REPORT 10
STANDING COMMITTEE ON LEGISLATION

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

Presented by Hon Graham Giffard MLC (Chair)

October 2007
STANDING COMMITTEE ON LEGISLATION

Date first appointed:
17 August 2005

Terms of Reference:
The following is an extract from Schedule 1 of the Legislative Council Standing Orders:

“4. Legislation Committee

4.1 A Legislation Committee is established.

4.2 The Committee consists of 5 members.

4.3 The functions of the Committee are to consider and report on any Bill referred by the House or under SO 125A.

4.4 Unless otherwise ordered any amendment recommended by the Committee must be consistent with the policy of a Bill.”

Members as at the time of this inquiry:
Hon Graham Giffard MLC (Chair) Hon Peter Collier MLC
Hon Giz Watson MLC (Deputy Chair) Hon Sally Talbot MLC
Hon Helen Morton MLC (substitute Member for Hon Ken Baston MLC)

Staff as at the time of this inquiry:
Denise Wong, Advisory Officer (Legal) Dr Colin Huntly, Advisory Officer (Legal)
Mark Warner, Committee Clerk Kerry-Jayne Braat, Committee Clerk

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Government Response

This Report is subject to Standing Order 337:

After tabling, the Clerk shall send a copy of a report recommending action by, or seeking a response from, the Government to the responsible Minister. The Leader of the Government or the Minister (if a Member of the Council) shall report the Government’s response within 4 months.

The four-month period commences on the date of tabling.
**LIST OF ABBREVIATIONS AND DEFINED TERMS**

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RECOMMENDATIONS FOR THE

REPORT OF THE STANDING COMMITTEE ON LEGISLATION

IN RELATION TO THE

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

RECOMMENDATIONS

1 Recommendations are grouped as they appear in the text at the page number indicated:

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Recommendation 1: The Committee recommends that the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended to insert a regulation-making power to allow for the development of a national register of advance health directives in consultation with other States and Territories.

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Recommendation 2: The Committee recommends that any form prescribed by regulations to the Acts Amendment (Consent to Medical Treatment) Bill 2006 as being required to constitute a valid statutory advance health directive for the purposes of proposed section 110Q(1) of the Guardianship and Administration Act 1990 should contain a clause in substantially the following terms:

“You are strongly encouraged to seek medical and/or legal advice concerning the terms of this directive. Please indicate whether you have received such advice and (optional) who provided you with this advice.”

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Recommendation 3: The Committee recommends that the register of advance health directives established at clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110RA of the Guardianship and Administration Act 1990, should be free from fees.
Recommendation 4: The Committee recommends that access to the register of statutory advance health directives, provided for at clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110RA of the Guardianship and Administration Act 1990, should be restricted to the treating health professional and, unless specifically excluded by the maker of the directive:

a) the guardian of the maker; and

b) the enduring guardian of the maker (if one has been appointed); and

c) the person responsible for the maker as defined by proposed section 110ZD of the Guardianship and Administration Act 1990 (if there is any).

Recommendation 5: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended as follows:

Page 17, line 25 — To delete “made more than 10 years before the time at which the treatment decision would otherwise operate”.

Page 18, lines 10 to 14 — To delete the lines.

Recommendation 6: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended as follows:

Page 18, after line 9 — To insert —

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(e) the views of any guardian of the maker, the enduring guardian of the maker (if such have been appointed), or the person responsible for the maker as defined by proposed section 110ZD (if there is any) concerning the treatment, unless such a person has been specifically precluded from expressing such a view in the advance health directive.
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Recommendation 7: The Committee recommends that the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended to expressly provide that a ‘person responsible’ for a patient under clause 11 of the bill, proposed section 110ZD of the Guardianship and Administration Act 1990 must act in the best interests of the patient when making a treatment decision for that patient.

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Recommendation 8: The Committee recommends that the Government ensure that all health professionals are fully informed of the requirements of proposed sections 110ZIA(1)(c), 110ZK(2)(a)(i) and (b) of the Guardianship and Administration Act 1990.

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Recommendation 9: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110ZK of the Guardianship and Administration Act 1990, be amended to include a definition of the phrase ‘good faith’ in the substantive terms of the advice provided by the State Solicitor’s Office which is reproduced at paragraph 18.10 of this Report.

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Recommendation 10: The Committee recommends that the Government ensure that all health professionals are fully informed of the requirements of proposed section 110ZK(2)(a)(ii) of the Guardianship and Administration Act 1990.

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Recommendation 11: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110ZK(2)(b) of the Guardianship and Administration Act 1990, be amended so that health professionals who fall within the ambit of the proposed section must also sight written evidence that the other health professional on whom they are relying has ascertained that the treatment action is in accordance with a treatment decision.

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Recommendation 12: The Committee recommends that the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended as follows:

Page 28, line 26 to Page 29, line 26 — To delete lines.
REPORT OF THE STANDING COMMITTEE ON LEGISLATION

IN RELATION TO THE

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

1 REFERRAL

1.1 On 5 September 2007, the Legislative Council referred the Acts Amendment (Consent to Medical Treatment) Bill 2006 (Bill) to the Standing Committee on Legislation (Committee) for inquiry with a reporting deadline of 18 October 2007. The policy of the Bill was not referred to the Committee for inquiry.

1.2 On 16 October 2007, the Committee sought and obtained an extension of its reporting deadline to 25 October 2007.

2 INQUIRY PROCEDURE

2.1 The Committee sought written submissions on the Bill by:

• placing the details of the inquiry on the Parliament’s website (www.parliament.wa.gov.au);

• issuing a media statement containing the key dates for the inquiry on 7 September 2007; and

• advertising the details of the inquiry in The West Australian newspaper on 12 September 2007.

2.2 Written submissions were received by the Committee from the following interested parties:

i) The Australian Christian Lobby.


iii) Dr Ruth Nicholls.

iv) Dr Lachlan Dunjey.

1 Parliament of Western Australia, Legislative Council, Parliamentary Debates (Hansard), 5 September 2007, pp4812-4814.

2 Parliament of Western Australia, Legislative Council, Parliamentary Debates (Hansard), 16 October 2007, p6041.
v) The Australian Family Association, Western Australian Division.

vi) The West Australian Voluntary Euthanasia Society Inc.

vii) The Christian Science Committee on Publication for Western Australia.

viii) The LJ Goody Bioethics Centre.

ix) The Health Consumers’ Council WA Inc.

x) The Australian Medical Association (WA).

xi) The Office of the Public Advocate.

xii) Mr Keith Wilson, Independent Advocate for People with Mental Illness.

2.3 On 19 September 2007 and 8 October 2007, briefings on the Bill, by way of public hearing, were held with:

- Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office (SSO); and
- Ms Sue Le Souef, Senior Assistant State Solicitor, SSO,

who were involved with the development of the Bill, including co-authoring the Discussion Paper which preceded the Bill\(^3\) (*Discussion Paper*) and instructing Parliamentary Counsel during the drafting of the Bill.\(^4\) During the first briefing, Ms Bush and Ms Le Souef tabled three papers titled:

- *Acts Amendment (Consent to Medical Treatment) Bill 2006 - Opening Statement*;
- *Acts Amendment (Consent to Medical Treatment) Bill 2006 - State Administrative Tribunal*; and
- *Acts Amendment (Consent to Medical Treatment) Bill 2006 - Liability of Health Professionals*.

2.4 These papers are attached to this Report as **Appendices 1 to 3**, respectively, for the information of the Legislative Council.

2.5 Public hearings were held on 26 September 2007 with:

\(^3\) Attorney General and Minister for Health, *Medical Treatment for the Dying: Discussion Paper*, May 2005. This discussion paper was prepared by Ms Le Souef and Ms Bush in conjunction with Mr John Young, also of the State Solicitor’s Office.

\(^4\) Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, 13 September 2007, p1.
• Ms Michele Kosky, Executive Director, and Ms Maxine Drake, Advocate, Health Consumers’ Council WA Inc; and

• Associate Professor Geoffrey Dobb, President, and Mr Peter Jennings, Acting Executive Director, Australian Medical Association (WA).

2.6 Valuable information was also obtained by the Committee through written correspondence. The following letters were particularly useful and are attached to this Report for the information of the Legislative Council:

• The enclosure to a letter from Ms Le Souef, Senior Assistant State Solicitor, SSO, dated 28 September 2007 (Appendix 4).

• The enclosure to a letter from Ms Le Souef, Senior Assistant State Solicitor, SSO, dated 11 October 2007 (Appendix 5).

• The enclosure to a letter from Ms Le Souef, Senior Assistant State Solicitor, SSO, dated 16 October 2007 (Appendix 6).

2.7 The Committee extends its appreciation to the individuals who, and the organisations which, provided evidence and information as part of the inquiry.

3 SCOPE OF THIS REPORT

3.1 While the Committee has analysed all of the provisions of the Bill, it has only provided comments on specific clauses and the issues raised in respect of them. These clauses are 5 and 11.

3.2 For the purposes of this Report, ‘consent’ includes the refusal of consent unless otherwise indicated.

3.3 Given that the policy of the Bill was not referred to the Committee for inquiry, the Committee identified the main points of policy which were agreed during the Second Reading of the Bill in the Legislative Council in order to clarify which matters were not open for the Committee’s inquiry. The main points of policy have been summarised in Table 1 below. While the Committee did not inquire into these matters, many submitters provided their views on policy issues and this Report has, where relevant, confirmed the policy position in relation to certain matters.

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5 Legislative Council Standing Order 230B provides that “Unless otherwise ordered, a standing committee is not to inquire into the policy of a Bill.”
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<td>1. “Persons can ensure that in the event of their becoming mentally incompetent and requiring medical treatment for any condition, including 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.”</td>
<td>Hansard 06.12.06/9244</td>
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<td>2. “clarifies the circumstances in which consent can be given or refused in the absence of an advance health directive, a guardian or an enduring guardian”</td>
<td>Hansard 06.12.06/9244</td>
</tr>
<tr>
<td>3. “clarifies and expands the protection from criminal and civil liability given to health professionals” by amending the Guardianship and Administration Act 1990 and The Criminal Code.</td>
<td>Hansard 06.12.06/9244</td>
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<td>4. Maintains the common law position that “a health professional is under no obligation to provide treatment that is not clinically indicated.”</td>
<td>Hansard 06.12.06/9244</td>
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<td>5. Does not permit euthanasia.</td>
<td>Hansard 06.12.06/9244</td>
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<td>6. “A person who is 18 years of age or over and has full legal capacity will be able to make and register an advance health directive containing treatment decisions in relation to his or her future treatment.”</td>
<td>Hansard 06.12.06/9244</td>
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<td>7. “a treatment decision in an advance health directive must be made voluntarily and without inducement or coercion. The maker must also understand the nature of the decision and the consequences of making it. A decision will not operate if at the time the treatment is required circumstances exist or have arisen that the maker did not anticipate when the directive was made and which would have caused the maker to change his or her mind about the decision.”</td>
<td>Hansard 06.12.06/9244</td>
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<td>8. The form of advance health directives under the Bill must at least substantially conform to legislative requirements.</td>
<td>Hansard 06.12.06/9244</td>
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<td>9. “The common law will be expressly preserved to enable a person to make treatment decisions about his or her future treatment, other than by means of the</td>
<td>Hansard 06.12.06/9244</td>
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### Policy

| 10. | A person who is “18 years or over and has full legal capacity, will be able to appoint in writing an enduring guardian or two or more joint enduring guardians to make personal and lifestyle decisions, including treatment decisions, on his or her behalf. An enduring power of guardianship will be operative only when the appointor is unable to make reasonable judgments about matters relating to his or her person.” |
| 11. | The form of an enduring power of guardianship under the Bill must at least substantially conform to legislative requirements. |
| 12. | “an enduring guardian will have the same functions, and is subject to the same limitations, as a plenary guardian appointed by the State Administrative Tribunal under the [Guardianship and Administration] Act.” |
| 13. | “Where a patient is unable to make reasonable judgments about proposed treatment, has made no relevant advance health directive and has no enduring guardian or guardian, the bill provides a mechanism whereby a “person responsible” may make treatment decisions on behalf of the patient. A “person responsible” is the first in order of priority of the persons in the following list who is of legal capacity; is reasonably available and is willing to make a treatment decision at the time the treatment is required; the patient’s spouse or de facto partner, if that person is 18 years or over and is living with the patient; the patient’s nearest relative who maintains a close personal relationship with the patient; the person who is 18 years or over and is the primary provider of care and support, including emotional support, to the patient but is not remunerated for providing that care and support; and any other person who is 18 years or over and maintains a close personal relationship with the patient.” |
| 14. | “The treatment decision is to be made by a person first in order of priority in the following list: the patient through an advance health directive, an enduring guardian, a guardian and a “person responsible”. … once a person has made a decision, … there is no role for other persons on the list in that particular treatment decision.” |
| 15. | The State Administrative Tribunal is to be vested with additional powers in relation to enduring powers of guardianship, advance health directives and treatment decisions. |

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<td>16. “A valid consent will be a defence [for health professionals] to trespass and assault, and a valid refusal of consent precludes treatment being given. Moreover, even if the relevant consent or refusal of consent is not valid, it is to be regarded as valid in two circumstances. The first situation is when a health professional reasonably believes that the patient is not competent, and relies in good faith on what is purportedly a valid treatment decision in an advance health directive or made by a guardian, an enduring guardian or a person responsible [even if the circumstances listed in proposed section 110ZK(3) of the Guardianship and Administration Act 1990 exist]. The second situation is when a health professional takes treatment action in circumstances in which it is reasonable for the health professional to rely on some other health professional, having ascertained whether the treatment action is in accordance with a treatment decision, and to assume that some other health professional has ascertained that the treatment is in accordance with a treatment decision.”</td>
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<td>17. “The bill will also enable urgent treatment to be lawfully provided when it is not practicable to determine whether there is a relevant treatment decision in an advance health directive, or to obtain the consent of an enduring guardian, a guardian or a person responsible.”</td>
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<td>18. “a health professional will be able to override a treatment decision in an advance health directive or made by a guardian, enduring guardian or person responsible and provide treatment if a patient needs urgent treatment, the patient is unable to make reasonable judgments in respect of the treatment and the health professional reasonably suspects that the patient has attempted to commit suicide and needs the treatment as a consequence.”</td>
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<td>19. If a health professional either (1) commences or continues palliative care; or (2) does not commence or discontinues any treatment, in accordance with a treatment decision, he or she is taken for all purposes to have done so in accordance with a valid treatment decision, even if the effect of doing so is to hasten the death of the patient.</td>
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<td>20. The Bill amends section 259 of The Criminal Code so as to (1) “put it beyond doubt that the present exemption from criminal responsibility for the administration in good faith of reasonable medical treatment, even where death ensues, encompasses the provision of palliative care.” and (2) “extend protection from criminal responsibility to the withholding or withdrawal of medical treatment in good faith, even where death ensues, where the non-provision or cessation of that treatment is reasonable in all the circumstances.”</td>
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<td>21. For the purposes of making non-treatment decisions for a person who is unable to make decisions about his or her person, that person’s enduring guardian (if any) has priority over the person’s guardian (if any).</td>
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4 BACKGROUND TO THE ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

4.1 The Bill was developed by the Government as a result of perceived uncertainty:

\[
\text{in the law in relation to the withdrawal or withholding of life-sustaining measures in circumstances of terminal illness or permanent unconsciousness, and the provision of palliative care ...}^6
\]

4.2 The Second Reading Speech for the Bill in the Legislative Council made it clear that the “principle of personal autonomy is central to the bill”.\(^7\)

4.3 The Bill proposes to amend the Guardianship and Administration Act 1990 (GA Act), the Civil Liability Act 2002 and The Criminal Code. The main aims of the proposed amendments are to:

- establish a simple, flexible statutory scheme which will allow people (through the making of statutory advance health directives) to consent, or refuse consent, to any future health treatment if and when they do not have the capacity to make their own decisions about their health treatment;
- allow people to appoint an enduring guardian who will make personal and lifestyle decisions, including decisions about health treatment, in the event that they do not have the capacity to make their own decisions about these matters;
- determine who may become a substituted decision-maker (for the purposes of making decisions about health treatment) for a person who does not have the capacity to make their own decisions about their health treatment and who, in the event of such incapacity, has not left instructions for his or her future health treatment in an advance health directive and does not have an enduring guardian or a guardian; and
- clarify and expand the protections available to health professionals from civil and criminal liability whenever they treat a person who is unable to make their own decisions about their health treatment.

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6 Hon Sue Ellery, then Parliamentary Secretary to the Minister for Health, Parliament of Western Australia, Legislative Council, Parliamentary Debates (Hansard), 6 December 2006, p9244.

7 Ibid.
Consent to Health Treatment

4.4 The Bill is not restricted to the health treatment of terminally ill patients - its scope extends to the health treatment of any patient who is (either permanently or temporarily) unable to make reasonable judgments about any health treatment:

- which their health professional is proposing; or
- which they are already receiving.

4.5 A patient’s consent to any health treatment is a critical issue because, while a patient cannot demand health treatment, a health professional cannot force treatment upon a patient. This general principle was summarised by Professor Loane Skene in the context of medical treatment as follows:

*People have the right to prevent others doing things to them. They do not have the right to require that they be treated in a particular way. This explains why it is misleading to talk about the ‘right to die’ or a ‘right to die with dignity’. The only rights - in the sense of legally enforceable rights - that a person has are the rights to refuse treatment, to be treated with reasonable care, and the like ... Indeed, there is no right to treatment of any kind - it is a matter of clinical judgement for the doctor in each case.*

4.6 Generally, a health professional who proceeds to treat a patient without that patient’s consent may be exposed to a civil action in trespass to the person or criminal prosecution for assault. Representatives of the SSO advised the Committee that the exceptions to the requirement for consent before treatment are:

- section 259 of *The Criminal Code*, which provides that a person is not criminally responsible for administering (in good faith and with reasonable
care and skill) surgical or medical treatment on another person if the treatment was for that other person’s benefit and the administration of the treatment was reasonable in all the circumstances. Where the person who was treated was an unborn child, the treatment must have been administered for the preservation of his or her mother’s life;\(^\text{13}\)

- situations of emergency;\(^\text{14}\) and

- the provision of ‘psychiatric treatment’ to an ‘involuntary patient’ and a ‘mentally impaired accused’ under section 109 of the Mental Health Act 1996.\(^\text{15}\)

4.7 An adult patient is presumed to be competent to make his or her own health treatment decisions, but this presumption may be rebutted.\(^\text{16}\) Where an adult patient is unable to make his or her own health treatment decisions, consent for his or her health treatment may be provided in the following ways:

- A health treatment decision made in advance by the patient. At common law, the patient may have made an advance health treatment direction, either in writing or orally, when he or she was competent to make the health treatment decision. The directive could indicate the type of health care which he or she does or does not wish to receive in the event that he or she becomes incapacitated. A validly made common law directive is binding on health professionals.\(^\text{17}\)

- A health treatment decision made by a parent or guardian of the patient where the patient lacks the maturity and intellectual capacity to consent to health treatment personally.\(^\text{18}\)

- A health treatment decision made by a guardian appointed by the State Administrative Tribunal (SAT) under Part 5 of the GA Act.\(^\text{19}\)

\(^{13}\) L Bush and S Le Souef, Senior Assistant State Solicitors, State Solicitor’s Office, Acts Amendment (Consent to Medical Treatment) Bill 2006 - Liability of Health Professionals, tabled on 19 September 2007, p1 (see Appendix 3).


\(^{15}\) Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p11 (see Appendix 4).

\(^{16}\) Halsbury’s Laws of Australia, LexisNexis, paragraph [280-3000].

\(^{17}\) L Bush and S Le Souef, Senior Assistant State Solicitors, State Solicitor’s Office, Acts Amendment (Consent to Medical Treatment) Bill 2006 - Opening Statement, tabled 19 September 2007, p1 (see Appendix 1).

\(^{18}\) Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p11 (see Appendix 4).
4.8 As can be seen from the above list of current methods of obtaining consent for health treatment when a patient is unable to consent personally:

This State has no legislation whereby a person may plan ahead for his or her health care in the event that he or she loses capacity to make decisions about health care.23 (emphasis added)

4.9 Among other things, the Bill will provide for additional methods of obtaining consent for health treatment in the event that a patient is not able to provide personal consent at the time of treatment. These additional methods are:

- a health treatment decision contained in an statutory advance health directive made or recognised under clause 11 of the Bill, proposed Part 9B of the GA Act; and

- a health treatment decision made by an enduring guardian appointed under an instrument made or recognised under clause 11 of the Bill, proposed Part 9A of the GA Act. Currently, there is no ability, either in common law or legislation, to appoint enduring guardians.24

4.10 The Bill will preserve the current methods for obtaining consent for the health treatment of patients who are unable to provide that consent personally. That is, the Bill will not affect the validity of common law advance health directives nor the other

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19 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p11 (see Appendix 4); and L Bush and S Le Souef, Senior Assistant State Solicitors, State Solicitor’s Office, Acts Amendment (Consent to Medical Treatment) Bill 2006 - Opening Statement, tabled 19 September 2007, p1 (see Appendix 1).

