time, and to all the circumstances of the case'. It is the last requirement that would ensure that the conflict between a patient's common law rights and a health professional's duty under the *Code* would not be entirely reconciled. A patient's consent to treatment is a relevant factor in determining whether a decision to withdraw or withhold treatment was reasonable. Martin CJ in *Rossiter*¹⁰³ stated that:

Plainly the phrase 'all the circumstances of the case' is quite broad enough to include the informed decision of a mentally competent patient. Having regard to the common law principles of self-determination to which I have referred, it is clearly 'reasonable' to act in accordance with the informed

¹⁰¹ [2004] EWHC 1879.

¹⁰² [2004] EWHC 1879 [19],[20].

¹⁰³ [2009] WASC 229.

decision of a mentally competent patient who refuses to consent to medical treatment.¹⁰⁴

It is submitted that the patient's informed consent is not the only or determining factor when considering whether the decision was reasonable. The language of s 259 of the *Criminal Code* (WA) and the equivalent s 282(1) of the *Code* (Qld) suggest otherwise. First, the section refers to all the circumstances, which strongly suggests that there is more than one factor to be considered. Secondly, the section makes no reference to consent. If it were intended that consent could be the sole or determining factor then the section could have been so expressed. Therefore, factors such as the patient's pain and suffering, the likelihood that the patient will recover, the likelihood of deterioration and the life expectancy of the patient could also be factors that determine whether the decision was reasonable.

The palliative care excuse set out in s 282A may, in certain circumstances, also apply to a health professional who withholds or withdraws life-sustaining treatment at the request of a patient.¹⁰⁵ However, its application is limited as palliative care is defined to mean care directed at maintaining or improving a patient's comfort in circumstances where, if not for the care, the patient would be subjected to pain and suffering. Only in exceptional circumstances such as those referred to in *Burke v The General Medical Council*¹⁰⁶ would withholding or withdrawing life-sustaining treatment come within the definition of palliative care. Furthermore, the requirement that the accused must not intend, by way of their care, to kill the patient may also prove to restrict the section's application to situations of withdrawal or withholding of life-sustaining treatment.

¹⁰⁴ [2009] WASC 229, [44].

¹⁰⁵ For a comprehensive discussion of the palliative care excuse see Ben White and Lindy Willmott 'The Edge of Palliative Care: Certainty, but at What Price?' (2004) 7 *Flinders Journal of Law Reform* 225; Andrew McGee, 'Double Effect in the *Criminal Code* 1899 (Qld): A Critical Appraisal' (2004) 4 *Queensland University of Technology Law and Justice Journal* 46.

¹⁰⁶ [2004] EWHC 1879, [19]–[20].

V THE NEED FOR REFORM?

The above analysis argues that health professionals are able to withdraw or withhold life-sustaining treatment pursuant to an advanced health directive or the directive of a substitute decision maker in accordance with the *GAA* without the risk of criminal liability. As stated this conclusion is reached because the decision to withdraw or withhold treatment can only be made at a time when such treatment is no longer a necessary of life. There is greater uncertainty as to the application of the *Code* provisions when a health professional complies with a competent patient's refusal of life-sustaining treatment in circumstances where that patient is not in the final stage of a terminal illness and is not in pain or suffering.

This analysis, however, rests on a number of assumptions about how *Code* provisions will be interpreted. The presumptions include that the withholding or withdrawing of life-sustaining treatment will be classified as an omission to act, rather than a positive act of commission. Further that all life-sustaining treatment will be considered medical treatment including the provision of artificial hydration and nutrition. Also a health professional will not be under a duty to provide such treatment to an incompetent patient in circumstances where the provisions of the *GAA* have been followed. With respect to a competent patient that she or he is not under the charge of a health professional, although the circumstances in which this will be the case are unclear. Finally, there is also uncertainty as to the application of s 282 of the *Code* to the withholding or withdrawal of life-sustaining treatment whether the patient is competent or not. Without certainty many health professionals may well be reluctant to comply with a patient's request and, consequently, a time consuming and expensive process of seeking judicial clarification will become more common. It is therefore desirable that Parliament legislate to clarify the law.

A *The Western Australian Legislative Response*

As stated above, the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA), amongst other things, amended the *Code* in that State to address the question of a medical professional's responsibility for withholding or withdrawing life-sustaining treatment. Section 259 of the *Criminal Code* (WA) as amended includes the following:

- (2) A person is not criminally responsible for not administering or ceasing to administer, in good faith and

with reasonable care and skill, surgical or medical treatment (including palliative care) if not administering or ceasing to administer the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.¹⁰⁷

It is suggested that the terms 'reasonableness', and 'all the circumstances of the case' provide a broad but not sufficiently defined excuse for criminal liability arising from a breach of the duty provisions. Importantly the provision fails to clarify the relevance of a patient consent in determining criminal responsibility. Furthermore, the question as to the reasonableness of the treatment remains one for the jury.

Despite this, the enactment of such a provision sends a clear message to health professionals that parliament has provided an excuse specifically directed to the withdrawal and withholding of life-sustaining measures. The fact that parliament has sought to clarify the law in such a way arguably also provides the impetus for judges to usurp the role of the jury in providing declaratory relief that a proposed withdrawal of life-sustaining measures would not attract criminal responsibility.