20 L Bush and S Le Souef, Senior Assistant State Solicitors, State Solicitor’s Office, Acts Amendment (Consent to Medical Treatment) Bill 2006 - Opening Statement, tabled 19 September 2007, p1 (see Appendix 1).


22 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p11 (see Appendix 4).

23 L Bush and S Le Souef, Senior Assistant State Solicitors, State Solicitor’s Office, Acts Amendment (Consent to Medical Treatment) Bill 2006 - Opening Statement, tabled 19 September 2007, p1 (see Appendix 1).

24 Hon Sue Ellery, Minister for Child Protection, Parliament of Western Australia, Legislative Council, Parliamentary Debates (Hansard), 4 September 2007, p4696.
forms of obtaining consent which are discussed at paragraph 4.7 of this Report. The interaction between common law and statutory advance health directives is discussed in further detail below at paragraphs 14.1 to 14.12 with respect to clause 11 of the Bill, proposed section 110ZB of the GA Act.

4.11 Under clause 11 of the Bill, proposed section 110ZJ of the GA Act, the order of priority of health treatment decisions will be as follows:

- A health treatment decision contained in an advance health directive (if any), whether it is made under common law or the Bill.

- If there is no relevant advance health directive, a health treatment decision made by an enduring guardian who is authorised to make a decision in respect of the treatment, is reasonably available and is willing to make a decision.

- If there is no relevant advance health directive and no enduring guardian who is available, able and willing to make a decision, a health treatment decision made by a guardian who is authorised to make a decision in respect of the treatment, is reasonably available and is willing to make a decision.

- If none of the other above methods of obtaining consent (or refusal to consent) for health treatment are available, a health treatment decision made by a ‘person responsible’ for the patient. The people who could potentially be the ‘person responsible’ are prescribed in clause 11, proposed section 110ZD of the GA Act. The people prescribed in proposed section 110ZD are similar to the people who are prescribed as substitute health treatment decision-makers in section 119(3) of the GA Act.\(^\text{25}\)

4.12 In situations where there is no advance health directive and no eligible substitute health treatment decision-maker for a patient who is unable to make reasonable judgments about proposed health treatment, the treating health professional would still be required to obtain consent for the proposed treatment (unless one of the exceptions to the requirement for consent\(^\text{26}\) exists) if he or she is to avoid committing trespass or assault. In these cases, the treating health professional (or another relevant officer in their organisation) would need to apply to the SAT for the appointment of a guardian with the authority to make treatment decisions.\(^\text{27}\) If the health professional proceeds to treat the patient without first obtaining consent, he or she would be committing

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\(^{26}\) Refer to paragraph 4.6 of this Report.

\(^{27}\) Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 8 October 2007, p11.
trespass but would be protected from criminal liability if he or she could satisfy the conditions prescribed in section 259 of *The Criminal Code*.\(^{28}\)

4.13 The SSO advised the Committee of the following legal consequences for a person who pretends to be a patient’s substituted decision-maker, if that person’s treatment decision is followed by a health professional and the treatment results in the death or injury of the patient:

> A person can be charged with an offence under the Criminal Code as a principal offender under section 7 of the code or with the civil tort of trespass. Even though the doctor gives the treatment, the person can be charged criminally as the principal offender under the code but also under the tort of trespass the person can have a civil action against him, even though the person did not actually take the action.\(^{29}\)

**Legal Position on Euthanasia Remains Unaffected**

4.14 As indicated in the Second Reading Speech for the Bill in the Legislative Council:

> the legal position in relation to euthanasia is not to be changed, and it is to be emphasised that the bill will not permit euthanasia.\(^{30}\)

4.15 The Bill must be read within the context of the current law, which provides that:

> Even with consent, a health professional is permitted, both civilly and criminally, to do only that which is lawful. In particular, unless authorised by statute, a health professional is not permitted to kill a patient, including by hastening a patient’s death. Thus euthanasia is unlawful\(^{31}\), even where the patient consents.\(^{32}\)

4.16 For example, under the Bill, the following activities would remain unlawful:

- Administering a lethal injection to a patient with the intent of causing his or her death, even if the patient requests it.\(^{33}\)

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\(^{28}\) *Ibid*, p12. Refer to paragraph 4.6 of this Report for a discussion of section 259 of *The Criminal Code*.


\(^{30}\) Hon Sue Ellery, then Parliamentary Secretary to the Minister for Health, Parliament of Western Australia, Legislative Council, *Parliamentary Debates (Hansard)*, 6 December 2006, p9244.

\(^{31}\) See Chapter XXVIII of *The Criminal Code*, particularly section 268, which provides that “It is unlawful to kill any person unless such killing is authorised or justified or excused by law.”


\(^{33}\) *Halsbury’s Laws of Australia*, LexisNexis, paragraph [280-3500].
“Withdrawing or withholding life-sustaining treatment where there is a duty to treat (as with the doctor/patient relationship) may be murder or manslaughter if this results in the death of the person, depending on the intention of the accused and the duty of care imposed on the accused.”

Assisting a patient to commit suicide.

4.17 The above activities should be contrasted with the following activities, which are currently lawful and would remain lawful after the commencement of the amendments proposed by the Bill:

- Administering a drug to a patient for the primary purpose of alleviating the patient’s pain, even if the health professional who is administering the drug knows that the drug will cause or hasten death. This is commonly known as the principle of ‘double effect’. The principle is reflected in clause 11 of the Bill, proposed section 110ZL(a) of the GA Act, in the context of a health professional who complies with a request for palliative care which is made by the patient in an advance health directive (either common law or statutory), or made by the patient’s enduring guardian, guardian or ‘person responsible’.

- Withdrawing or withholding treatment at the request of a competent adult patient. This is reflected in clause 11 of the Bill, proposed section 110ZL(b) of the GA Act, in the context of a health professional who complies with a request to withdraw or withhold treatment which is made by the patient in an advance health directive (either common law or statutory), or made by the patient’s enduring guardian, guardian or ‘person responsible’.

- Withdrawing or withholding treatment that is futile.

4.18 It was noted by the Committee that the Australian Medical Association (WA) and the West Australian Voluntary Euthanasia Society Inc were of the view that the Bill does not alter the legal position on euthanasia, but that the Australian Christian Lobby, the

34 Ibid, paragraph [280-3510]. See for example, section 262 of The Criminal Code.
35 See sections 273 and 288 of The Criminal Code.
36 Halsbury’s Laws of Australia, LexisNexis, paragraph [280-3505].
37 Ibid, paragraph [280-3510].
38 Ibid, paragraphs [280-3030] and [280-3510].
39 Mr Peter Jennings, Acting Executive Director, Australian Medical Association (WA), Transcript of Evidence, 26 September 2007, p11; and Submission No 6 from the West Australian Voluntary Euthanasia Society Inc, 20 September 2007.
Coalition for the Defence of Human Life, Dr Lachlan Dunjey and a private submitter were of the view that the Bill does amend the law in this respect:  

- The Australian Christian Lobby opposed the Bill:

  unless certain minimum safeguards are addressed. If these amendments are not made, there is a strong possibility that the AHD can and will be used as a method of euthanasia.

  ...

  The AHD should only come into force in a limited set of circumstances in which natural death could be expected to occur within a certain timeframe if medical assistance were unavailable. Patients should not be able to refuse basic nursing or palliative care, such as the provision of food or water.

  ...

  safeguards must be in place to prevent misuse of advance directives, either to overrule or misinterpret the patient’s requests or to allow them to express suicidal intent.

- The Coalition for the Defence of Human Life was concerned that the Bill would allow substitute health treatment decision-makers to make treatment decisions with the intent of killing patients, and therefore legalise actions which would otherwise be in breach of The Criminal Code:

  The “person responsible” could do so with the intention of causing the death of the person. This could be out of malice (for example, to gain access to an inheritance). It could be out of sympathy (thinking a person of that age or state of health or disability was ‘better off dead’).

  The “person responsible” could also make such a decision without any intention of causing death but out of recklessness (for example, a lack of belief in medical treatment in favour of alternative medicine or ‘faith healing’).

40 Submission No 1 from Australian Christian Lobby, September 2007; Submission No 2 from the Coalition for the Defence of Human Life, 13 September 2007, pp1-4; Submission No 4 from Dr Lachlan Dunjey, 18 September 2007, p3; and Private Submission, pp1 and 2.

41 Submission No 1 from Australian Christian Lobby, September 2007, p3.

42 Ibid, p5.

Similarly, the Coalition was concerned that medical practitioners would be authorised by the Bill to commit wilful murder as long as “he can point to anything in an advance directive or a treatment decision by a person responsible to justify his action.” The Coalition recommended the following amendment to what appears to be a previous version of clause 11 of the Bill, proposed section 110ZK of the GA Act (Coalition’s recommendation 1):

Page 25, after line 26 insert new subsection:

(4) A health professional is not to take treatment action to give effect to a treatment decision in (a) an advance health directive made by the patient or (b) made by the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD if:

(i) the treatment decision is made with the intention of ending the patient’s life or

(ii) the treatment decision will have the effect of ending the patient’s life and is not in accordance with good medical practice.

Dr Dunjey agreed with the recommendations made by the Coalition for the Defence of Human Life, including the Coalition’s recommendation 1.

Committee Comment

The Committee is satisfied that the Bill will not affect the current legal position on euthanasia.

5 SUPPLEMENTARY NOTICE PAPER NUMBER 149 ISSUE NUMBER 4

The Committee was aware of the proposed amendments to clause 11 of the Bill contained in Supplementary Notice Paper Number 149 Issue Number 4, dated 16 August 2007 and prepared a ‘marked-up’ version of the affected clause for the information of the Legislative Council. This document is attached to this Report as Appendix 7.

Where the amendments proposed in the Supplementary Notice Paper are substantive in nature, the Committee has provided an explanation of the effect of these proposed amendments under the headings of the relevant provisions of the Bill.

46 Submission No 4 from Dr Lachlan Dunjey, 18 September 2007, p3.
**Provision of Nutrition and Hydration**

6.1 During the Committee’s consideration of the proposed definition of ‘life sustaining measure’ at clause 5(2) of the Bill, the question arose as to whether the definition could be argued to extend to the provision of nutrition and hydration.

6.2 The only reported decision of a superior court in Australia on this question is that of Morris J in the Victorian case of *Gardner, re BWV* [2003] VSC 173 (*Gardner*). This single judge Supreme Court decision is directly relevant.

6.2.1 Morris J in *Gardner* was faced with a situation in which a decision concerning medical treatment was made by a patient guardian, namely the Victorian Public Guardian. The Public Guardian was seeking a declaration of the court that a decision to deny nutrition and hydration via a percutaneous endoscopic gastrostomy (PEG) was a decision concerning ‘medical treatment’.

6.2.2 The statutory definition of ‘medical treatment’ that was considered in *Gardner* is considerably narrower than that proposed by the Bill. Medical treatment as defined in the relevant Victorian Act specifically excludes ‘palliative care’, while that is included in the Bill’s proposed definition of ‘medical treatment’.\(^{47}\)

6.2.3 Despite the more restricted application of the term ‘medical treatment’ in the case before him, Morris J had no difficulty in finding that the meaning of ‘medical treatment’ extended to the artificial provision of nutrition and hydration. The following passage from the judgment could not be any more succinct on this point:

> ... unquestionably in my judgment, the use of a PEG for artificial nutrition and hydration, or for that matter any form of artificial feeding, is a "medical" procedure. Artificial nutrition and hydration involves protocols, skills and care which draw from, and depend upon, medical knowledge. Artificial nutrition and hydration will inevitably require careful choice of and preparation of materials to be introduced into the body, close consideration to dosage rates, measures to prevent infection and regular cleaning of conduits.\(^{48}\)

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\(^{47}\) See sections 3, 4 and 5B of the *Medical Treatment Act 1988* (Vic).

6.2.4 While the decision of Morris J in this case is yet to be affirmed by courts outside of Victoria, it is in keeping with overseas authority on the same question.\textsuperscript{49}

6.3 On this question, evidence provided to the Committee by the SSO was as follows:

\begin{quote}
The term “life sustaining measure” includes artificial nutrition and hydration. ... This approach is consistent with judicial determinations that the non-natural provision of food and water to patients who are in a persistent vegetative state or who are permanently unconscious constitutes a medical procedure. ... While a person may refuse the natural provision of food and water, a substitute decision maker will not be able to refuse the natural provision of food and water on a person’s behalf as it does not constitute treatment.\textsuperscript{50}
\end{quote}

7 **CLAUSE 11, PARTS 9A TO 9D INSERTED INTO GUARDIANSHIP AND ADMINISTRATION ACT 1990**

What Constitutes Being ‘Unable to Make Reasonable Judgments’?

7.1 Proposed clause 11 of the Bill contains proposed new Parts 9A to 9D of the GA Act. During the Committee’s consideration of this provision, the question arose as to why the term ‘unable to make reasonable judgments’ was used in preference to such terms as ‘under a legal incapacity’ or ‘lacking capacity’. The Committee noted that in various other places in proposed clause 11 the term ‘full legal capacity’ is used.

7.2 In a written response to this question provided by SSO to the Committee, the term ‘full legal capacity’ as used in proposed clause 11 of the Bill was described as follows:

\begin{quote}
The term “full legal capacity” as used in proposed sections 110B and 110P of the Bill reflects, and is consistent with, the use of the same words in sections 50, 69, 71, 79 105, 108 of the Guardianship and Administration Act 1990. The term is used particularly in the law of contract and signifies the mental capacity necessary for a person to be bound by a contract. The relevant test is set out in Gibbons v Wright (1954) 91 CLR 423 in which the High Court indicated that, to be bound by a contract, a person must have ‘such soundness of mind as to be capable of understanding the general nature of what he is doing by his participation’ (at 437) and ‘the capacity to understand [the] transaction when it is explained’ (at 438). The mental state
\end{quote}


\textsuperscript{50} Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, p3.
required to render a contractual arrangement binding is appropriately the mental state required for the appointment of an enduring guardian (proposed section 110B) or the making of an advance health directive (proposed section 110P), as the focus for determining the capacity necessary for those two acts ought be upon whether the person appointing the enduring guardian or making the advance health directive understands the legal implications of the arrangements being entered into.  

7.3 The SSO thereafter went on to explain the rationale for using the term ‘unable to make reasonable judgments’ elsewhere in proposed clause 11 of the Bill as follows:

An enduring power of guardianship and an advance health directive have effect when the person making them is, respectively, “unable to make reasonable judgments in respect to matters relating to his or her person” (proposed section 110F) or “unable to make reasonable judgments in respect of any treatment proposed” (proposed section 110S). The powers of a ‘person responsible’ are also predicated upon the patient being ‘unable to make reasonable judgments in respect of any treatment proposed’ (proposed section 110ZD). The language used is compatible with that adopted in sections 4, 43, 51, 64, 70 and 106 of the Guardianship and Administration Act. It is appropriate that the language of ‘reasonable judgments’ rather than ‘full legal capacity’ is used as the issue is not whether the person has the required legal understanding of the role of an enduring guardian or of the effect of an advance health directive but whether, in respect of particular treatment proposed, the person is capable of making a reasonable judgment as to the appropriateness or otherwise of that treatment.

7.4 With respect to the application of the ‘reasonable judgement’ test discussed above, the Committee noted that the operative question is whether or not the person is capable of making a reasonable judgment. This means that any relevant inquiry must be directed to the abstract question of a person’s ability to make judgments rather than to question the relative merits of their decisions per se.

7.5 The most recent reported Western Australian decision on the meaning of the phrase ‘unable to make reasonable judgments’ in the context of the GA Act is the SAT case of FS [2007] WASAT 202. In that case the SAT considered the operation of the

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51 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p12 (see Appendix 4).
52 Ibid.
phrase “unable, by reason of a mental disability, to make reasonable judgments in respect of matters relating to all or any part of his estate” in section 64(1)(a) of the GA Act. In a decision that referred favourably to judicial opinion from other Australian jurisdictions, the SAT summarised the operation of the phrase in section 64(1)(a) of the GA Act as follows:

109 In the cognitive process outlined above the making of a ‘reasonable judgment’ is the outcome of a process that involves knowledge, understanding and evaluation.

110 The effect of all of this as it relates to the operation of section 64(1)(a) of the GA Act, is to require the Tribunal to consider the extent to which a person with a mental disability is able to engage in the cognitive process that culminates in an ability to make a ‘reasonable judgment’ (which will vary from person to person and may include a lack of any observed ability), and then to set that ability against the requirements of the person’s individual estate and circumstances.

7.6 The Health Consumers’ Council WA Inc submission to the Committee on the Bill expressed some concern about the protection afforded to health professionals under clause 11 at the proposed new section 110ZK(3)(a). This provision deems the following decision to have been made by a patient with full legal capacity:

(2) If a health professional -

(a) takes treatment action -

(i) reasonably believing that the patient is unable to make reasonable judgments in respect of the treatment action; and

(ii) relying in good faith on what is purportedly a treatment decision -

(I) in an advance health directive made by the patient; or

(II) made by the patient’s guardian or enduring guardian or the person


The above proposed blanket protection is afforded to relevant health professionals even where; “the patient is in fact able to make reasonable judgments in respect of the treatment action”\(^56\).

In a recent House of Representatives Committee report, the potential for an anticipatory health care decision to obviate any tension between the views of an incapacitated patient’s close family and the requirements of medical ethics was addressed as follows:

> Where there is patient incapacity, the intersection of medical ethics and the wishes of the patient or family will sometimes be fraught, particularly where a situation arises that is not covered by an extant advance care directive. There are certainly no easy answers to the dilemmas that can arise in this context.\(^57\)

Two relevant cases highlight how treatment actions, which may or may not accord with treatment decisions of persons responsible, might be resolved in very different ways. In a 1995 decision of the English Family Court,\(^58\) the views of the patient’s mother were held to have the following influence on a treatment decision regarding a patient in a persistent vegetative state:

> I have no doubt that, although the mother’s views must be taken into account they cannot prevent the course being taken which is considered to be in the best interests of the patient.\(^59\)

That decision can be contrasted with a New South Wales Supreme Court judgment delivered in 2000 in which a treatment decision was made by health professionals to terminate the provision of artificial feeding and antibiotics for a patient in a ‘chronic vegetative state’. The patient’s sister was granted a court order negating the treatment decision. While there are a number of factors limiting the application of this judgment to other cases, the fact that such a treatment decision was made and then prevented by court order is of some significance to the Committee when, in the words of His Honour Justice O’Keefe: “Mr Thompson is unarguably alive. He moves,  

\(^{57}\) Commonwealth of Australia, House of Representatives, Standing Committee on Legal and Constitutional Affairs Report, Older people and the law, September 2007, p112.  
\(^{58}\) Re: G [1995] 2 FCR 46.  
\(^{59}\) Ibid, at p52.
responds, is able to write, articulate and to control a number of muscular and bodily functions.\textsuperscript{60}

Committee Comment

7.11 The Committee accepts that there is cause for careful consideration of proposed new section 110ZK(3)(a) given the potentially wide protection offered to relevant health professionals.\textsuperscript{61}

7.12 The Bill does not attempt to change the current process whereby professional medical judgment is the principle determining factor in either triggering a treatment action or determining when medical treatment is futile. The Committee notes that a further matter of relevance in this regard is that treating health professionals are also required to determine in the first instance whether or not a person is able to make reasonable judgments concerning such treatment.

8 CLAUSE 11, PROPOSED SECTION 110N GUARDIANSHIP AND ADMINISTRATION ACT 1990 - REVOCATION OR VARIATION OF ENDURING POWER OF GUARDIANSHIP

Process of Revoking Enduring Power of Guardianship

8.1 During the Committee’s consideration of clause 11 of the Bill at proposed new Part 9A of the GA Act, a question arose regarding the revocation of an enduring guardian.

8.2 In particular, given the prescriptive detail set down in the Bill relating to the formal appointment of an enduring power of guardianship at proposed new section 110E of the GA Act, proposed new section 110N appeared to give the impression that only the SAT had the power to revoke a properly executed enduring power of guardianship.