Notwithstanding that s 259(2) does not put beyond doubt that a health professional is excused from acting pursuant to the informed request of a patient, Martin CJ in *Rossiter*,¹⁰⁸ held that, if his interpretation of the duty provision was incorrect, s 259(2) provided the plaintiff with an excuse for discontinuing treatment in accordance with the defendant's request. His Honour stated that the 'entire thrust of the legislation which resulted in the introduction of subsection (2) of s 259 was aimed at giving force and effect to the common law principle of autonomy and self-determination... [i]t would be utterly inconsistent with the legislative objective to construe s 259 as detracting from that common law position'.¹⁰⁹ His Honour also finds support for his conclusion in the Second Reading Speech of the Acts Amendment (Consent to Medical Treatment) Bill 2006. The Hon Sue Ellery stated that:

Furthermore, the law in relation to the withdrawal or withholding of life-sustaining measures in circumstances of terminal illness or permanent unconsciousness, and the provision of palliative care, is perceived as uncertain and

¹⁰⁷ *Acts Amendment (Consent to Medical Treatment) Act 2008 (WA)* s 18.

¹⁰⁸ [2009] WASC 229 [43].

¹⁰⁹ [2009] WASC 229 [48].

as not providing sufficient protection to health professionals involved in end-of-life decision making and treatment. The principle of personal autonomy is central to the bill. The bill establishes a simple, flexible scheme whereby persons can ensure that, in the event that they become mentally incompetent and require medical treatment for any condition, including a terminal illness, their consent, or otherwise, to specified treatment can be made clear in an advance health directive and or alternatively treatment decisions can be made by an enduring guardian chosen by them. The bill also clarifies the circumstances in which consent can be given or refused in the absence of an advanced health directive, a guardian or an enduring guardian, and clarifies and expands the protection from criminal and civil liability given to health professionals.¹¹⁰

As noted, while the enactment of s 259(2) and the decision in *Rossiter* will provide some comfort to Western Australian health professionals who are requested to withhold or withdraw life-sustaining treatment, the inclusion of the requirement that the decisions be reasonable ‘having regard to all the circumstances of the case’ does leave open the possibility that a future decision by a court of criminal jurisdiction would not give the patient’s consent the pre-eminence given to it in *Rossiter*.¹¹¹ It is certainly unlikely that a criminal court would be prepared to read the sections of the *Code* in light of the common law.¹¹² Furthermore, to the extent to which reference can be made to second reading speeches in interpreting the *Code*, the speech does not entirely support his Honour’s conclusion. The statements with respect to self-determination and autonomy are made in reference to a patient who is terminally ill or permanently unconscious.

¹¹⁰ Acts Amendment (Consent to Medical Treatment) Bill 2006, Second Reading Hon Sue Ellery (6 December 2006) p 9244

¹¹¹ It is certainly unlikely that a criminal court would be prepared to read the sections of the *Code* in light of the common law, an interpretation method inconsistent with principles of *Code* interpretation. See *Brennan v R* (1936) 55 CLR 253, 263; *R v Barlow* (1997) 188 CLR 1, 31–32; and *Charlie v The Queen* (1999) 199 CLR 387, 394.

¹¹² The interpretation method deployed by Martin CJ would certainly appear to be inconsistent with principles of *Code* interpretation: see *Brennan v R* (1936) 55 CLR 253, 263; *R v Barlow* (1997) 188 CLR 1, 31–32; and *Charlie v The Queen* (1999) 199 CLR 387, 394.

It is suggested therefore that greater clarification is required. One possible way of achieving clarity is to amend the s 259(2) excuse to give primacy to the patient's consent. This could be achieved by simply adding the words 'is at the request by or on behalf of a patient or'¹¹³ immediately after the words 'not administering or ceasing to administer the treatment.'

The enactment in Queensland of a subsection in similar terms to that enacted in Western Australia, which included the suggested amendments, giving primacy to consent and patient autonomy, would provide an excuse of general application that would be applicable not only to a breach of s 285 but also to a breach of the other duty provisions. Furthermore, in the highly unlikely event that the courts reject the *Bland* principle that the withdrawal or withholding of treatment is an omission or that life-sustaining treatment in certain circumstances is not a necessity of life, the excuse would in any event apply to exculpate a health professional.

VI CONCLUSION

Despite the lack of prosecutions,¹¹⁴ the ambiguity in the criminal law has the potential to influence the practice of health professionals. It is therefore important that any actual or potential conflict between a patient's common law rights and the duties imposed on health professionals be resolved. As the population ages and medical technologies continue to improve, decisions regarding when people should be allowed to die will become more common. To allay fears regarding the legality of conduct of withholding or withdrawing life-sustaining treatment, and to ensure that 'society's notions of what is the law and what is right ... coincide[s]',¹¹⁵ it is submitted that the *Criminal Code* of Queensland should be amended by including a subsection similar to s 259 (2) of the *Criminal Code 1913* (WA). As argued above, however, it is important

¹¹³ Further clarification could specify that a request on behalf of a patient must come from a substitute decision maker pursuant to the *GAA*, and that the request by a patient includes an advanced health directive. Furthermore, the legislature could specify whether a request by a patient must be an informed request.

¹¹⁴ See Corns, above n 7. Chris Corns refers to one prosecution in Victoria in 1996 of a nurse who removed a breathing tube from a patient. Due to the inability to prove causation the judge directed an acquittal of the accused.

¹¹⁵ *Airedale NHS Trust v Bland* (*Bland*) [1993] AC 789, 877 (Lord Lowry).

that any such amendment give primacy to the role of the patient's consent in determining whether a health professional's decision to withdraw or withhold life-sustaining treatment was culpable.