8.3 This question gave rise to the following exchange between the Committee and the SSO:

\textit{Ms Bush:} The State Administrative Tribunal has no authority to revoke an enduring power of guardianship while the appointor has full legal capacity. SAT steps in where the person is incompetent and unable to revoke the directive for him or herself. Revocation by an appointor can be carried out during a period of capacity under the common law, most simple of which would be to tear up the document, or strike it through.

\textit{CHAIR:} Or make another one?

\textsuperscript{60} Northridge v Central Sydney Area Health Service (2000) 50 NSWLR 549, at paragraph 106.

\textsuperscript{61} Clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110ZK of the Guardianship and Administration Act 1990 is discussed further at paragraphs 18.1 to 18.29 of this Report.
Ms Bush: Possibly. I think it is proposed section 110T -

CHAIR: If you are the patient and you are not actually in possession of the document, how do you revoke it?

Ms Bush: They could just tell somebody that they had changed their mind. They could say that they have changed their mind, they could ask to have it torn up - whatever they wanted to have done, to show their intent that the power does not exist anymore.

Hon HELEN MORTON: So verbal instruction for that is equally as good?

Ms Bush: Yes. Naturally, it would have to be communicated and -

Hon HELEN MORTON: - and witnessed?

Ms Bush: - it would particularly need to be communicated to the enduring guardian who will no doubt have a copy of the power. It does not have to be witnessed. There are no formal requirements for revocation in the bill. 62

8.4 The above exchange appears to confirm that the express vesting of jurisdiction in the SAT to grant an order revoking an appointment of enduring powers of guardianship is not intended to otherwise interfere with the common law of agency. The law of agency provides that a principal may unilaterally revoke an agency at any time during which the principal has legal capacity. Such revocation may be in writing but can be equally effective when communicated orally63 or by conduct.64

9 CLAUSE 11, PROPOSED SECTIONS 110O AND 110ZA GUARDIANSHIP AND ADMINISTRATION ACT 1990 - RECOGNITION OF INSTRUMENTS CREATED IN ANOTHER JURISDICTION

Recognition of Validly Executed Enduring Powers of Guardianship and/or Advance Health Directives from Other Australian Jurisdictions

9.1 The Committee considered clause 11 of the Bill at proposed sections 110O and 110ZA of the GA Act. These proposed sections grant the SAT the power to make an


63 See The Margaret Mitchell (1858) 4 Jur NS 1193; Sw 382; 166 ER 1174; R v Wait (1823) 11 Pr 518; 147 ER 551.

64 See Samper v Hade (1889) 10 LR (NSW) L 270; Atkinson v Cotesworth (1825) 3 B & C 647; 107 ER 873.
order enforcing certain interstate enduring powers of guardianship or advance health directions respectively as if they had been properly executed in Western Australia.

9.2 The question arose during the Committee’s consideration of these proposed new sections of the GA Act as to whether the same judicial courtesy is afforded by equivalent legislation in other States and Territories.

9.3 The advice received by the Committee from the SSO on this point was that, despite some variation in mechanics, there would in fact be provision in a number of other jurisdictions for mutual recognition of Western Australian enduring powers of guardianship. The mutual enforceability of advance health directives is not as clearly drawn.\textsuperscript{65}

**Recommendation 1:** The Committee recommends that the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended to insert a regulation-making power to allow for the development of a national register of advance health directives in consultation with other States and Territories.

### 10 **CLAUSE 11, PROPOSED SECTION 110Q GUARDIANSHIP AND ADMINISTRATION ACT 1990 - FORMAL REQUIREMENTS OF STATUTORY ADVANCE HEALTH DIRECTIVES**

**Prescribing the Form of Statutory Advance Health Directives in Subsidiary Legislation**

10.1 Proposed section 110Q(1)(a) of the GA Act at clause 11 of the Bill provides that a *pro-forma* for statutory advance health directives will be prescribed in new regulations.

10.2 During the Committee’s investigations the question arose as to why a *pro-forma* statutory advance health directive should not be provided in Schedule 3 of the GA Act along with the other forms.

10.3 This question was raised with the SSO by the Committee as shown by the following extract:

*Yes, in my experience with enduring powers of attorney, there have been a lot of problems because the form is in the act and it is not easily amenable to amendment. There are actually quite serious problems with the form, which will probably be amended in due course. There is a review of the act going on at the moment. I am on the committee reviewing it. It is much better to have a form in*

\textsuperscript{65} See section 89 of the Powers of Attorney Act 2006 (ACT); section 6O of the Guardianship Act 1987 (NSW); sections 34 and 40 of the Powers of Attorney Act 1998 (Qld); and section 81A of the Guardianship and Administration Act 1995 (Tas).
regulations, because if there is a problem, then it is far easier to amend without going through the complete legislative process.\textsuperscript{66}

\section{Clauses 11, Proposed Section 110R Guardianship and Administration Act 1990 - Requirements in Relation to Treatment Decision in Advance Health Directive}

\subsection{Voluntary and Informed Treatment Decisions}

\subsubsection{Clause 11 of the Bill, at proposed section 110R of the GA Act, invalidates any treatment decision made in a statutory advance health directive if it is not made voluntarily or if it is made under inducement or coercion. Similarly, any treatment decision made in a statutory advance health directive by a person who does not understand the nature or consequences of the decision will also be invalid under this provision.}

\subsubsection{The question arose as to why there was no statutory requirement to provide some independent assurance that a treatment decision in a statutory advance health directive was indeed:

- voluntary, and
- informed.}

\subsubsection{One submission received by the Committee stressed the importance of ensuring that:

\textit{an appropriately qualified medical practitioner has explained to the patient the nature and purpose of the treatment, as well as any risks or side effects, and what alternatives are available.}\textsuperscript{67}

\subsubsection{The Committee also notes the recent recommendation of a Commonwealth House of Representatives Committee that:

\textit{the Australian Government include advance health care planning services provided by medical practitioners on the Medicare Benefits Schedule.}\textsuperscript{68}

\subsubsection{A similar question arose in connection with proposed sections 110B and 110P of the GA Act which require the appointor of an enduring power of guardianship, and the


\textsuperscript{67} Submission No 2 from the Coalition for the Defence of Human Life, 13 September 2007, p4.

maker of an advance health directive respectively to possess full legal capacity at the
time the appointment or directive is made out.

11.6 The SSO explained the policy position on this question with particular reference to the
enduring power of guardianship in the following terms:

There is no provision in the bill to ensure that the appointor of an
enduring guardian has full legal capacity when making the
appointment. If such a test of capacity was imposed, it would require
a medical assessment of the appointor at the time the appointment
was made. This requirement would restrict the scheme. It would
result in a less accessible and flexible scheme; and it would
compromise the principles of freedom of choice and the right to self-
determination. It would also be inconsistent with the requirements for
making an enduring power of attorney under the Guardianship and
Administration Act, and also with the requirements for making a will
in this state. There is no requirement for a test of capacity at the time
a will is made.

Part 9 proceeds on the basis that an appointor has the capacity to
make the appointment. The part has been drafted on that basis.
However, should a health professional have any concerns about the
capacity of the appointor at the time of the appointment, an
application could be made to the State Administrative Tribunal
pursuant to proposed section 110K.69

11.7 The Committee observed that the SAT is required, by section 4 of the GA Act, to
apply certain principles in determining guardianship and administration matters.
These include at section 4(2):

(a) The primary concern of the State Administrative Tribunal
shall be the best interests of any represented person, or of a
person in respect of whom an application is made.

(b) Every person shall be presumed to be capable of:

(i) looking after his own health and safety;

(ii) making reasonable judgments in respect of matters
relating to his person;

(iii) managing his own affairs; and

69 Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19
(iv) making reasonable judgments in respect of matters relating to his estate,

until the contrary is proved to the satisfaction of the State Administrative Tribunal.

11.8 The statutory advance health directive provisions in the Bill attempt to ensure that they will only be enforceable when they are made by a fully informed adult with no formal lack of capacity.\(^\text{70}\) In addition, an otherwise valid statutory advance health directive will not apply where the circumstances at the time of potential application are significantly different to those envisaged when the document was made.\(^\text{71}\)

11.9 The Committee noted that potential difficulties with these aspects of advance health directives lead the Law Reform Commission of Western Australia (LRCWA) to recommend in 1991 that they not be introduced into the Western Australian statute book. Specifically, the LRCWA expressed the following view of ‘living wills’ (their term for advance health directives):

2.8 In general terms, therefore, the living will concept has the major objection that a will is likely to be -

(a) too specific, thereby failing to cover all circumstances;

(b) too general, thereby causing interpretative problems; or

(c) too discretionary …\(^\text{72}\)

11.10 The Committee further notes the Victorian requirement for a “refusal of treatment certificate” to be completed by a person and then witnessed by a medical practitioner and another person.\(^\text{73}\) The witnesses to the certificate must be satisfied:

(a) that a patient has clearly expressed or indicated a decision-

(i) to refuse medical treatment generally; or

(ii) to refuse medical treatment of a particular kind-


\(^{71}\) Clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed sections 110S(2) and (3) of the Guardianship and Administration Act 1990.


\(^{73}\) Section 5 of the Medical Treatment Act 1988 (Vic).
for a current condition; and

(b) that the patient's decision is made voluntarily and without inducement or compulsion; and

(c) that the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) for that condition and that the patient has appeared to understand that information; and

(d) that the patient is of sound mind and has attained the age of 18 years … 74

11.11 In 1991 the LRCWA recommended that a similar provision should be introduced in Western Australia.75

Committee Comment

11.12 While the Committee acknowledges the benefits of independent assurance that a person’s advance health directive is indeed both voluntary and informed, the policy requirement that the legislation be simple and flexible must also be observed. For this reason the Committee makes the following recommendation:

Recommendation 2: The Committee recommends that any form prescribed by regulations to the Acts Amendment (Consent to Medical Treatment) Bill 2006 as being required to constitute a valid statutory advance health directive for the purposes of proposed section 110Q(1) of the Guardianship and Administration Act 1990 should contain a clause in substantially the following terms:

“You are strongly encouraged to seek medical and/or legal advice concerning the terms of this directive. Please indicate whether you have received such advice and (optional) who provided you with this advice.”

74  Ibid, section 5(1).
12 Clause 11, Proposed Section 110RA Guardianship and Administration Act 1990 - Register for Statutory Advance Health Directives

Introduction

12.1 Clause 11 of the Bill proposes the insertion of a new s110RA into the GA Act. The Committee’s inquiries relating to this provision revealed that it was inserted in the Legislative Assembly. The drafting of the provision has received some adverse comment to the extent that the SSO advised the Committee that it is proposed to re-draft it. The preferred form of the proposed section 110RA is referred to below in paragraphs 12.27 to 12.30 in this Report in connection with the Supplementary Notice Paper Number 149 Issue Number 4.

Mandatory or Voluntary Registration

12.2 On the basis that a registration facility will operate exclusively in relation to advance health directives, the Committee considered the question of whether or not such registration should be mandatory.

12.3 In the Discussion Paper, it was stated that:

*It is not presently proposed that there be compulsory registration of written advance health directives as this would not sit comfortably with the preferred position to introduce a simple, flexible and accessible scheme. However, a case can be made for the establishment, subject to cost constraints and the very significant issue of meeting privacy concerns, of some mechanism or programme which would enhance the effectiveness of advance health directives by increasing the prospects of their existence becoming known to health providers.*

12.4 In considering this question, the Committee was assisted by the following extract from a recent report of a Commonwealth House of Representatives Committee detailing the comparative current registration regimes in other jurisdictions for enduring powers of attorney:

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Table 3.1  Current power of attorney registration requirements by jurisdiction

<table>
<thead>
<tr>
<th>State / territory</th>
<th>Registration requirement</th>
</tr>
</thead>
</table>
| ACT               | **Powers of Attorney Act 2006, S. 29** Powers of attorney are deeds...
|                   | A deed may be registered (see Registration of Deeds Act 1957) and must be registered for a dealing with land by the attorney to be registered (see Land Titles Act 1925, s 130). |
| NSW               | **Powers of Attorney Act 2003, S. 51** Powers of attorney may be registered...
|                   | by the Registrar-General in the General Register of Deeds kept under the Conveyancing Act 1919. 
|                   | S. 52 (1) A conveyance or other deed affecting land executed on or after 1 July 1920 under a power of attorney has no effect unless the instrument creating the power has been registered. |
| NT                | **Powers of Attorney Act 1980, S. 7** Registration
|                   | (1) An instrument creating or revoking a power may be registered. |
| QLD               | **Powers of Attorney Act 1998, S. 25** Registration of powers of attorney and instruments revoking powers
|                   | (1) A power of attorney may be registered.
|                   | (2) An instrument revoking a power of attorney may be registered... |
| SA                | **Powers of Attorney and Agency Act 1984, S. 6** Enduring powers of attorney
|                   | (1) An enduring power of attorney may be created ... by deed...
|                   | Deeds may be registered in accordance with the **Registration of Deeds Act 1935, Part 2**. |
| Tas               | **Powers of Attorney Act 2000, S.A.** Register of powers of attorney
|                   | (1) The Recorder must keep a register of all powers of attorney.
|                   | (2) The register consists of all powers of attorney, instruments varying or revoking a power of attorney and other instruments relating to powers of attorney that are lodged with the Recorder under this or any other Act. |
| Vic               | **Instruments Act 1958, S. 125C.** Enduring power of attorney to be a deed
|                   | An enduring power of attorney that complies with this Division is to be taken to be and have effect as a deed, even if it is not expressed to be executed under seal.
|                   | May be registered as a deed. |
| WA                | **Guardianship and Administration Act 1990,** Can be registered in accordance with the **Transfer of Land Act 1893** |

3.108 The only state in which an enduring power of attorney must be registered in order to be activated is Tasmania.96 However, it appears that not all enduring powers of attorney are registered due to the $90.50 registration fee. As a consequence it is not clear how many powers of attorney have been made.97

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96  State Trustees Ltd, Submission No. 88, p. 10.
97  Ms Anita Smith, Australian Guardianship and Administration Committee, Transcript of Evidence, 5 June 2007, p. 5.
The Committee received submissions on this question from the Christian Science Committee on Publication for Western Australia and the Health Consumers’ Council WA Inc to the effect that registration should be mandatory and that a mere failure to register should not affect the validity of an otherwise conforming statutory advance health directive.\(^7\)

The only Australian jurisdiction that makes the registration of anticipatory health care documents mandatory is Tasmania, which requires appointments of enduring guardians to be registered in order to be enforceable.\(^9\)

When the question of mandatory registration was raised by the Committee with the SSO, the rationale for voluntary registration was explained as per the following extract:

> It has been made optional, the intention again being that there has to be a flexible system. There may be people who are not able, for whatever reason, to register their directive, or do not want to register their directive, because it may contain sensitive material. They may be elderly. They may not able to get the requisite forms. They may not be able to go onto the Internet. It could deprive a range of people from being able to have a statutory advance health directive.\(^8\)

Flexibility is an important requirement of any statutory system of advance health directives, but the importance of this aspect is even greater where it is envisaged to operate alongside an existing common law system. It is perhaps not widely understood within the community that the common law already provides individuals with the ability to make anticipatory health care decisions. However, as noted by a recent House of Representatives Committee: “it has always been the case that an individual of sound mind has the right to refuse (or accept) medical treatment or advice,”\(^8\) This right can be exercised in advance of any treatment either verbally or in writing.

The Committee further noted that given a mandatory registration regime, the effect of non-registration would be a nullity. This is because of the saving of relevant common law at proposed section 110ZB of the GA Act. As a consequence, where a qualifying

\(^7\) Submission No 7 from the Christian Science Committee on Publication for Western Australia, 21 September 2007, p4; and Submission No 9 from the Health Consumers’ Council WA Inc, September 2007, p1.

\(^9\) Section 32(2)(d) of the Guardianship and Administration Act 1995 (Tas).

\(^8\) Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, p14.

\(^8\) Commonwealth of Australia, House of Representatives, Standing Committee on Legal and Constitutional Affairs Report, Older people and the law, September 2007, p112.
advance health directive is not registered in a mandatory regime, it would still constitute a binding common law directive.

Committee Comment

12.10 The Committee accepted the theoretical benefits of mandatory registration of statutory advance health directives from the perspective of certainty for treating health professionals. However, given the complimentary status of common law anticipatory health care documents vis-à-vis the proposed statutory advance health directives, the Committee considers that the voluntary registration system provided for in the Bill should be adopted.

Maintenance of the Register

12.11 During the Committee’s inquiries into the Bill the question was raised as to how the register might be established and maintained in parallel with or ‘piggy-backed’ onto an existing register such as the organ donor’s register. This may obviate the need for the whole-scale re-creation of database architecture and protocols, and result in significant cost and efficiency savings.

12.12 Minimising cost pressures on the operation of the register will have a major impact on any proposed fee structure relating to the registration of advanced health directives. The need to keep any associated fees to an absolute minimum in the context of a voluntary register was stressed by the submission on the Bill from the Health Consumers’ Council WA Inc, which stated: “No fees should be payable by any person wishing to register an advance health directive.”82 The West Australian Voluntary Euthanasia Society Inc submission recommended that only “minimal fees be charged for such registration.”83

12.13 Given that the details of the register are proposed to be settled in regulations to the Bill, this matter is noted below in paragraphs 12.27 to 12.30 in this Report with respect to Supplementary Notice Paper Number 149 Issue Number 4.

Committee Comment

12.14 Assuming the establishment of an accessible and well-maintained register of statutory advance health directives, the Committee is of the view that it is in the public interest to encourage it to be as widely utilised as possible.

12.15 Given that an equally binding anticipatory health care decision can be made at common law without the need for registration, the setting of any registration fees will

run contrary to the objective of the register. The Committee therefore makes the following recommendation:

**Recommendation 3:** The Committee recommends that the register of advance health directives established at clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110RA of the *Guardianship and Administration Act 1990*, should be free from fees.

**Access to the Register**

12.16 The Committee acknowledged that the issue of access to the register involves two somewhat competing principles. Firstly there is the overriding principle of individual autonomy which requires that a person has a right to receive only that medical treatment to which they would grant informed consent. On the other hand there is the right of a person to have all matters affecting their medical care kept confidential.

12.17 These two principles come into sharp contrast when matters concerning access to any voluntary register of advance health directives are considered.

12.18 The first question which must be considered is the status of any such register. That is to say, will treating health professionals be deemed to have constructive notice of the contents of any such register? This matter was raised by the Committee with the SSO in the following exchange:

*Hon GIZ WATSON:* With regard to this register, if it is put in place by regulations, would it then constitute constructive notice in a legal sense?

*Ms Bush:* That was what I was going to say before. I think for a health professional to act in good faith would require that the register be checked.

*Hon GIZ WATSON:* Because that is -

*Ms Bush:* Depending on the urgency of the circumstances, but then we are getting into a different territory again. They would have to make reasonable inquiries. So, for example, if they normally access the register on-line and the Internet is down, that might be taken into consideration. I think it is whatever is reasonable in the circumstances.  

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12.19 The ambiguity on this point is a matter of concern to the Committee. Constructive notice is deemed knowledge of the register’s contents. A good faith presumption that a health practitioner will check the register is an altogether different proposition.

12.20 Precision on this point is rightly a matter for clarification in the Bill rather than in regulations relating to the administration of the register.

12.21 The Committee also observes that, given there is already some cross-jurisdictional recognition of proposed statutory advance health directives,\(^85\) there are good reasons for developing the register in harmony with systems used in other jurisdictions. This appears to give further weight to the argument in favour of building on existing registers in the development of the proposed register.

12.22 The issue of national consistency and coverage of advance health care planning was considered by a recent Commonwealth House of Representatives Committee. The relevant Committee recommended that:

_the Australian Government propose that the Standing Committee of Attorneys-General work towards national consistency and coverage of legislation governing advance health care planning among the Australian jurisdictions. This work should also include the development of straightforward, nationally-consistent and user-friendly advance care directive documentation and witnessing arrangements._\(^86\)

12.23 Given that related registers such as those in other jurisdictions and the nation-wide organ-donor’s register would presumably have been designed to deal with the competing privacy and self-determination issues, any such nation-wide registers suggest themselves to the Committee as a promising vehicle for achieving cross-jurisdictional harmony in this important area. Accordingly, the Committee refers to Recommendation 1 in this Report.

12.24 The relevance of the organ donor’s register to a register of advance health directives was the subject of some comments by the Australian Medical Association (WA) in evidence to the Committee:

_In Western Australia all of the organ donor coordinators have access to the organ donor registry; therefore, they are able to ascertain_

\(^85\)See section 89 of the _Powers of Attorney Act 2006_ (ACT) (recognition of interstate enduring power of attorney); section 6O of the _Guardianship Act 1987_ (NSW) (recognition of interstate enduring guardian); sections 34 of the _Powers of Attorney Act 1998_ (Qld) (recognition of interstate enduring power of attorney) and 40 (recognition of interstate enduring health care document); and section 81A of the _Guardianship and Administration Act 1995_ (Tas) (recognition of interstate enduring guardian).

somebody’s wishes, whether they be positive or negative. That works well. The access is confined to a relatively small group and that access is hardly secure. In order for this to work in the context of advance health care directives, it would be necessary for doctors generally to have access to a register. Again, the register could only work if it was known that all expressions of advance health care directives were on the register and then that may create some difficulties, if you like - not being a lawyer - in determining whether there are any conflicts between a common law position, where somebody has expressed a view, and what is actually on the register. It might need to be determined by the courts or by others. Having a register to which medical practitioners have access and which described people’s wishes, would certainly be useful and provide a degree of certainty. That access would need to be secure and real time; that is, be available 24 hours a day, rather like the organ donation register. It is not impossible conceptually for it to work in that kind of way.

Privacy concerns relating to the register could be addressed by providing for a penalty for unauthorised access to the register. This could be provided for in the regulations made by the Minister pursuant to proposed section 110ZAA of the GA Act.

In light of the foregoing, the Committee makes the following recommendation:

**Recommendation 4:** The Committee recommends that access to the register of statutory advance health directives, provided for at clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110RA of the Guardianship and Administration Act 1990, should be restricted to the treating health professional and, unless specifically excluded by the maker of the directive:

a) the guardian of the maker; and

b) the enduring guardian of the maker (if one has been appointed); and

c) the person responsible for the maker as defined by proposed section 110ZD of the Guardianship and Administration Act 1990 (if there is any).

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87 Associate Professor Geoffrey Dobb, President, Australian Medical Association (WA), *Transcript of Evidence*, 26 September 2007, p7.
This Supplementary Notice Paper contains provision\(^{88}\) for an amendment to clause 11 of the Bill, at proposed section 110RA of the GA Act and the inclusion in the Bill of regulation-making powers with respect to the proposed register of advance health directives.\(^{89}\)

As indicated above, the Committee believes that proposed section 110ZAA of the GA Act should also clarify the status of the register in terms of constructive notice. In the event that this is not done, some provision in the regulation making power should direct the Attorney General’s Department towards the issue of the good faith requirement on the part of health professionals to check the register when a treatment decision is made pursuant to proposed section 110S of the GA Act.

Proposed clause 11 of the Bill, at proposed section 110ZAA of the GA Act, should include the ability for regulations concerning extra-jurisdictional access to the register to be made.

Proposed clause 11 of the Bill, at proposed section 110ZAA(2)(h) of the GA Act,\(^{90}\) should be recast to include a proviso to the effect that any fees set should reflect the voluntary nature of the register and should not of themselves be a disincentive to registration. The regulation-making power should also include a proviso for the fee structure to be open to independent review to ensure that this objective is observed.

**CLAUSE 11, PROPOSED SECTION 110S GUARDIANSHIP AND ADMINISTRATION ACT 1990 - OPERATION OF TREATMENT DECISIONS IN STATUTORY ADVANCE HEALTH DIRECTIVES GENERALLY**

Circumstances in which an Otherwise Operational Treatment Decision in a Statutory Advance Health Directive would not Operate

- It is proposed that the SAT should have the jurisdiction to determine the validity or otherwise of advanced health directives at clause 11 of the Bill, proposed section 110W of the GA Act.

- In the first instance however, the treating health professional must determine the extent to which a treatment decision is subject to the granting or withholding of consent.

- It will be for the treating health professional in the first instance to ascertain whether or not a treatment decision in an advance health directive operates. One of the key

\(^{88}\) At items 1/11 and 5/11.

\(^{89}\) At proposed section 110ZAA of the Guardianship and Administration Act 1990.

\(^{90}\) Supplementary Notice Paper Number 149 Issue Number 4, p2, item 5/11.
questions concerning the putative operation of a treatment decision in an advance health directive is whether or not that anticipatory health care decision envisaged the relevant circumstances surrounding the actual treatment decision in question. Clause 11 of the Bill, proposed section 110S(2) of the GA Act reads as follows:

Subject to subsection (3), a treatment decision in an advance health directive operates only in the circumstances specified in the directive.

13.4 The importance of a correspondence between the circumstances envisaged in an advance health directive with the actual circumstances surrounding the treatment decision can be appreciated by the following comments of Lord Goff of Chieveley:

… where the patient’s refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; … in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred.91

13.5 The Bill reflects this position at clause 11, proposed section 110S(3) of the GA Act which reads:

Subject to subsection (4), a treatment decision in an advance health directive does not operate if circumstances exist or have arisen that -

(a) the maker of the directive did not anticipate at the time of making the directive; and

(b) would have caused the maker to change his or her mind about the treatment decision.

13.6 The Committee observed that the word ‘circumstances’ in proposed section 110(3) of the GA Act is not defined in clause 11 of the Bill. The presumption arises therefore, that it extends to ‘circumstances’ generally and not merely to medical circumstances. In response to this question, the SSO confirmed for the Committee that: “The terms of proposed section 110S(2) are sufficiently broad to include non-health related circumstances.”92

13.7 The question arose in the course of the Committee’s inquiry as to why clause 11, proposed section 110S(4) of the GA Act places specific matters of inquiry on treating health professionals where an advance health directive is more than 10 years old. In particular, the Committee was uncertain why the period of 10 years was specified. In

92 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p6 (see Appendix 4).
response to this question, the Committee was advised: “It was just a policy decision to choose 10 years.”

Committee Comment

13.8 Treating health professionals are required to determine if the circumstances anticipated in advance health directives match the circumstances surrounding a treatment decision in all cases. Clause 11 of the Bill, at proposed section 110S(3) of the GA Act applies to all advance health directives from the time that they are signed and witnessed.

13.9 The Committee notes that clause 11 of the Bill, at proposed section 110S(4) of the GA Act does not invalidate statutory advance health directives after 10 years. The provision merely requires treating health professionals to consider a number of factors when determining if a 10 year old (or older) advance health directive might not match the circumstances surrounding a treatment decision.

13.10 In addition, clause 11 of the Bill provides that all of the factors listed at proposed section 110S(4) of the GA Act can be considered in connection with statutory advance health directives that are less than 10 years old. The only distinction, is that in the case of 10 year old statutory advance health directives, the factors must be taken into consideration.

13.11 In light of the foregoing, the Committee formed the view that there is no useful purpose in limiting the mandatory application of the relevant considerations at proposed section 110S(4) of the GA Act to those advance health directives more than 10 years old. Given the utility of the relevant considerations in determining the operability of an advance health directive, the relevant considerations should be applied in all cases.

13.12 Accordingly, the Committee makes the following recommendation:

Recommendation 5: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended as follows:

Page 17, line 25 — To delete “made more than 10 years before the time at which the treatment decision would otherwise operate”.

Page 18, lines 10 to 14 — To delete the lines.

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Relevant Considerations When Determining the Operation of an Advance Health Directive

13.13 As indicated above, clause 11 of the Bill, proposed sections 110S(4)(a) to (d) of the GA Act contain four relevant considerations in connection with the determination of the validity of an advance health directive. These factors must be considered in the case of 10 year old advance health directives, and may be considered in any other case. The relevant considerations are as follows:

(a) the maker’s age at the time of the directive was made and at the time the treatment decision would otherwise operate;

(b) the period that has elapsed between those times;

(c) whether the maker reviewed the treatment decision at any time during that period and, if so, the period that has elapsed between the time of the last such review and the time at which the treatment decision would otherwise operate;

(d) the nature of the condition for which the maker needs treatment, the nature of that treatment and the consequences of providing and not providing that treatment.

13.14 The question arose during the Committee’s inquiry as to why the views of interested persons should not be included in such a list of relevant considerations. The Committee could find no objection on the basis of the policy of the Bill as to why such an inclusion should not be made. The Committee therefore recommends as follows:

Recommendation 6: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended as follows:

Page 18, after line 9 — To insert —

“(e) the views of any guardian of the maker, the enduring guardian of the maker (if such have been appointed), or the person responsible for the maker as defined by proposed section 110ZD (if there is any) concerning the treatment, unless such a person has been specifically precluded from expressing such a view in the advance health directive.”
Process of Revoking a Treatment Decision in a Statutory Advance Health Directive

13.15 During the Committee’s consideration of clause 11 of the Bill at proposed new Part 9B of the GA Act, a question arose regarding the revocation of an advance health directive.

13.16 In particular, given the prescriptive detail set down in the Bill relating to the formal appointment of an advance health directive at proposed new section 110Q of the GA Act, proposed new section 110Z gives the impression that only the SAT had the power to revoke a properly executed enduring power of guardianship.

13.17 This question gave rise to the following exchange between the Committee and the SSO:

**CHAIR:** ... In practice, how will the maker of such a directive revoke the directive? Who is expected to determine whether a treatment decision has been revoked in this way? Why does the proposed section not prescribe who this person must be? How is that person to be expected to know that the maker has changed his or her mind about the treatment decision? Do you anticipate that, in practice, someone inquiring into the validity of a treatment decision in the statutory advance health directive will often be required to apply to SAT for a declaration that the treatment decision is revoked? …

**Ms Bush:** Proposed section 110S(6) refers to a situation in which it is known in fact that the maker of the directive has changed his or her mind. It deems that the directive has been revoked, so it does not operate at all. How it is to be revoked is a matter for the maker. They will need to communicate their revocation. As we have just discussed, it is common law revocation.95

13.18 The above exchange appears to confirm that the express vesting of jurisdiction on the SAT to grant an order revoking an advance health directive is not intended to otherwise interfere with the common law of agency. As noted above (see paragraph 8.4 in this Report), the law of agency provides that a principal may unilaterally revoke an agency at any time during which the principal has legal capacity. Such revocation may be in writing but can be equally effective when communicated orally96 or by conduct.97

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95 Hon Graham Giffard MLC, Chair, Standing Committee on Legislation, and Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, pp21-22.

96 See *The Margaret Mitchell* (1858) 4 Jur NS 1193; Sw 382; 166 ER 1174; *R v Wait* (1823) 11 Pr 518; 147 ER 551.

97 See *Samper v Hade* (1889) 10 LR (NSW) L 270; *Atkinson v Cotesworth* (1825) 3 B & C 647; 107 ER 873.
Interaction between Common Law and Statutory Advance Health Directives

14.1 In response to the Committee’s enquiries about the way in which the proposed statutory advance health directive provisions relate to the current common law position, the SSO advised as follows:

The current law, in essence, is that a health professional may provide medical treatment to a patient only if the patient personally consents to that treatment or, as in the case of emergencies, consent is implied. Treatment without consent exposes the health professional to civil or criminal proceedings for trespass or assault. The only relevant exceptions to this general principle are:

a) the ability of a parent or guardian, where their child lacks the maturity and intellectual capacity personally to consent to treatment, to consent to treatment on the child’s behalf;

b) the ability of a guardian to consent, pursuant to the Guardianship and Administration Act 1990, on behalf of a represented person;

c) specific statutory modifications, such as those in section 109 of the Mental Health Act 1996 and the present section 119 of the Guardianship and Administration Act 1990;

d) the powers of the Supreme Court, exercising its parens patriae jurisdiction.

A person is unable to give a valid consent if, at the time consent is required, he or she lacks the necessary mental capacity. The intention of the Bill is to enable a person, in the event that circumstances preclude a personal consent at the time treatment is or may be required, to specify his or her treatment wishes in advance and, or in the alternative, to nominate an enduring guardian to give consent (or to refuse consent where it would otherwise be implied) on the patient’s behalf. In other words, the Bill expands the mechanisms by which consent may be given by a patient. Patients’ autonomy is respected and, where a patient has elected to use an advance health directive or to appoint an enduring guardian, clarity is given to health professionals considering treatment options.
There is currently facility at common law for persons to indicate their treatment wishes in advance, but the content of the applicable principles is uncertain. The Bill preserves those principles but establishes a detailed statutory advance health directive scheme which provides certainty, a role for the State Administrative Tribunal and consistency with the broader consent regime of which advance health directives are a part. Provision for the appointment of enduring guardians is the other critical component of that consent regime - there is no equivalent common law concept. In the interests of the consent regime's consistency, the Bill also clarifies the authority of guardians in relation to medical treatment and has modified the existing section 119 of the Guardianship and Administration Act 1990.

While the Bill will give greater autonomy to patients and assist health professionals in those circumstances where a patient could not validly make a decision as to treatment, reliance upon advance health directives and substitute decision makers carries with it a significantly increased risk that a consent thought to be valid was, for factual or legal reasons which were not obvious or could not have been readily detected, in fact invalid. The Bill's protection provision is intended to address this risk by deeming lawful a treatment decision by a health professional where that health professional in good faith believed that the decision was in accordance with a valid advance health directive or the valid directions of a substitute decision maker.

14.2 As discussed above, the common law principles of revocation are to apply to both the proposed statutory advance health directives, and the proposed enduring powers of guardianship under the Bill. It is of further significance that where a person has a valid statutory advance health directive and has also appointed an enduring guardian, the advance health directive has precedence in any treatment decision covered by that anticipatory directive.

14.3 One of the questions which emerged in the course of the Committee's inquiry was what effect a later statutory or common law advance health directive would have on an earlier anticipatory health care decision. This question appears to have been addressed in evidence to the Committee by the SSO:

Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor's Office, 28 September 2007, Enclosure, pp 11-12 (see Appendix 4).

If it is known that the person had changed their mind and they could have informed their enduring guardian of a change of mind, then under 110S(6), the treatment decision would be deemed to have been revoked, if in actual fact there had been a change of mind, and that is communicated to an enduring guardian, who communicates it to the health professional. I think for all practical purposes, if there is an enduring guardian, a health professional would consult that enduring guardian. If the enduring guardian does have information, that will be part of the circumstances that the health professional will consider.\textsuperscript{100}

Committee Comment

14.4 Given that individuals will be free to choose either a statutory form advance health directive, or a common law anticipatory health treatment decision, it is essential that the two methodologies should be complementary and compatible. The Committee’s inquiry has determined that the Bill in its present form achieves this requirement.

Jurisdictional Questions concerning Common Law and Statutory Advance Health Directives

14.5 During the course of the Committee’s inquiry the question arose as to where jurisdiction to decide questions surrounding common law anticipatory health care decisions might lie. In a written response from the SSO, the question was addressed as follows:

The State Administrative Tribunal’s jurisdiction under proposed sections 110V-110ZA of the Guardianship and Administrative [sic] Act 1990 is confined to “advance health directives” as defined in proposed section 3(1), i.e to advance health directives made under Part 9B and instruments recognised under proposed section 110ZA.

If an issue arose as to the validity of a common law advance health directive, that issue would have to be decided in the context of court (or possibly State Administrative Tribunal) proceedings in which the validity of the relevant consent was a material issue or by way of an action for declaration in the Supreme Court.

Consideration was given to vesting in the State Administrative Tribunal a jurisdiction in relation to common law directives akin to that vested in the Tribunal in relation to statutory advance health directives. However, the policy decision was made to allow the

\textsuperscript{100} Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, p17. Refer also to Ms Bush’s comments at page 22 of that transcript.
validity of common law directives, and their implications in particular contexts, to be determined in the ordinary way outside the new statutory scheme. A case can be made for vesting the State Administrative Tribunal with jurisdiction in relation to common law directives, at least where (as under the proposed section 110ZJ) the validity or application of a common law directive to proposed treatment had direct implications for whether or not it is open to a substitute decision maker to make a treatment decision.101

14.6 A separate, but related question which arose during the Committee’s inquiry into the Bill was from which Court a validly appointed enduring guardian should seek a binding declaration if they wished to dispute a common law advance health directive. The same written response from the SSO, addressed this question as follows:

by reason of the proposed section 110ZJ, the ability of a substitute decision-maker to make a treatment decision will be dependent, in the event that a patient has made a common law directive, upon the validity of that directive. If an enduring guardian or other substitute decision maker (or, for that matter, a health professional or other interested party) is uncertain as to the validity or operation of a common law directive, the only mechanism to resolve that uncertainty in the short term would be by way of an action for a declaration in the Supreme Court.102

14.7 The broad jurisdiction of the Supreme Court to determine the validity or otherwise of common law anticipatory health care directives is not within the scope of the Bill. Any dispute arising from the interaction between a purported common law anticipatory health care directive and the ability of a substitute decision-maker to make a treatment decision pursuant to proposed section 110ZJ appears to fall outside the jurisdiction of the SAT.

14.8 The possibility of transferring to the SAT of a limited jurisdiction to resolve such matters without reference to the Supreme Court in the first instance was addressed in the following terms by the SSO:

A scheme which would permit the State Administrative Tribunal to determine the validity, construction and application to particular circumstances of common law advance health directives (i.e. an expression by a legally competent adult, in advance, of the type of treatment he or she wants or does not want in the event of the person's subsequent incapacity) undoubtedly has the merit of

101 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 11 October 2007, Enclosure, p1 (see Appendix 5).
simplicity. It would also avoid the potential (such as in the case of an intended advance health directive arguably not meeting the procedural requirements of proposed section 110Q) for jurisdictional uncertainty and for successive proceedings in the Tribunal and the Supreme Court to determine whether a statutory advance health directive was valid and, if not, whether it nevertheless took effect as a valid common law directive.¹⁰³

14.9 The possible objections to such a scheme were summarised in the following terms by the SSO:

At the same time, care must be taken to ensure that any regime is consistent conceptually and legally with the proper roles of the Supreme Court (a judicial body) and of the State Administrative Tribunal (an administrative tribunal exercising judicial-type functions, either by way of de novo review of administrative decisions or by way of the exercise of original jurisdiction in a limited range of circumstances where specialist expertise is thought desirable). As a matter of legal principle and of comity, the State Administrative Tribunal ought not, unless there is a very clear rationale for doing so, to be vested with the determination of issues which ought properly be the province of a Court. The fact that the Tribunal’s procedures may provide a simpler or more flexible mechanism to deal with particular applications would not, of itself, ordinarily be sufficient justification for the transfer to the Tribunal of jurisdiction in relation to such applications.

The State Administrative Tribunal’s current jurisdiction under the Guardianship and Administration Act 1990 is set out in section 13 of the Act. In essence, the Tribunal is vested with the jurisdiction formerly vested in the Guardianship Board, a specialist body. The regime established by the Acts Amendment (Consent to Medical Treatment) Bill 2006 is intended to be compatible with section 13. Vesting the Tribunal with the jurisdiction to determine the validity of legal rights existing independently of that regime (in particular, common law directives) was seen as vesting in the State Administrative Tribunal a jurisdiction which lay, and should properly remain, with the Supreme Court. Common law directives are ipso facto not creatures of statute. Just as the validity and legal consequences of contemporaneous personal consents are seen as properly the function of a Court, so the validity, construction and

¹⁰³ Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 16 October 2007, Enclosure, p1 (see Appendix 6).
operation of common law directives (which in character are simply personal consents given in advance) were seen as issues which ought properly be determined by a judicial body, applying and developing common law principles, rather than by a body of the nature of the State Administrative Tribunal.  

Committee Comment

14.10 The Committee notes that any dispute arising out of the application of proposed section 110ZJ of the GA Act with respect to the priority of a substitute decision maker over a purported common law anticipatory health care directive can only be determined by the Supreme Court.

14.11 The Committee has been advised that it is both feasible, and arguably within the policy of the Bill, for a limited jurisdiction to be given to the SAT concerning the interplay of purported common law anticipatory health care directives and the views of enduring guardians for the purposes of proposed section 110ZJ.

14.12 The Committee notes that, at present, there is no indication that any such jurisdiction will be vested on the SAT despite the acknowledged simplicity and accessibility benefits.

15 Clause 11, Proposed Section 110ZD Guardianship and Administration Act 1990 - Circumstances in Which Person Responsible May Make Treatment Decision

Introduction

15.1 Proposed section 110ZD of the GA Act provides that a ‘person responsible’ may make a treatment decision on behalf of a patient who is unable to make reasonable judgments about any treatment proposed to be provided to the patient. Proposed section 110ZD(3) lists, in order of priority, who can be a ‘person responsible’. Among other things, the ‘person responsible’ must be:

- of full legal capacity;
- reasonably available; and
- willing to make a treatment decision in respect of the treatment being given or proposed.

104 Ibid, pp1-2 (see Appendix 6).
The Committee noted that the people prescribed in proposed section 110ZD(3) are similar to the people who are currently prescribed as substitute health treatment decision-makers in section 119(3) of the GA Act.105

Who Determines the ‘Person Responsible’?

The person who will have the task of determining who will be the ‘person responsible’ on each occasion that a treatment decision is required from a ‘person responsible’ is the health professional who is treating, or who proposes to treat, the patient. The health professional’s task would involve considering the list of people who are prescribed in proposed section 110ZD(3) and making some reasonable inquiries about people who could potentially be on the list in order to determine who is the most appropriate person in each circumstance.106

The SSO provided the following information as to why, in its view, proposed section 110ZD does not explicitly state that it is the treating health professional who must decide who will be the ‘person responsible’ in each case:

With all of these questions, the provisions are probably couched in the third person. Rather than saying “A health professional must do this,” we are talking in more impersonal terms. The person who has to assess who is the person responsible, by default has to be the person who is going to provide the treatment, because it is that person who is responsible for making sure he or she has valid consent. We are back to the basics of consent. The health professional has to get consent from somebody, either through the patient in the advance health directive, or through a substitute decision maker. The health professional, under proposed section 110ZD has to look at the list and try to determine who is the correct person responsible. They have to do that in order to get consent. It has to be the health professional, because it is the health professional who needs consent in order to carry out treatment. That is why we tried to stress at the beginning that all of these provisions have to be seen against the background of consent. It is consent to treatment. This is what a person in an advance health directive is doing. This is what a substitute decision maker is doing - they are consenting or refusing consent to treatment. All of these clauses revolve around the health professional proposing to give treatment. It might not be in hospital; it could be a dentist, it could be an optometrist - anything that requires physical contact and could otherwise constitute an assault.


106 Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, p23.
With the drafting, there really is no need to refer to who makes the decision; I think it is probably the same again with what we have discussed under proposed section 110S. We are looking at who needs the consent and who is carrying out the action for which they need consent.\textsuperscript{107}

What if the ‘Person Responsible’ does not act in the Best Interests of the Patient?

15.5 It was noted by the Committee that section 51 of the GA Act requires guardians to act in the best interests of the persons they represent. Enduring guardians who are appointed under the Bill will also be subject to this requirement because clause 11, proposed section 110H of the GA Act, among other things, applies section 51 of the GA Act to enduring guardians and their appointers as if they were guardians and represented persons under the GA Act, respectively. Section 51 of the GA Act provides as follows:

51. Guardian to act in best interests of represented person

(1) Subject to any direction of the State Administrative Tribunal, a guardian shall act according to his opinion of the best interests of the represented person.

(2) Without limiting the generality of subsection (1), a guardian acts in the best interests of a represented person if he acts as far as possible —

(a) as an advocate for the represented person;

(b) in such a way as to encourage the represented person to live in the general community and participate as much as possible in the life of the community;

(c) in such a way as to encourage and assist the represented person to become capable of caring for himself and of making reasonable judgments in respect of matters relating to his person;

(d) in such a way as to protect the represented person from neglect, abuse or exploitation;

(e) in consultation with the represented person, taking into account, as far as possible, the wishes of that

\textsuperscript{107} Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, p23.
person as expressed, in whatever manner, or as gathered from the person’s previous actions;

(f) in the manner that is least restrictive of the rights, while consistent with the proper protection, of the represented person;

(g) in such a way as to maintain any supportive relationships the represented person has; and

(h) in such a way as to maintain the represented person’s familiar cultural, linguistic and religious environment.

(3) Nothing in subsection (2)(a) shall be read as authorising a guardian to act contrary to the Legal Practice Act 2003.

15.6 However, the Bill is silent on the issue of a ‘person responsible’ being required to act in the best interests of the patient. The LJ Goody Bioethics Centre and a private submitter suggested that the Bill should also state that a ‘person responsible’ must act in the best interests of the patient. In the view of the SSO, an express requirement is not necessary because a ‘person responsible’ would be regarded as being subject to the same obligation as a guardian and an enduring guardian. The anticipated legal ramifications for enduring guardians and ‘persons responsible’ who do not act in the bests interests of a patient are summarised at page 7 of Appendix 4.

15.7 This issue was considered in the Discussion Paper. The following factors were considered by the authors of the Discussion Paper to be relevant considerations for any substitute health treatment decision-maker when making a treatment decision for the patient:

- consideration by the substitute decision-maker of the proposed treatment, the risks associated with the treatment, the consequences to the appointor if the treatment is not carried out and any alternative treatment;

- whether the treatment to be carried out is only to promote the health and wellbeing of the appointor;

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108 Submission No 8 from the LJ Goody Bioethics Centre, 20 September 2007, p4; and Private Submission, p2.

109 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, pp6-7 (see Appendix 4).

110 Ibid, p7 (see Appendix 4).
• whether the appointor is permanently incapacitated;
• if it appears that the appointor is temporarily incapacitated, when it is likely that he or she will regain capacity;
• consultation with the appointor, taking into account, as far as possible, his or her past and present wishes and feelings;
• the beliefs and values that would be likely to influence the appointor’s decision if he or she had capacity;
• consultation with family members and other concerned persons;
• any other factors.\textsuperscript{111}

Committee Comment

15.8 The Committee noted the advice provided by the SSO but remains concerned that a ‘person responsible’ for the treatment decisions of a patient who is otherwise unable to make reasonable judgments about his or her proposed treatment is not expressly required under the Bill to act in the best interests of the patient when making a treatment decision. Therefore, the Committee recommends that the Bill be amended to make this an explicit obligation on ‘persons responsible’. Section 51(2) of the GA Act and page 39 of the Discussion Paper are instructive on what can constitute acting in the best interests of a patient.

Recommendation 7: The Committee recommends that the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended to expressly provide that a ‘person responsible’ for a patient under clause 11 of the bill, proposed section 110ZD of the Guardianship and Administration Act 1990 must act in the best interests of the patient when making a treatment decision for that patient.

16 CLAUSE 11, PROPOSED PART 9D GUARDIANSHIP AND ADMINISTRATION ACT 1990 - TREATMENT DECISIONS IN RELATION TO PATIENTS UNDER LEGAL INCAPACITY

Meaning of ‘Advance Health Directive’ in Proposed Part 9D

16.1 The Committee noted that the phrase ‘advance health directive’, as it is used in proposed Part 9D of the Guardianship and Administration Act 1990, includes common law advance health directives:

In this Part —

“advance health directive” includes a directive given by a person under the common law containing treatment decisions in respect of the person’s future treatment.

Meaning of ‘Reasonably’ and ‘Reasonable’ in relation to Health Professionals

16.2 In various sections of proposed Part 9D of the GA Act, health professionals are required to hold a ‘reasonable’ belief, suspicion or assumption about certain matters in order to be authorised to treat a patient in particular circumstances.

16.3 Proposed section 110ZIA of the GA Act authorises health professionals to provide treatment to a patient despite the fact that the provision of the treatment is inconsistent with a treatment decision (made either in an advance health directive or by a patient’s substitute health treatment decision-maker) if:

- the patient needs urgent treatment; and
- the patient is unable to make reasonable judgments in respect of the treatment; and
- “the health professional who proposes to provide the treatment reasonably suspects that the patient has attempted to commit suicide and needs the treatment as a consequence.” (emphasis added)

16.4 The aim of proposed section 110ZK of the GA Act is to provide health professionals with a defence to a civil action in trespass and a criminal prosecution in assault where the health professional has treated a patient in purported compliance with a treatment decision (made either in an advance health directive or by a patient’s substitute health treatment decision-maker). A health professional will only be able to rely on the protections afforded by proposed section 110ZK if he or she is able to satisfy the conditions prescribed in the proposed section. Among other things, the health professional must have treated the patient:

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113 Whether it is a common law or statutory advance health directive.


115 Whether it is a common law or statutory advance health directive.

116 Proposed section 110ZK is further discussed in paragraphs 18.1 to 18.29 of this Report.
• (if he or she is to rely on the protection under proposed section 110ZK(2)(a))
  “reasonably believing that the patient is unable to make reasonable
  judgments in respect of the treatment action” (emphasis added); or

• (if he or she is to rely on the protection under proposed section 110ZK(2)(b)):

  (i) in circumstances where it is reasonable for the health
      professional to rely on some other health professional having
      ascertained whether the treatment action is in accordance
      with a treatment decision; and

  (ii) reasonably assuming that some other health professional has
       ascertained that the treatment action is in accordance with a
       treatment decision, (emphases added).

16.5 When the Committee queried the meaning of ‘reasonable’ and ‘reasonably’ in these
contexts, the SSO explained that the terms are to be interpreted as imposing an
objective standard on the health professional:

  Ms Le Souef: The terms “reasonable” and “reasonably”, as used in
part 9D, are not subjective terms. For example, in proposed section
110ZK, the decisions of health professionals referred to are to be
judged according to the objective, impersonal standards of how a
reasonable health professional would have acted in the
circumstances. It is not a subjective meaning.

  …

  Ms Bush: It is an accepted legal definition. The terms “reasonable”
and “reasonably” are used in law, especially in areas of negligence.
In the old days, it was often referred to as being judged by the
standard of the man on the Clapham omnibus; it is what an objective
health professional or an objective dentist, or whoever would be
considered to be reasonable, depending on the circumstances and on
whose conduct we are looking at. You put someone in those shoes
and look at the objective standards.

  …

  Ms Bush: … The terms “reasonable” and “reasonably” are not
subjective. It is not what a particular health professional thinks; it is
what a health professional standing in his shoes would objectively
decide.
Ms Le Souef: It does not give discretionary powers to a health professional.\footnote{117}

16.6 The term ‘reasonable man’, now known as ‘reasonable person’, has been defined as:

\begin{quote}
A person with the characteristics of an ordinary man in the defendant’s position. A fictitious, imaginary, or hypothetical person of ordinary prudence, intelligence, and skill under the circumstances …\footnote{118}
\end{quote}

Committee Comment

16.7 The Committee is satisfied that, in the context of proposed sections 110ZIA(1)(c), 110ZK(2)(a)(i) and (b), the terms ‘reasonable’ and ‘reasonably’ have an accepted legal meaning and impose an objective standard on health professionals. However, given that the terms are not defined in the Bill, the Committee recommends that the Government ensure that all health professionals are fully informed of the requirements of these proposed sections of the GA Act.

Recommendation 8: The Committee recommends that the Government ensure that all health professionals are fully informed of the requirements of proposed sections 110ZIA(1)(c), 110ZK(2)(a)(i) and (b) of the Guardianship and Administration Act 1990.

17 Clause 11, Proposed Section 110ZJ Guardianship and Administration Act 1990 - Order of Priority of Persons Who May Make Treatment Decision in Relation to Patient

Treatment Decisions Binding Except in ‘Urgent Treatment’ Situations

17.1 One effect of proposed section 110ZJ of the GA Act is that treatment decisions made under the Bill are binding on health professionals unless urgent treatment under proposed section 110ZI is required, in which case, the health professional may treat a patient in the absence of a treatment decision in relation to the patient. In this sense, proposed section 110ZJ mirrors the common law position with respect to health treatment in emergency situations.\footnote{119}

\footnotesize
\begin{itemize}
\item \footnotemark[118] The Hon Dr PE Nygh and P Butt, General Editors, Butterworths Australian Legal Dictionary, Butterworths, Perth, 1997, p983.
\item \footnotemark[119] Refer to paragraph 4.6 of this Report.
\end{itemize}
17.2 The Committee noted advice from the SSO that proposed section 110ZI of the GA Act does not authorise the making of urgent treatment decisions retrospectively.\textsuperscript{120}

17.3 The proposed section also provides the order of priority of treatment decisions made under the Bill (refer to paragraph 4.11 of this Report).

**Supplementary Notice Paper Number 149 Issue 4**

17.4 Amendment 11/11 on the Supplementary Notice Paper puts forward an amendment to proposed section 110ZJ(2). Proposed section 110ZJ(2) provides that, where a patient is unable to make reasonable judgments about any treatments which are proposed for him or her, the treating health professional must, in the first instance, follow the treatment decision which is contained in an advance health directive (if any), whether it be made under common law or the Bill. The ‘marked-up’ version of proposed section 110ZJ is provided below and also appears in Appendix 7 of this Report.

**110ZJ. Order of priority of persons who may make treatment decision in relation to patient**

(1) Subject to section 110ZI, this section applies if a patient is unable to make reasonable judgments in respect of any treatment proposed to be provided to the patient.

(2) If the patient has made an advance health directive containing a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided in accordance with the treatment decision.

(2) If a patient has made an advance health directive containing a treatment decision in respect of—

(a) refusal of the treatment, whether or not that treatment is provided must be decided in accordance with the treatment decision; or

(b) requesting the treatment, the health professional must take that treatment decision into account in determining whether or not that treatment is provided.

(3) If—

(a) subsection (2) does not apply; and

(b) the patient has an enduring guardian who —

(i) is authorised to make a treatment decision in respect of the treatment; and

(ii) is reasonably available; and

(iii) is willing to make a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided by the enduring guardian.

(4) If —

(a) subsections (2) and (3) do not apply; and

(b) the patient has a guardian who —

(i) is authorised to make a treatment decision in respect of the treatment; and

(ii) is reasonably available; and

(iii) is willing to make a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided by the guardian.

(5) If —

(a) subsections (2) to (4) do not apply; and

(b) there is a person responsible for the patient under section 110ZD,

whether or not the treatment is provided to the patient must be decided by the person responsible.

17.5 The apparent effect of the proposed amendment is to mirror the general principle that a patient can refuse to consent to health treatment but cannot demand health treatment because that remains a matter of clinical judgment for the health professional in each case.\(^{121}\) Proposed new subsection (2)(a) confirms that a patient’s refusal to consent (in an advance health directive\(^{122}\)) to a proposed treatment is binding on health

\(^{121}\) Refer to paragraph 4.5 of this Report.

\(^{122}\) Whether it is a common law or statutory advance health directive.
professionals, while proposed new subsection (2)(b) requires the treating health professional to take the patient’s request for the treatment (in an advance health directive) into account when determining whether or not to provide the treatment in question.

17.6 It appears that proposed new subsection (2)(b) may have been intended to go beyond the current legal position of allowing health professionals full discretion as to which treatment is most clinically appropriate for a particular patient by requiring the health professional to take the request for the treatment into consideration. However, the proposed new subsection (2)(b) must be read in the context of the rest of the Bill, which deals with the issue of a patient’s consent to health treatment which is being proposed by his or her treating health professionals. The Bill does not allow patients to direct their health professionals in relation to which treatments are most appropriate for them; the Bill only provides patients with additional methods of consenting to treatment once it has been proposed by their health professionals.

17.7 Proposed section 110ZJ, as it currently exists, is predicated on the treating health professional having already determined which type of treatment will be offered to a patient. Given that approach, proposed new subsection (2)(b) would only require the treating health professional to take the patient’s consent to the treatment (in an advance health directive) into account when determining the issue of consent. This effect is different to the effect of existing subsection (2), which provides that treatment decisions about the proposed treatment contained in an advance health directive are binding on the treating health professional, subject of course, to the treatment decision being lawful.

Committee Comment

17.8 The Committee is of the view that the proposed amendment would change the effect of proposed section 110ZJ(2) so as to come into conflict with one aspect of the policy of the Bill; that is, to make a patient’s valid and lawful treatment decisions in an advance health directive (whether it is a common law or statutory advance health directive) binding on the health professionals who are treating, or proposing to treat, the patient.

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123 This is already the case at common law: refer to paragraph 4.17 of this Report. This is also the effect of current proposed section 110ZI(2) of the Guardianship and Administration Act 1990.
124 Whether it is a common law or statutory advance health directive.
125 For example, this approach is also reflected in clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed sections 110ZD(1), 110ZG(1), 110ZI(1)(c), 110ZIA(1)(c) and clause 12 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed new section 119 of the Guardianship and Administration Act 1990.
126 Whether it is a common law or statutory advance health directive.
127 Whether it is a common law or statutory advance health directive.
Introduction

18.1 Under proposed section 110ZK of the GA Act, it is proposed that a health professional who treats a patient in apparent compliance with a valid treatment decision consenting to the treatment will have a defence to a civil action in trespass and criminal prosecution for assault. A health professional who refrains from treating a patient or withdraws treatment in apparent compliance with a valid treatment decision refusing consent to the treatment is also protected in this way.

18.2 The protection is only afforded if the conditions prescribed in proposed subsections (2)(a) or (b) are met by the health professional. If these conditions are satisfied, the treatment action that is taken is deemed to have been validly consented to by the patient, and a "valid consent by a patient is a defence to trespass and assault and a valid refusal of consent precludes treatment being given." The treatment action that is taken is deemed by proposed subsection (2) to have been authorised even if it transpires that the treatment decision that was relied upon was actually invalid for any reason, as long as the conditions in proposed subsections (2)(a) or (b) are met.

18.3 Importantly, the opportunity for protection under the proposed section only arises in circumstances where the health professional has taken treatment action that is in accordance with what he or she understood to be a valid treatment decision (made either in an advance health directive, or by a substitute health treatment decision-maker). It would not arise if the health professional had taken treatment action that only accorded with his or her own decision.

18.4 While the SSO was unaware of the numbers of civil actions for trespass brought against health professionals in the past 10 years, the SSO was of the view that such
actions are rare. The SSO also advised the Committee that there are no statistics available for criminal prosecutions for assault against health professionals, but the SSO was informed by the Office of the Director of Public Prosecutions that there is “no recollection of such a prosecution since 1999 when the present Director commenced in the position.”

18.5 The Committee noted that the proposed section does not provide a defence for health professionals against actions in negligence.

**Protection for Health Professionals who must rely on their own Judgment of the Patient’s Decision-Making Abilities and Investigations as to Treatment Decisions**

18.6 Proposed section 110ZK(2)(a) is intended to provide a defence for trespass or assault to health professionals who, in their circumstances of employment, have the responsibility for both obtaining consent for health treatment and for carrying out the health treatment. Examples of such a position are:

- a surgical registrar in a teaching hospital;
- a dentist in a private dental surgery; and
- a chiropractor in private practice.

18.7 In order for the protection in proposed section 110ZK(2)(a) to be afforded to a health professional with the above responsibilities, the health professional must treat the patient:

i) “reasonably believing that the patient is unable to make reasonable judgments in respect of the treatment action; and”

ii) “relying in good faith on what is purportedly a treatment decision —

(I) in an advance health directive made by the patient; or

(II) made by the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD”

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133 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p10 (see Appendix 4).


137 *Ibid*. 
18.8 The question of whether the treating health professional was ‘reasonable’ in his or her belief that a patient was unable to make reasonable judgments about the treatment action would be determined according to the belief that would be held by a reasonable health professional in the same circumstances as the treating health professional; that is, the test is an objective one. The meaning of the term ‘reasonable’ in this context has already been discussed in this Report at paragraphs 16.2 to 16.7.

18.9 The requirement of ‘good faith’ in the health professional’s reliance upon a purportedly valid treatment decision (made either in an advance health directive138, or by a substitute health treatment decision-maker) would involve the health professional honestly coming to the view that, having considered the information available to him or her, the treatment decision is valid.139 The SSO provided the following general comments on the term ‘good faith’:

The concept of anything done in “good faith” is not a fixed one for all purposes and in all contexts. Good faith sometimes is said to be simply the absence of bad faith, which effectively translates into an absence of dishonesty. In other contexts, good faith is seen as encompassing an obligation to act with appropriate regard for the consequences of an act or a decision. All that one can say is that each case will be determined on its own facts, but that a health professional taking treatment action in the circumstances referred to in proposed section 110ZK, who acts honestly and who genuinely attempts to carry out his or her responsibilities, would ordinarily be held to have acted in good faith. In determining whether there is an advance health directive, a health professional would probably be required to make reasonable inquiries as to the existence of the document, for example, by asking relatives or friends of the patient, checking hospital records, and accessing the register for advance health directives.140

18.10 The SSO further advised the Committee that a health professional would only satisfy the ‘good faith’ requirement in proposed section 110ZK(2)(a)(ii) if the following three elements are met:

Firstly, the factual material provided to the health professional must “purport” to be a treatment decision, i.e. must appear to be a treatment decision in the sense contemplated by the … [Bill].
Secondly, the health professional must establish that, in proceeding to

138 Whether it is a common law or statutory advance health directive.
139 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p10 (see Appendix 4).
140 Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 19 September 2007, p32.
treat or not treat the patient, he or she relied upon the factual material made available constituting a “treatment decision” authorised by the Act. Thirdly, the health professional must establish that his or her assumption that the “treatment decision” was valid was in good faith, ie arrived at honestly after considering the issue of its validity. 141

Committee Comment

18.11 The Committee is of the view that it would be helpful if the Bill provided some guidance on what is meant by the phrase ‘good faith’ and therefore, what is to be required of health professionals before they can rely on the protection afforded by proposed section 110ZK(2)(a). Accordingly, the Committee recommends that, for the purposes of proposed section 110ZK(2)(a)(ii) of the GA Act, the phrase ‘good faith’ should be defined in the substantive terms of the SSO’s advice which is reproduced at paragraph 18.10 of this Report. Additionally, the Committee recommends that the Government ensure that all health professionals are fully informed on what will be required of them under proposed section 110ZK(2)(a)(ii) of the GA Act.

Recommendation 9: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110ZK of the Guardianship and Administration Act 1990, be amended to include a definition of the phrase ‘good faith’ in the substantive terms of the advice provided by the State Solicitor’s Office which is reproduced at paragraph 18.10 of this Report.

Recommendation 10: The Committee recommends that the Government ensure that all health professionals are fully informed of the requirements of proposed section 110ZK(2)(a)(ii) of the Guardianship and Administration Act 1990.

Protection for Health Professionals who may rely on Other People’s Investigations as to Treatment Decisions

18.12 Proposed section 110ZK(2)(b) is intended to provide a defence for trespass or assault to health professionals who, in their circumstances of employment, have the responsibility of treating patients but do not ordinarily have the responsibility of obtaining the relevant consent to the treatment. Examples of such positions include:

141 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p10 (see Appendix 4).
nurses who administer treatment in a hospital environment who would ordinarily rely on, for example, a registrar having obtained the relevant consent for the treatment;

consultants, who would usually and appropriately arrange for a registrar in the surgical team to obtain the consent that is necessary for a surgical procedure; and

dental nurses who work in a dental surgery.

18.13 In order for the protection in proposed section 110ZK(2)(b) to be afforded to a health professional with the above responsibilities, the health professional must treat the patient:

i) “in circumstances where it is reasonable for the health professional to rely on some other health professional having ascertained whether the treatment action is in accordance with a treatment decision; and”

ii) “reasonably assuming that some other health professional has ascertained that the treatment action is in accordance with a treatment decision”.

18.14 The question of whether the treating health professional was ‘reasonable’ in his or her reliance on another health professional ascertaining that the treatment of the patient was in accordance with a treatment decision would be determined according to the belief that would be held by a reasonable health professional in the same circumstances as the treating health professional; that is, the test is an objective one. The meaning of the term ‘reasonable’ in this context has already been discussed in this Report at paragraphs 16.2 to 16.7.

18.15 During the Committee’s consideration of proposed section 110ZK(2)(b), the question arose as to whether the health professionals falling within the ambit of that proposed section should also be required to reasonably believe that the patient was unable to make reasonable judgments in respect of the treatment action that was taken. The SSO’s response was that the additional requirement is not necessary because the operation of proposed subsection (2)(b) is predicated on the patient being unable to make reasonable judgments in respect of the proposed treatment. That is, the term ‘treatment decision’, as it is used in proposed subsection (2)(b), is intended to mean a ‘valid and applicable treatment decision’, and:

142 L Bush and S Le Souef, Senior Assistant State Solicitors, State Solicitor’s Office, Acts Amendment (Consent to Medical Treatment) Bill 2006 - Liability of Health Professionals, tabled on 19 September 2007, pp2-3 (see Appendix 3).

143 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 11 October 2007, Enclosure, p2 (see Appendix 5).
A treatment decision will be valid and applicable, and so the treatment action authorised, if, relevantly to the amendments proposed by the Bill:

(a) either the advance health directive met the statutory requirements and applied to the treatment contemplated or a substitute decision-maker had been properly appointed, and

(b) the patient was unable to make reasonable judgments in respect of the proposed treatment.\(^{144}\)

Committee Comment

18.16 The Committee noted that proposed subsection (2)(b) is consistent with the policy of the Bill, one aspect of which is to provide health professionals whose role is to treat patients but not to obtain consent for the treatment, to be protected from trespass and assault if they reasonably rely on another health professional having ascertained that the proposed treatment is duly authorised.

18.17 However, the Committee is of the view that the Bill should impose an additional requirement on health professionals before they can rely on the protection afforded by proposed section 110ZK(2)(b). The Committee recommends that health professionals who propose to use the defence provided by subsection (2)(b) should also be required to sight written evidence that the other health professional on whom they are relying has ascertained that the treatment action is in accordance with a treatment decision.

Recommendation 11: The Committee recommends that clause 11 of the Acts Amendment (Consent to Medical Treatment) Bill 2006, proposed section 110ZK(2)(b) of the Guardianship and Administration Act 1990, be amended so that health professionals who fall within the ambit of the proposed section must also sight written evidence that the other health professional on whom they are relying has ascertained that the treatment action is in accordance with a treatment decision.

Health Professionals are still Protected if Treatment Decision was Invalid

18.18 The apparent intent of proposed section 110ZK is to provide a defence against trespass and assault for health professionals who purport to treat a patient in accordance with a valid treatment decision even if it transpires that the treatment decision was actually invalid for any reason, as long as the conditions in proposed subsections (2)(a) or (b) are met.

\(^{144}\) Ibid.
Proposed subsection (3) prescribes eight scenarios in which the protection offered in proposed subsection (2) will still operate, despite the fact that a treatment decision that was purportedly relied upon by a health professional was invalid:

(3) Subsection (2) applies in the circumstances described in subsection (2)(a) even if —

(a) the patient is in fact able to make reasonable judgments in respect of the treatment action; or

(b) what purports to be the advance health directive, guardianship order or enduring power of guardianship is invalid or has been revoked; or

(c) what purports to be the treatment decision in the advance health directive is invalid or has been revoked; or

(d) the appointment of one or some of the persons who made the treatment decision purportedly as joint guardians or joint enduring guardians has been revoked by the State Administrative Tribunal under section 90(1)(c)(i) or 110N(1)(b); or

(e) the circumstances in which the treatment decision in the advance health directive or the guardianship order or enduring power of guardianship may be acted on in fact do not exist or have not arisen; or

(f) the advance health directive, guardianship order or enduring power of guardianship in fact does not authorise the making of the treatment decision; or

(g) the person who made the treatment decision purportedly as the person responsible for the patient under section 110ZD was not the person responsible for the patient under that section; or

(h) the person who made the treatment decision purportedly as the person first in order of priority under section 110ZJ was not the person first in order of priority under that section.

The SSO advised the Committee that:
Proposed section 110ZK(3) makes explicit what is in any event implicit in proposed section 110ZK(2) in that it puts it beyond doubt that even if, as a matter of law, a consent given or withdrawn in an advance health directive or by a substitute decision maker is invalid, the protection given by proposed section 110ZK(2) will operate.\textsuperscript{145}

**Operation of Proposed Section 110ZK**

18.21 In an effort to fully appreciate the effect of proposed section 110ZK, the Committee found it particularly useful to discuss the practical application of the proposed section in hypothetical scenarios. Some of these discussions are summarised here for the information of the Legislative Council:

- An advance health directive (whether common law or statutory) contains a direction that a particular kind of operation may be performed only if the patient is ‘blind’. At the time that the advance health directive comes to be relied upon, debate might ensue both as to the extent of the patient’s sight from a medical perspective, and as to whether the word ‘blind’ is to be equated only with loss of sight or whether it also encompasses very significant loss of sight. This scenario would fall within proposed section 110ZK(3)(e) and proposed section 110ZK(2)(a) will still operate to protect a health professional from liability in trespass and assault where he or she carries out the relevant operation in the good faith belief that the patient is ‘blind’, even though, as a matter of fact or on the proper interpretation of the advance health directive, the patient was not ‘blind’ at the time the operation was performed.\textsuperscript{146}

- “An example of the operation of proposed section 110ZK(2) in a proposed section 110ZK(3)(e) scenario would be a patient rendering the operation of an advance health directive dependent upon the patient’s sister not being in Western Australia. The patient may have appointed the sister to be the patient’s enduring guardian, the intention being that the advance health directive would be relied upon by health professionals only if the sister was unavailable. If the health professional made inquiries and was led to believe that the sister was out of the state, and, in the belief that that was the case, relied upon the patient’s advance health directive as giving consent for relevant treatment, the health professional would be protected by proposed

\textsuperscript{145} Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p9 (see Appendix 4).

\textsuperscript{146} Ibid, pp9-10.
section 110ZK from liability in trespass to the patient should it transpire that the sister was in fact in Western Australia at the relevant time.”

- “An example of a scenario in which proposed section 110ZK(3)(f) would operate would be a patient determining that he or she consented to a particular form of treatment only if he or she contracted liver cancer. Health professionals who in good faith provided that treatment following a diagnosis of liver cancer would be protected from liability in trespass to the patient, notwithstanding that subsequent tests revealed that the patient had not suffered from liver cancer.”

- “An unconscious female patient who is not breathing has made a valid statutory advance health directive, which states that she must not receive CPR if she stops breathing and she is over the age of 70, and a copy of the directive is read by her doctor who withholds the performance of CPR believing that the patient is 71 years old but the patient is in fact 69 years old. The patient dies as a result of the withholding of treatment.” The doctor would be protected in this case if he or she can show that he or she had relied in good faith upon the advance health directive; that is, if he or she had satisfied himself or herself that the patient was in fact aged over 70. If the doctor had miscalculated the patient’s age, it may be harder to prove that he or she had acted in good faith.

Are Protections for Health Professionals Enhanced at the Expense of Protections for Patients?

18.22 The SSO provided the following explanations of the policy behind proposed section 110ZK:

\[
\text{It is not appropriate to speak in terms of the protection of the patient being reduced in order to enhance the protection of the health professional. Provided that proposed section 110ZK’s criteria are met, giving statutory protection to the health professional extinguishes any entitlement which the patient would have had to seek damages from the health professional in the event that treatment was} \\
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147 Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 8 October 2007, p5.
148 Ibid.
149 Hon Giz Watson MLC, Deputy Chair, Standing Committee on Legislation, Transcript of Evidence, 8 October 2007, p7.
150 Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 8 October 2007, p7.
provided without the patient’s consent. However, the patient’s common law entitlement to damages arises only because the legislative regime proposed in the bill allows the patient to grant or refuse consent through advance health directives and substitute decision makers in circumstances where consent could not ordinarily have been granted or refused. In other words, under the bill a patient’s self-autonomy is enhanced by the legislative regime, and in that sense the patient is given greater protection, but the extension of the circumstances in which a consent will be valid and the attendant legal and factual uncertainties correspondingly increase the range of circumstances in which a health professional may inadvertently, albeit entirely genuinely, act inconsistently with the patient’s consent expressed through an advance health directive or a substitute decision maker.\textsuperscript{152}

Proposed section 110ZK endeavours to strike a balance between, on the one hand, the interests of patients in being subjected to or deprived of medical treatment only where valid consents are given and, on the other hand, the interests of health professionals in knowing that they will not be subject to liability in trespass if they have acted in good faith in the belief that a valid consent was given, ie in the belief that the medical treatment was authorised.\textsuperscript{153}

18.23 Given the SSO’s advice that “Proposed section 110ZK(3) makes explicit what is in any event implicit in proposed section 110ZK(2)\textsuperscript{154} the Committee was not convinced of the need for proposed section 110ZK(3). In addition, the Committee was concerned that proposed subsection (3) gives the impression that health professionals will be protected from trespass and assault in virtually any situation, to the detriment of patients. For example, the Health Consumers’ Council WA Inc was of the view that proposed section 110ZK is “imbalanced and unnecessarily in favour of health professionals to the detriment of patients as it removes freedom of choice for patients.”\textsuperscript{155}

18.24 The Committee considered how the proposed subsection could be amended in order to remove the potential for creating this impression. The following amendments were contemplated:

\begin{itemize}
\item \textsuperscript{152} Ibid. p4.
\item \textsuperscript{153} Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, p9 (see Appendix 4).
\item \textsuperscript{154} Ibid.
\item \textsuperscript{155} Letter from Ms Michele Kosky, Executive Director, and Ms Madeleine Cox, Committee Member, Health Consumers’ Council WA Inc, 2 October 2007, p1.
\end{itemize}
• Deleting proposed subsection (3).

• Rewording proposed subsection (3) in order to emphasise the types of matters which health professionals must take into account before they are protected under proposed section (2).

18.25 In the SSO’s view, proposed subsection (3) should be retained in its current form. However, faced with the two options suggested by the Committee, the SSO preferred the option of deleting subsection (3):

Our preference is the retention of subsection (3) in its present form. However, because the subsection operates to make explicit what would in any event be implied in its absence, the subsection could be deleted.

…

Subsection (3) identifies the range of circumstances in which what is on the face of it a valid consent in an advance health directive or by a substitute decision maker, may (for factual or legal reasons) be not valid. Absent the protection given by subsection (2), a health professional who was mistaken as to any of those circumstances having application to the consent given or refused for the treatment contemplated, would have committed a trespass. A belief that a consent was valid, no matter how reasonable that belief, is no defence to a civil claim. (Under section 24 of the Criminal Code, an honest and reasonable belief that a patient had consented would be a defence to a criminal offence.)

If subsection (3) were not present, there can be little doubt that the operation of subsection (2) would be unaffected. Subsection (3) clarifies and makes explicit what is implied in subsection (2)(a) - that is, that provided the three elements described above are satisfied, the health professional will be protected from liability even if the relevant consent or refusal of consent was invalid for any of the reasons set out in subsection (3). The subsection does not strengthen subsection (2)’s protection. It merely makes clear the scope of that protection by, as it were, listing the circumstances in which, depending upon the facts of a particular case, the protection may be availed of if the criteria in subsection (2) are satisfied.

In one sense, subsection (3) strengthens patients’ protection in that it provides, statutorily, something of a “check-list” of matters which a health professional should consider when determining whether there has been a valid consent or consent refusal in an advance health
directive or by a substitute decision maker. The presence of that “check list” clearly has implications for when a health professional can genuinely be said to have come to the conclusion, in good faith, that a particular health decision was authorised.\textsuperscript{156}

Committee Comment

18.26 The Committee remains concerned that proposed subsection (3) gives the impression that health professionals will be protected from trespass and assault in virtually any situation, to the detriment of patients. It recommends that proposed subsection (3) be deleted.

Recommendation 12: The Committee recommends that the Acts Amendment (Consent to Medical Treatment) Bill 2006 be amended as follows:

Page 28, line 26 to Page 29, line 26 — To delete lines.

Clarification of Drafting

18.27 Currently, the words used in proposed subsection (3) appear to restrict the operation of the proposed subsection to the “circumstances described in subsection (2)(a)”. The Committee queried why there is this apparent restriction when it is a clear policy of the Bill that health professionals who:

- (fall within proposed subsection (2)(a)) reasonably believe that the patient who they are treating is unable to make reasonable judgments in respect of the treatment action and rely in good faith on a purported treatment decision; and
- (fall within proposed subsection (2)(b)) are relying reasonably on another health professional to ascertain that the treatment action is in accordance with a treatment decision,

are all intended to be protected from trespass and assault.\textsuperscript{157}

18.28 In response, the SSO confirmed that the intent was to ensure that health professionals falling within proposed subsection (2)(b) would also be protected in the scenarios set out in proposed subsection (3).\textsuperscript{158} The SSO suggested that:

\textsuperscript{156} Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 19 October 2006, Enclosure, pp1-2.

\textsuperscript{157} See, for example, Hon Sue Ellery, then Parliamentary Secretary to the Minister for Health, Parliament of Western Australia, Legislative Council, \textit{Parliamentary Debates (Hansard)}, 6 December 2006, p9245.
Ambiguity in the operation of section 110ZK(3) in this regard could, it would seem, be removed by, for example, deleting the words "applies in the circumstances described in subsection (2)(a)" in the opening lines of section 110ZK(3).\textsuperscript{159}

Committee Comment

18.29 In the event that proposed section 110ZK(3) remains in the Bill, the Committee agrees with the SSO’s suggested amendment.

19 INTERACTION OF THE ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006 WITH THE MENTAL HEALTH ACT 1996

19.1 During the Committee’s inquiry into the Bill, the question arose as to how the Bill would interact with the operation of the Mental Health Act 1996 in relation to patients with a mental illness. This topic was dealt with in detail by the SSO in correspondence and during the hearing on 8 October 2007. The Committee refers the Legislative Council to the information provided by the SSO in pages 8 to 9 of Appendix 4\textsuperscript{160} and to pages 10 to 11 of the transcript of the hearing\textsuperscript{161}.

19.2 An important aspect of the information provided to the Committee is that a person’s status as an ‘involuntary patient’\textsuperscript{162} or a ‘mentally impaired accused’\textsuperscript{163} under the Mental Health Act 1996 is crucial to the issue of consent to the health treatment of that person. An ‘involuntary patient’ and a ‘mentally impaired accused who is in an authorised hospital’\textsuperscript{164} can be given ‘psychiatric treatment’\textsuperscript{165} without their consent; that is, the Mental Health Act 1996 would override the provisions of the Bill in those circumstances.

158 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 11 October 2007, Enclosure, p3 (see Appendix 5).
159 Ibid.
160 Letter from Ms Sue Le Souef, Senior Assistant State Solicitor, State Solicitor’s Office, 28 September 2007, Enclosure, pp8-9 (see Appendix 4).
161 Hon Giz Watson MLC, Deputy Chair, Standing Committee on Legislation, and Ms Linda Bush, Senior Assistant State Solicitor, State Solicitor’s Office, Transcript of Evidence, 8 October 2007, pp10-11.
162 ‘Involuntary patient’ means “a person who is for the time being the subject of — (a) an order under section 43(2)(a), 49(3)(a), 50 or 70(1) for detention of the person in an authorised hospital as an involuntary patient; or (b) a community treatment order”: section 3 of the Mental Health Act 1996.
163 ‘Mentally impaired accused’ means “an accused in respect of whom a custody order has been made and who has not been discharged from the order”: section 3 of the Mental Health Act 1996 and section 23 of the Criminal Law (Mentally Impaired Accused) Act 1996.
165 For these purposes, ‘psychiatric treatment’ means “treatment for mental illness” which does not involve “(a) treatment that is prohibited by section 99; (b) psychosurgery; or (c) electroconvulsive therapy”: sections 3 and 108 of the Mental Health Act 1996.
166 Section 109 of the Mental Health Act 1996.
19.3 In addition to this, a treatment decision which is made by a patient in an advance health directive (whether under common law or statute), or by a substitute health treatment decision-maker would not constitute the “informed consent”\(^{167}\) that is required for a person to undergo ‘psychosurgery’ or ‘electroconvulsive therapy’\(^{168}\).

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Hon Graham Giffard MLC
Chair
25 October 2007

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\(^{167}\) See *Ibid*, Part 5, Division 2.

\(^{168}\) See *Ibid*, Part 5, Divisions 4 and 5.
APPENDIX 1

STATE SOLICITOR’S OFFICE DOCUMENT -
OPENING STATEMENT
APPENDIX 1

STATE SOLICITOR’S OFFICE DOCUMENT - OPENING STATEMENT

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

OPENING STATEMENT

The Acts Amendment (Consent to Medical Treatment) Bill 2006 amends the Guardianship and Administration Act 1990 to provide for a comprehensive statutory scheme for the giving or refusal of consent to treatment in circumstances where a person is not competent, that is, he or she is unable to make reasonable judgments in respect of medical, surgical or dental treatment or other health care at the time that such treatment is required.

The scheme must be considered in the context of the civil and criminal law as it relates to consent to treatment.

A fundamental concept, reflecting ordinary principles of freedom of choice, respect for the individual and the right to self-determination, is that a civil action in trespass and a criminal prosecution for assault may be brought against a health professional if treatment is given without consent, irrespective of whether a patient is competent.

Consent is required not only for end of life decision making but for all health care. For example, consent is required for the administration of daily medication and for physiotherapy and optometry services to a resident of a nursing home.

Where a person is not competent the current legal position is as follows:

- At common law, a legally competent adult may indicate in an advance health care direction, either in writing or orally, the type of health care he or she wants or does not want in the event of subsequent incapacity. A directive of this kind is sometimes referred to as a “living will”. It is most often used to refuse life-sustaining treatment in the event of terminal illness or a state of persistent or permanent unconsciousness. A health professional must comply with such a direction.

- The Guardianship and Administration Act 1990 makes provision for substitute decision making on behalf of persons who are not competent. Part 5 of the Act provides for the appointment by the State Administrative Tribunal of a guardian with authority to consent to treatment or health care for a represented person. Further, section 119 of the Act provides a mechanism whereby a medical practitioner or a dentist may lawfully provide treatment to an incompetent patient if consent is given by the person first in order of priority in a list of specified persons.

- A health professional may provide treatment in circumstances of emergency without consent.

However, this State has no legislation whereby a person may plan ahead for his or her health care in the event that he or she loses capacity to make decisions about health care.
The Bill reforms the law by introducing mechanisms to enable an adult, while competent, to:

- set out in writing, in an advance health directive, the treatment which he or she will consent to or refuse consent to if, in the future, he or she is unable to make reasonable judgments about that treatment (although there is no legal entitlement for a person to demand treatment).

- to appoint an enduring guardian to make treatment decisions (and other personal and lifestyle decisions) on his or her behalf if, in the future, he or she is unable to make reasonable judgments about those matters.

The Bill also provides a mechanism whereby a person responsible may make treatment decisions on behalf of a patient. This mechanism is similar to that in section 119 of the Guardianship and Administration Act 1990 but the authority of the person responsible is now consistent with the provisions relating to advance health directives and enduring guardians.

The Bill expressly preserves the common law relating to a person's entitlement to make treatment decisions in respect of the person's future treatment. This will enable an informal direction to be given either in writing or orally, for example in circumstances where it may not be practicable for a person to comply with the statutory requirements.
APPENDIX 2
STATE SOLICITOR’S OFFICE DOCUMENT - STATE ADMINISTRATIVE TRIBUNAL
APPENDIX 2
STATE SOLICITOR’S OFFICE DOCUMENT - STATE ADMINISTRATIVE TRIBUNAL

STATE ADMINISTRATIVE TRIBUNAL

The State Administrative Tribunal is to be vested with the following powers:

- to make a declaration that an enduring power of guardianship is valid or invalid; (clause 110G);
- to make a declaration as to the incapacity of an appointor at the time when an enduring guardian needs to make a treatment decision (clause 110L);
- to make an order as to the exercise of an enduring power of guardianship and the construction of its terms (clause 110M);
- to make an order revoking an enduring power of guardianship, revoking the appointment of an enduring guardian or varying the terms of an enduring power of guardianship (a power which is retrospective) (clause 110N);
- to make an order recognising the enduring power of guardianship created under the law of another jurisdiction as valid in this State (clause 110O);
- to make a declaration as to the validity of an advance health directive or a treatment decision in an advance health directive (clause 110W);
- to make a declaration as to the incapacity of the maker of an advance health directive at the time when treatment needs to be given (clause 110X);
- to make an order as to how to give effect to a treatment decision in an advance health directive or the construction of the terms of an advance health directive (clause 110Y);
- to make a declaration that a treatment decision is deemed revoked if the maker has changed his or her mind about the treatment decision since making the directive (clause 110Z);
- to make an order recognising the advance health directive created under the law of another jurisdiction as an advance health directive valid in this State (clause 110ZA);
- to make a declaration as to who is the "person responsible" for making a treatment decision on behalf of a patient and as to the incapacity of the patient when a treatment decision needs to be made (clause 110ZG)
APPENDIX 3
STATE SOLICITOR’S OFFICE DOCUMENT - LIABILITY OF HEALTH PROFESSIONALS
APPENDIX 3
STATE SOLICITOR’S OFFICE DOCUMENT - LIABILITY OF HEALTH PROFESSIONALS

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL, 2006
LIABILITY OF HEALTH PROFESSIONALS

CURRENT LEGAL POSITION

A fundamental concept, reflecting ordinary principles of autonomy and self-determination, is that a civil action in trespass and a criminal prosecution for assault may be brought against a health professional if treatment is given without consent.

A valid consent can be given by a competent patient, either at the time of treatment or by means of a common law advance direction giving consent; by a parent on behalf of a child where the child lacks the requisite maturity; by implication, under the doctrine of necessity, in circumstances of emergency and the like; or by statutorily authorised substitute decision makers.

However, this is subject to:

- section 259 of the Criminal Code which, in the absence of consent, removes criminal responsibility for the administration in good faith of medical treatment for a person’s benefit if the provision of such treatment was in all the circumstances reasonable;
- the doctrine of necessity under which consent is not required in emergency situations.

It is not a defence to a civil trespass claim that the health professional believed, even reasonably, that a valid consent had been given. On the other hand, an honest and reasonable belief that a valid consent has been given will, by reason of section 24 of the Criminal Code, be a defence to a criminal prosecution.

Even with consent, a health professional is permitted, both civilly and criminally, to do only that which is lawful. In particular, unless authorised by statute, a health professional is not permitted to kill a patient, including by hastening a patient’s death. Thus euthanasia is unlawful, even where the patient consents.

PROTECTION UNDER THE BILL

The Bill provides an appropriate measure of protection for health professionals.

SECTION 50 GUARDIANSHIP AND ADMINISTRATION ACT, CLAUSE 110S(1)(b), CLAUSE 110ZD(6)

A valid consent will be a defence to trespass and assault and a valid refusal of consent precludes treatment being given. However, the patient’s consent or refusal of consent must be given at the time that treatment is proposed. This, of course, is not possible where the patient is not competent. Consequently, the Bill contains a number of deeming provisions as follows:
Legislation Committee

- If there is a valid treatment decision in a valid advance health directive, the decision to consent to or refuse consent to the treatment is deemed to be a valid consent or a valid refusal of consent by the patient as if the treatment decision had been made by the patient with full legal capacity at the time of the proposed treatment (clause 110S(1)(b)).

- A valid treatment decision made by a guardian, an enduring guardian or person responsible will be deemed to be a valid consent or a valid refusal of consent by the patient as if the treatment decision had been made by the patient with full legal capacity at the time of the proposed treatment (section 50 Guardianship and Administration Act and clause 110H: guardian, enduring guardian; clause 110ZD(6): person responsible).

CLAUSE 110ZK

Clause 110ZK extends the protection given to health professionals by deeming certain consents to be valid. The protection does not undermine fundamental consent principles.

The clause applies where a consent or a refusal of consent to treatment in an advance health directive or by an enduring guardian, a guardian or a person responsible is invalid for reasons such as those set out in subclause (3): for example, where the patient is in fact competent or where the advance health directive, the guardianship order or the enduring power of guardianship in fact does not authorise the making of the treatment decision.

Clause 110ZK will provide an appropriate measure of protection for health professionals from civil actions and criminal prosecutions even if the consent or refusal of consent is not valid in the following two circumstances.

The first situation (clause 110ZK(2)(a)) is where a health professional reasonably believes that the patient is not competent and relies in good faith on what is purportedly a valid treatment decision in an advance health directive or made by a guardian, an enduring guardian or a person responsible. This protection would typically be available to a health professional, such as a surgical registrar in a teaching hospital, who has responsibility both for obtaining consent and for carrying out the surgery.

The second situation (clause 110ZK(2)(b)) is where a health professional takes treatment action in circumstances where it is reasonable for that health professional to rely on some other health professional having ascertained whether the treatment action is in accordance with a treatment decision and to assume that some other health professional has ascertained that the treatment is in accordance with a treatment decision. A nurse who administers treatment in a hospital in circumstances where the nurse does not have responsibility within the hospital system for obtaining the relevant consent to the treatment, would not ordinarily fall within the first situation of protection because the nurse would not have turned his or her mind to the particular patient’s competency and consent circumstances. Nevertheless, the nurse will have protection if it was reasonable for him or her to assume that the consent had been obtained by, for example, a registrar. Another example of the operation of this
protection is the situation where the appropriate and usual practice of a consultant is to arrange for a registrar in the surgical team to obtain the consent necessary for a surgical procedure and where it was reasonable for that consultant to have assumed at the time of the procedure that consent had in fact been obtained. If, however, the same registrar had requested that a nurse obtain the required consent, then the registrar would not be protected, even if he or she reasonably assumed that the nurse had obtained the consent, as the registrar would not have been entitled to rely on some other health professional in the hospital system having obtained the consent.

Provided that the health professional falls within these situations, the Bill will provide protection from civil actions and criminal prosecutions in that the health professional will be deemed to have acted in accordance with a valid treatment decision made by the patient with full legal capacity. A valid consent by a patient is a defence to trespass and assault and a valid refusal of consent precludes treatment being given.

It is to be noted that the terms "reasonable" and "reasonably" as used in this clause are not subjective terms. The decisions of the health professional are to be judged according to the objective impersonal standards of how a reasonable health professional would have acted in all the circumstances.

**CLAUSE 110ZI**

Clause 110ZI enables urgent treatment to be lawfully provided, without the need for consent, where it is not practicable for the health professional to determine whether there is a relevant treatment decision in an advance health directive or to obtain the consent of a guardian, an enduring guardian or a person responsible. In the absence of such urgency there is no reason for a health professional to provide treatment without consent.

**CLAUSE 110ZL**

Clause 110ZL makes it clear that any existing protection (under civil or criminal law) is available where there is a valid consent to the provision of palliative care even if an incidental effect of providing that care may be to hasten the death of a patient. The clause does not change but reinforces the current legal position.

**SECTION 259 CRIMINAL CODE**

The amendments to section 259 of the *Criminal Code* do not apply where there is a deemed consent or refusal of consent to which section 50 *Guardianship and Administration Act* and clauses 110S(1)(b), 110ZD(6) and 110ZK apply.

The legal position in this State in relation to the cessation of life support (assuming that the patient has not otherwise refused consent to the continuation of such support) would appear to be that a health professional will not be in breach of the *Criminal Code* if he or she acts in good faith in the interests of the patient and, in accordance with accepted medical standards and practice, withholds or withdraws artificial life support serving no therapeutic or medical benefit.
However, in the interests of certainty, sub-section (2) is to be inserted into section 259 of the Criminal Code to extend protection from criminal responsibility to the withholding or withdrawal of medical treatment in good faith, even where death ensues, where the non-provision or cessation of that treatment is reasonable in all the circumstances. The defence runs with the sections of the Criminal Code which impose obligations, for example section 262 which imposes a duty to provide necessaries of life (if, in fact, a health professional can be categorised as having charge of a patient and the relevant treatment is a "necessary").

Again in the interests of certainty, section 259 is to become subsection (1) and amended. A reference to palliative care has been included to put it beyond doubt that the present exemption from criminal responsibility for the administration in good faith of reasonable medical treatment, even where death ensues, encompasses the provision of palliative care. The amendment enshrines the principle that the provision of palliative care in these circumstances can be characterised as being for a person's benefit.
APPENDIX 4

ENCLOSURE TO STATE SOLICITOR’S OFFICE LETTER
DATED 28 SEPTEMBER 2007
APPENDIX 4
ENCLOSURE TO STATE SOLICITOR’S OFFICE LETTER DATED
28 SEPTEMBER 2007

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006
STANDING COMMITTEE ON LEGISLATION

QUESTIONS ON NOTICE

1. Recognition of Western Australian documents

The following jurisdictions in Australia have statutory provisions relating to the recognition of documents from other jurisdictions relevant to advance health care planning.

ACT

In the ACT under the Powers of Attorney Act 2006 a competent adult, by an enduring power of attorney, can appoint two or more adult donees to take care of property and financial affairs and also to make decisions about day to day affairs and give consent to lawful medical treatment, the donation of body parts, blood or tissue and the withdrawal or withholding of medical treatment. Section 89 of the Act makes provision for recognition of enduring powers of attorney as follows:

"89. Recognition of enduring powers of attorney made under other laws

(1) This section applies if –

(a) a document (the interstate enduring power of attorney) is expressed to be a power of attorney or guardianship document made under the law of a State or another Territory, and

(b) the interstate enduring power of attorney is not –

(i) revoked if the principal loses decision-making capacity; or

(ii) expressed to be irrevocable, whether completely or for a stated period.

(2) An interstate enduring power of attorney to which this section applies is taken to be an enduring power of attorney made under, and in compliance with, this Act, to the extent that the powers it gives could validly have been given by an enduring power of attorney made under this Act."
New South Wales

In New South Wales under the Guardianship Act 1987 an adult person can appoint an enduring guardian to make decisions once he or she ceases to be competent. Section 60 of the Act makes provision for recognition of enduring guardians as follows:

"60O Recognition of enduring guardians appointed in other States and Territories

(1) An instrument appointing an interstate enduring guardian has effect in this State as if it were an instrument appointing an enduring guardian made under, and in compliance with, this Part, but only to the extent that the functions it confers under the law of the State or Territory in which it was made could validly have been conferred by an instrument appointing an enduring guardian made under this Part.

(2) In particular, an instrument to which subsection (1) applies:

(a) has effect in this State subject to any limitations on the functions it confers that apply to it under the law of the State or Territory in which it was made, and

(b) does not operate to confer any function on an enduring guardian in this State that cannot be conferred on an enduring guardian by or under this Part.

(3) A document signed by an Australian legal practitioner that certifies that an instrument appointing an interstate enduring guardian was made in accordance with the formal requirements of the law of the State or Territory in which it was made is admissible in any proceedings where the appointment is in issue and is prima facie evidence of the matter so certified.

(4) Subsections (1)-(3) apply to an instrument appointing an interstate enduring guardian even if, at the time it was made, it was not an instrument appointing an enduring guardian within the meaning of this section.

(5) In this section:

"interstate enduring guardian" means a person who is appointed as a guardian by an instrument (or an instrument belonging to a class of instruments) prescribed by the regulations that is made under a law of a State or Territory (other than New South Wales)."

Queensland

The Powers of Attorney Act 1998 provides that an adult may, by an advance health directive, give directions about future health matters, elaborate upon those directions, and appoint an attorney to make decisions about health care matters on behalf of the
person if the directions prove inadequate. Section 40 of the Act makes provision for recognition of an advance health directive as follows:

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

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

The Act also allows a competent adult to appoint an attorney under an enduring power of attorney to make decisions about financial or personal matters including health care. Section 34 makes provision for recognition of an enduring power of attorney as follows:

"34 Recognition of enduring power of attorney made in other States

If an enduring power of attorney is made in another State and complies with the requirements in the other State, then, to the extent the powers it gives could validly have been given by an enduring power of attorney made under this Act, the enduring power of attorney must be treated as if it were an enduring power of attorney made under, and in compliance with, this Act."

Tasmania

In Tasmania, the Guardianship and Administration Act 1995 allows a competent adult to appoint an enduring guardian. Section 81A makes provision for recognition of an instrument appointing an enduring guardian as follows:

"81A. Instruments made under corresponding laws

(1) Where it appears to the Minister that a law in force in another State, or in a Territory or country has substantially the same effect as Part 5 of this Act, the Minister may by notice published in the Gazette declare that the law is a corresponding law for the purpose of this section.

(2) Subject to subsection (3), if an instrument appointing an enduring guardian that is made in another State, or in a Territory or country under a corresponding law complies with that corresponding law, the instrument is taken to be an instrument appointing an enduring guardian made in accordance with Part 5.

(3) An instrument referred to in subsection (2) is valid only to the extent that it would be valid if it were an instrument appointing an enduring guardian made in accordance with Part 5.

(4) For the purposes of this section, a certificate, from a legal practitioner or from the Registrar of a relevant Court, Board or Tribunal
exercising a guardianship jurisdiction, that the instrument appointing an enduring guardian satisfies the requirements of the relevant corresponding law is evidence of that fact.

(5) An instrument appointing an enduring guardian recognised in accordance with this section must be registered in accordance with section 89(1)(c).

(6) A notice under subsection (1) is not a statutory rule for the purposes of the Rules Publication Act 1953.”

2. Registration of Documents

The following jurisdictions in Australia have statutory provisions relating to the lodgement of documents relevant to advance health care planning:

Queensland

The Powers of Attorney Act 1998 provides that an adult may, by an enduring power of attorney, appoint an attorney to make decisions about health care matters on behalf of the person. Section 60 of the Act makes provision for the registration of an enduring power of attorney as follows:

"60. Registration of powers of attorney and instruments revoking powers

(1) An enduring power of attorney may be registered.

(2) An instrument revoking an enduring power of attorney may be registered.

(3) Subject to another Act, if an enduring power of attorney has been registered, it may not, unless a different intention appears from the enduring power of attorney, cease to authorise the attorney to deal with land for the principal until an instrument revoking the enduring power of attorney has been registered."

South Australia

In South Australia, the Consent to Medical Treatment and Palliative Care Act 1995 enables a competent adult to give a direction about the medical treatment that the person wants, or does not want, if he or she is at some future time in the terminal phase of a terminal illness or in a persistent vegetative state and incapable of making decisions about medical treatment when the question of administering the treatment arises.

The Act allows a competent adult, by a medical power of attorney, to appoint a medical agent with power to make decisions on his or her behalf about medical treatment including refusal of consent, in the event of incapacity.

Section 14 of the Act makes provision for the registration of treatment decisions and medical powers of attorney as follows:
14. Register

(1) The Minister must establish a register of—
   (a) directions under section 7 of this Act ("treatment directions"); and
   (b) medical powers of attorney.

(2) The Minister must appoint a suitable person (referred to below as the "Registrar") to administer the register.

(3) A person who has given a treatment direction, or granted a medical power of attorney, may, on application to the Registrar, have the direction or power of attorney registered in the register.

(4) An application under subsection (3) must be accompanied by—
   (a) a copy of the direction or power of attorney (to be held by the Registrar for the purposes of this section); and
   (b) a fee prescribed by regulation.

(5) The Registrar must, at the request of a medical practitioner responsible for the treatment of a person by whom a registered direction or power of attorney was given, or any other person with a proper interest in a registered direction or power of attorney, produce the direction or power of attorney for inspection by that medical practitioner or other person.

(6) The Registrar must, on application by a person who gave a registered treatment direction or granted a registered power of attorney, register the revocation of the direction or power of attorney and remove it from the register.

Tasmania

In Tasmania, the Guardianship and Administration Act 1995 allows a competent adult to appoint an enduring guardian. Section 32(2)(d) of the Act relevantly provides that an instrument is not effective to appoint an enduring guardian unless it is registered with the Guardianship and Administration Board.

Victoria

In Victoria, the Medical Treatment Act 1988 provides that a competent adult can complete a "refusal of treatment certificate" to refuse medical treatment generally or of a particular kind for a current condition. Section 5E of the Act makes provision for the retention of a treatment certificate as follows:

5E. Copies of refusal of treatment certificate

(1) The Board of a public hospital or denominational hospital and the proprietor of a private hospital or nursing home must take reasonable steps to ensure that a copy of any refusal of treatment certificate applying to a
person who is a patient in the hospital or home and of any notification of the cancellation of such a certificate:

(a) is placed with the patient's record kept by the hospital or home; and

(b) is given to the chief executive officer (by whatever name called) of the hospital or home;

(c) is given to the principal registrar of the Tribunal within 7 days after the certificate is completed.

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

3. Proposed section 110S(2)

The terms of proposed section 110S(2) are sufficiently broad to include non-health related circumstances.

Situations may arise in which the circumstances specified in an advance health directive are so unreasonable as to suggest that the maker was not competent at the time of making the directive. In such cases, an application may be made to the State Administrative Tribunal under proposed section 110W for a declaration that the directive is invalid.

4. Proposed section 110S(4)

It is not appropriate to include, as a further matter to be listed in proposed section 110S(4), a requirement for a health professional to consult with a relative (or other person) in determining whether sub-section (3) applies in relation to a treatment decision in an advance health directive.

The matters listed in sub-section (4) are factual matters that must be taken into account in determining whether circumstances have changed since the maker made the directive. Consultation with relatives (or other persons) is one of the modes for determining the matters in sub-section (4) and any other matters that are relevant to the assessment made by a health professional as to whether or not a treatment decision in an advance health directive operates or not.

5. "Best Interests"

The proposed section 110H, in applying to an enduring guardian the obligation cast by section 51 of the Guardianship and Administration Act 1990 upon a guardian, requires an enduring guardian to "act according to his opinion of the best interests" of
the appointor. A "person responsible" would, by virtue of the nature of his or her role, also be regarded as subject to that obligation.

If an enduring guardian acted other than in what he or she believed to be the best interests of the patient, the appointment of that person as an enduring guardian would be liable to be revoked by the State Administrative Tribunal, pursuant to proposed section 110N(b)(ii), on the grounds of "misconduct" or "such default as ... renders the person unfit to continue as an enduring guardian".

The law governing the legal consequences of an enduring guardian or "person responsible" (or, for that matter, a guardian) giving or refusing consent to treatment for reasons other than that he or she believed the decision to be in the best interests of the patient, is complex and uncertain, drawing in strands from a number of legal contexts. It is arguable that the enduring guardian or person responsible would have the following legal exposures:

1. A civil action for damages might be brought by the patient or, in the event of the patient's death, by the patient's estate or dependants, on the grounds that the enduring guardian or "person responsible" had failed to exercise the duty of care which (by analogy with Bennett v Minister of Community Welfare (1992) 176 CLR 408) is likely to be held to arise out of the relationship created between the patient and the substitute decision maker by the latter's acceptance of the decision maker's role. The action, to be successful, would require proof of negligence and that the treatment decision made resulted in harm to the patient for which damages could be awarded.

The enduring guardian or "person responsible" would not be protected by section 114 of the Guardianship and Administration Act 1990 because the decision, being for purposes other than what the person believes to be in the patient's best interests, would be regarded as having been made "dishonestly" or "in bad faith".

2. In the event that the enduring guardian or the "person responsible" made a profit in consequence of the decision made, an action in equity asserting a breach of fiduciary duty might be brought seeking the payment of the profit to the patient or, as the case may be, to the patient's estate;

3. There is the possibility, depending on the precise circumstances, of criminal charges being laid under the Criminal Code. For example, if an enduring guardian or "person responsible" refused consent to the treatment of a person for improper reasons, it might be argued that the person was in breach of section 262; ie that the person had, to the extent of the power to grant or withhold consent, "charge" of the patient and was bound to provide to the patient "the necessities of life" (as to which see the observations, albeit in relation to the application to medical practitioners, of the comparable section 151 of the Crimes Act 1961 (NZ), of Thomas J. in the New Zealand case of Auckland Area Health Board v Attorney-General [1993] 1 NZLR 235, at 250, 255).
6. Proposed section 110ZI

Proposed sections 110ZI and 110ZIA apply in different circumstances and it is therefore not necessary to make proposed section 110ZI subject to proposed section 110ZIA.

Proposed section 110ZI applies where it is not practicable for the health professional to determine whether there is a treatment decision. The proposed section includes a situation where the health professional suspects suicide.

Proposed section 110ZIA applies in circumstances where there is a treatment decision and the health professional suspects suicide.

7. Mental Health Act 1996

Under the Bill, directives as to future psychiatric treatment and psychiatric treatment decisions by substitute decision makers have effect in the ordinary way, subject only to any statutory provisions in the Mental Health Act 1996 which expressly or by necessary implication enable a treatment decision to be overridden.

Thus section 109 of the Mental Health Act enables psychiatric treatment to be given to an involuntary patient and to a mentally impaired accused person in an authorised hospital, irrespective of whether the patient consents to that treatment, i.e. notwithstanding wishes expressed in an advance health directive or by a substitute decision maker.

The position is less clear in relation to the provision of non-psychiatric medical treatment, because the intended operation of section 110 of the Act is itself unclear. However, the better view would appear to be that the power of the Chief Psychiatrist to approve the giving of non-psychiatric medical treatment to an involuntary patient or a mentally impaired accused is to be read as subject to any valid refusal of consent by the patient, whether through the medium of an advance health directive or by a substitute decision maker.

The effect of section 101 of the Mental Health Act, combined with sections 95-98 in relation to the requirements for a valid "informed consent", is that consent to psychosurgery cannot be given by an advance health directive or vicariously by a substitute decision maker as the patient must personally give consent to such treatment, in accordance with the statutory requirements, at the time that the psychosurgery is required.

It is to be noted that one of the criteria which section 26 of the Mental Health Act specifies must be met before a person can be made an involuntary patient is whether "the person has refused or, due to the nature of the mental illness, is unable to consent to the treatment" required for the mental illness (s.26(1)(c)). A person who has made an advance health directive in which he or she consents to future psychiatric treatment would still be regarded, for the purposes of section 26, as "unable to consent to the treatment". Similarly, the availability of a substitute decision maker is not relevant to whether, at the time consideration was being given to making the person an
involuntary patient, the person had the capacity to consent. However, the content of any advance health directive and the stance adopted, or likely to be adopted by a substitute decision maker would be relevant to whether section 26(1)(d) is satisfied and generally to the discretion exercised when a decision is made as to whether a person should be detained or made the subject of a community treatment order.

8. Protection afforded by proposed section 110ZK

(a) In the absence of the protection given by the proposed section 110ZK, a patient or, in the event of a patient's death, the patient's estate or dependants, would have a claim in damages for the tort of trespass against a health professional who provided medical treatment, or who withheld medical treatment in circumstances where it would ordinarily have been able to be provided applying principles of necessity, if it emerged that the advance health directive or the substitute decision maker consent upon which the health professional relied, was in fact invalid. If a health professional meets the criteria in proposed section 110ZK, the health professional is protected from such a trespass claim. Correspondingly, the patient or, as the case may be, the patient's estate and dependants are deprived of such a trespass claim.

Proposed section 110ZK endeavours to strike a balance between, on the one hand, the interests of patients in being subjected to or deprived of medical treatment only where valid consents are given and, on the other hand, the interests of health professionals in knowing that they will not be subject to liability in trespass if they have acted in good faith in the belief that a valid consent was given, ie in the belief that the medical treatment was authorised.

(b) Proposed section 110ZK(3) makes explicit what is in any event implicit in proposed section 110ZK(2) in that it puts it beyond doubt that even if, as a matter of law, a consent given or withdrawn in an advance health directive or by a substitute decision maker is invalid, the protection given by proposed section 110ZK(2) will operate.

Proposed section 110ZK(3)(e) addresses the situation where an advance health directive, a guardianship order or the terms of appointment of an enduring power of guardian is drafted to operate in a particular case only where some precondition is met. The provision is to be read with proposed section 110S(2) which declares that a treatment decision in an advance health directive "operates only in the circumstances specified in the directive".

An example of the operation of proposed section 110ZK(3)(e) would be a direction in an advance health directive that a particular kind of operation may be performed only if the patient is "blind". At the time the advance health directive comes to be relied upon, debate might ensue both as to the extent of the patient's sight from a medical perspective and as to whether the word "blind" is to be equated only with total loss of sight or whether it encompasses also very significant loss of sight. Proposed section 110ZK will operate, in such a circumstance, to protect a health professional from liability in trespass where he or she carries out the relevant operation in the good faith belief that
the patient is "blind" - even though, as a matter of fact or on the proper interpretation of the advance health directive, the patient was not "blind" at the time the operation was performed.

9. Proposed section 110ZK: "good faith"

The "good faith" criterion which proposed section 110ZK requires that a health professional satisfy in order to gain the protection given by that section, is a criterion which is very commonly used in statutory provisions granting protection.

A health professional will have relied in "good faith" on what is purportedly a treatment decision if the health professional, having considered the information available, has honestly come to the view that the treatment decision which on the face of it is contained in an advance health directive or which the health professional understands is made by a guardian, enduring guardian or person responsible under section 110ZD, is indeed valid. In essence, reliance will have been in good faith only if the health professional has turned his or her mind to whether the documentation or oral information provided constitutes, under the Act, a valid consent or valid refusal of consent to treatment and has formed the view that it does (as to which see generally Mid Density Developments Pty Ltd v Rockdale Municipal Council (1995) 44 FCR 290 and State of South Australia v Clark (1986) 19 ACSR 606).

It would be fair to say that the more a "treatment decision" was at odds with what the health professional believed to be in a patient's best interests, the more extensive the enquiries which the health professional would be expected to make before being able to claim that his or her reliance on a purported treatment decision was in good faith.

It is to be emphasised that there are three elements which must be satisfied for the protection given by section 110ZK(2)(ii) to be available. Firstly, the factual material provided to the health professional must "purport" to be a treatment decision, i.e. must appear to be a treatment decision in the sense contemplated by the Act. Secondly, the health professional must establish that, in proceeding to treat or not treat the patient, he or she relied upon the factual material made available constituting a "treatment decision" authorised by the Act. Thirdly, the health professional must establish that his or her assumption that the "treatment decision" was valid was in good faith, i.e. arrived at honestly after considering the issue of its validity.

10. Frequency of civil and criminal proceedings for trespass and assault

We are unaware of the numbers of civil actions for trespass brought against health professionals in the past 10 years, although such actions are rare. An example of an action which included a claim in trespass is the Western Australian case of Wiltshire-Butler v Hardecastle [2002] WADC 13 in which the plaintiff's action in trespass against the defendant orthopaedic surgeon was unsuccessful.
There are no statistics available in relation to criminal prosecutions for assault against health professionals but advice from the Office of the Director of Public Prosecutions indicates no recollection of such a prosecution since 1999 when the present Director commenced in the position.

11. Extent of modification of the law of consent to health care

The current law, in essence, is that a health professional may provide medical treatment to a patient only if the patient personally consents to that treatment or, as in the case of emergencies, consent is implied. Treatment without consent exposes the health professional to civil or criminal proceedings for trespass or assault. The only relevant exceptions to this general principle are:

(a) the ability of a parent or guardian, where their child lacks the maturity and intellectual capacity personally to consent to treatment, to consent to treatment on the child's behalf;

(b) the ability of a guardian to consent, pursuant to the Guardianship and Administration Act 1990, on behalf of a represented person;

(c) specific statutory modifications, such as those in section 109 of the Mental Health Act 1996 and the present section 119 of the Guardianship and Administration Act 1990;

(d) the powers of the Supreme Court, exercising its parens patriae jurisdiction.

A person is unable to give a valid consent if, at the time consent is required, he or she lacks the necessary mental capacity. The intention of the Bill is to enable a person, in the event that circumstances preclude a personal consent at the time treatment is or may be required, to specify his or her treatment wishes in advance and, or in the alternative, to nominate an enduring guardian to give consent (or to refuse consent where it would otherwise be implied) on the patient's behalf. In other words, the Bill expands the mechanisms by which consent may be given by a patient. Patients' autonomy is respected and, where a patient has elected to use an advance health directive or to appoint an enduring guardian, clarity is given to health professionals considering treatment options.

There is currently facility at common law for persons to indicate their treatment wishes in advance, but the content of the applicable principles is uncertain. The Bill preserves those principles but establishes a detailed statutory advance health directive scheme which provides certainty, a role for the State Administrative Tribunal and consistency with the broader consent regime of which advance health directives are a part. Provision for the appointment of enduring guardians is the other critical component of that consent regime - there is no equivalent common law concept. In the interests of the consent regime's consistency, the Bill also clarifies the authority of guardians in relation to medical treatment and has modified the existing section 119 of the Guardianship and Administration Act 1990.
While the Bill will give greater autonomy to patients and assist health professionals in those circumstances where a patient could not validly make a decision as to treatment, reliance upon advance health directives and substitute decision makers carries with it a significantly increased risk that a consent thought to be valid was, for factual or legal reasons which were not obvious or could not have been readily detected, in fact invalid. The Bill's protection provision is intended to address this risk by deeming lawful a treatment decision by a health professional where that health professional in good faith believed that the decision was in accordance with a valid advance health directive or the valid directions of a substitute decision maker.

12. Legal Capacity

The term "full legal capacity" as used in proposed sections 110B and 110P of the Bill reflects, and is consistent with, the use of the same words in sections 50, 69, 71, 79, 105, 108 of the Guardianship and Administration Act 1990. The term is used particularly in the law of contract and signifies the mental capacity necessary for a person to be bound by a contract. The relevant test is set out in Gibbons v Wright (1954) 91 CLR 423 in which the High Court indicated that, to be bound by a contract, a person must have "such soundness of mind as to be capable of understanding the general nature of what he is doing by his participation" (at 437) and "the capacity to understand [the] transaction when it is explained" (at 438). The mental state required to render a contractual arrangement binding is appropriately the mental state required for the appointment of an enduring guardian (proposed section 110B) or the making of an advance health directive (proposed section 110P), as the focus for determining the capacity necessary for those two acts ought be upon whether the person appointing the enduring guardian or making the advance health directive understands the legal implications of the arrangements being entered into.

An enduring power of guardianship and an advance health directive have effect when the person making them is, respectively, "unable to make reasonable judgments in respect to matters relating to his or her person" (proposed section 110F) or "unable to make reasonable judgments in respect of any treatment proposed" (proposed section 110S). The powers of a "person responsible" are also predicated upon the patient being "unable to make reasonable judgments in respect of any treatment proposed" (proposed section 110ZD). The language used is compatible with that adopted in sections 4, 43, 51, 64, 70 and 106 of the Guardianship and Administration Act. It is appropriate that the language of "reasonable judgments" rather than "full legal capacity" is used as the issue is not whether the person has the required legal understanding of the role of an enduring guardian or of the effect of an advance health directive but whether, in respect of particular treatment proposed, the person is capable of making a reasonable judgment as to the appropriateness or otherwise of that treatment.
APPENDIX 5

ENCLOSURE TO STATE SOLICITOR’S OFFICE LETTER
DATED 11 OCTOBER 2007
APPENDIX 5
ENCLOSURE TO STATE SOLICITOR’S OFFICE LETTER DATED
11 OCTOBER 2007

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006
STANDING COMMITTEE ON LEGISLATION
FURTHER QUESTIONS ON NOTICE
FROM HEARING ON 8 OCTOBER 2007

1 (a) Which Court has jurisdiction over common law advance health directives? Was any consideration given to granting jurisdiction for these to the State Administrative Tribunal?

(a) The State Administrative Tribunal's jurisdiction under proposed sections 110V-110ZA of the Guardianship and Administrative Act 1990 is confined to "advance health directives" as defined in proposed section 3(1), i.e. to advance health directives made under Part 9B and instruments recognised under proposed section 110ZA.

If an issue arose as to the validity of a common law advance health directive, that issue would have to be decided in the context of court (or possibly State Administrative Tribunal) proceedings in which the validity of the relevant consent was a material issue or by way of an action for declaration in the Supreme Court.

Consideration was given to vesting in the State Administrative Tribunal a jurisdiction in relation to common law directives akin to that vested in the Tribunal in relation to statutory advance health directives. However, the policy decision was made to allow the validity of common law directives, and their implications in particular contexts, to be determined in the ordinary way outside the new statutory scheme. A case can be made for vesting the State Administrative Tribunal with jurisdiction in relation to common law directives, at least where (as under the proposed section 110ZJ) the validity or application of a common law directive to proposed treatment had direct implications for whether or not it is open to a substitute decision maker to make a treatment decision.

(b) It is noted that the order of priority between advance health directives and enduring guardians at proposed 110ZJ includes common law advance health directives. In what Court would a common law advance health directive be disputed by a validly appointed enduring guardian seeking a binding declaration?

(b) For the purposes of the proposed Part 9D of the Guardianship and Administration Act, an "advance health directive" includes, as one would anticipate, a common law directive (s.110ZC). One consequence is that, by reason of the proposed section 110ZJ, the ability of a substitute decision-maker to make a treatment decision will be dependent, in the event that a patient has made a common law directive, upon the validity of that directive.

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If an enduring guardian or other substitute decision maker (or, for that matter, a health professional or other interested party) is uncertain as to the validity or operation of a common law directive, the only mechanism to resolve that uncertainty in the short term would be by way of an action for a declaration in the Supreme Court.

Of course, if the patient's views expressed in a common law advance health directive were the same as the treatment decision made by the first in priority of the substitute decision makers (on the assumption of, or conditioned upon, the directive's invalidity or inapplicability), there would be no need to determine whether the common law directive was valid or applicable. A valid treatment decision would have been made (i.e. a valid consent given to the treatment), whether in the patient's common law directive or by the substitute decision maker.

2 Should section 110ZK(2)(b) require not only that the other health professional has ascertained that the treatment action is in accordance with a treatment decision (cf. s.110ZK(2)(a)(i)) but also that the health professional has ascertained that the patient is unable to make reasonable judgments in respect of the treatment action (cf. s.110ZK(2)(a)(ii))?

The terms "treatment decision" in proposed sections 110ZK(2)(b)(i) and 110ZK(2)(b)(ii) are intended to be read as meaning a "valid and applicable treatment decision". In other words, proposed section 110ZK(2)(b) is intended to address the circumstances where one health professional reasonably relies upon another health professional having ascertained that the treatment action proposed is authorised.

A treatment decision will be valid and applicable, and so the treatment action authorised, if, relevantly to the amendments proposed by the Bill:

(a) either the advance health directive met the statutory requirements and applied to the treatment contemplated or a substitute decision-maker had been properly appointed, and

(b) the patient was unable to make reasonable judgments in respect of the proposed treatment.

Accordingly, proposed section 110ZK(2)(b) is intended to reflect both (i) and (ii) of proposed section 110ZK(2)(a).

3 If proposed section 110ZK(2) is intended to protect:

(a) health professionals who reasonably believe the patient whom they are treating is unable to make reasonable judgments in respect of the treatment action and rely in good faith on a purported treatment decision, and

(b) health professionals who are relying on another health professional to ascertain that the treatment action is in accordance with a treatment decision,
why does proposed (3) only apply to the circumstances described in (2)(a) and not (2)(b)?

Section 110ZK(3) is not intended to protect only the health professionals falling within proposed section 110K(2)(a) in the situations set out in section 110ZK(3). The intention was that, in the latter circumstances, a health professional falling within section 110ZK(2)(b) would also be protected.

Ambiguity in the operation of section 110ZK(3) in this regard could, it would seem, be removed by, for example, deleting the words "applies in the circumstances described in subsection (2)(a)" in the opening lines of section 110ZK(3).
APPENDIX 6
ENCLOSURE TO STATE SOLICITOR’S OFFICE LETTER
DATED 16 OCTOBER 2007
APPENDIX 6

ENCLOSURE TO STATE SOLICITOR’S OFFICE LETTER DATED
16 OCTOBER 2007

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

STANDING COMMITTEE ON LEGISLATION

FURTHER QUESTION ON NOTICE:
COMMON LAW DIRECTIVES AND POLICY CONSIDERATIONS

Clarification has been requested in relation to this Office’s observation, in the context of discussing the issue of whether consideration had been given to granting to the State Administrative Tribunal jurisdiction in relation to common law advance health directives, that "the policy decision was made to allow the validity of common law directives and their implications in particular contexts, to be determined in the ordinary way outside the new statutory scheme".

A scheme which would permit the State Administrative Tribunal to determine the validity, construction and application to particular circumstances of common law advance health directives (i.e. an expression by a legally competent adult, in advance, of the type of treatment he or she wants or does not want in the event of the person's subsequent incapacity) undoubtedly has the merit of simplicity. It would also avoid the potential (such as in the case of an intended advance health directive arguably not meeting the procedural requirements of proposed section 110Q) for jurisdictional uncertainty and for successive proceedings in the Tribunal and the Supreme Court to determine whether a statutory advance health directive was valid and, if not, whether it nevertheless took effect as a valid common law directive.

At the same time, care must be taken to ensure that any regime is consistent conceptually and legally with the proper roles of the Supreme Court (a judicial body) and of the State Administrative Tribunal (an administrative tribunal exercising judicial-type functions, either by way of de novo review of administrative decisions or by way of the exercise of original jurisdiction in a limited range of circumstances where specialist expertise is thought desirable). As a matter of legal principle and of comity, the State Administrative Tribunal ought not, unless there is a very clear rationale for doing so, to be vested with the determination of issues which ought properly be the province of a Court. The fact that the Tribunal’s procedures may provide a simpler or more flexible mechanism to deal with particular applications would not, of itself, ordinarily be sufficient justification for the transfer to the Tribunal of jurisdiction in relation to such applications.

The State Administrative Tribunal’s current jurisdiction under the Guardianship and Administration Act 1990 is set out in section 13 of the Act. In essence, the Tribunal is vested with the jurisdiction formerly vested in the Guardianship Board, a specialist body. The regime established by the Acts Amendment (Consent to Medical Treatment) Bill 2006 is intended to be compatible with section 13. Vesting the Tribunal with the jurisdiction to determine the validity of legal rights existing independently of that regime (in particular, common law directives) was seen as vesting in the State Administrative Tribunal a jurisdiction which lay, and should properly remain, with the Supreme Court. Common law directives are ipso facto not creatures of statute. Just as the validity and legal consequences of contemporaneous personal consents are seen as properly the function of a Court, so the validity, construction and operation of common law directives (which in character are simply
personal consents given in advance) were seen as issues which ought properly be determined by a judicial body, applying and developing common law principles, rather than by a body of the nature of the State Administrative Tribunal.

Vesting the State Administrative Tribunal with a general jurisdiction in relation to common law directives, in circumstances where general jurisdiction in relation to contemporaneous consents lies with the Supreme Court would on the face of it be difficult to rationalise. However, as the Bill proposes that the Tribunal will be vested with original jurisdiction in respect of advance health directives and the powers of substitute decision makers, a case can be made (as was suggested in our previous observations) for the Tribunal to be vested with jurisdiction in relation to the validity, construction and operation of common law directives where resolution of those issues determined, say, the validity of a decision which a substitute decision maker had made or was contemplating.

Thus, while it would seem inappropriate for the State Administrative Tribunal (in contrast with the Supreme Court) to determine at large whether a common law directive was valid and so whether proposed treatment was or was not authorised, it is certainly arguable that it would not be inappropriate for the Tribunal to determine a common law directive's validity where (as under the proposed section 110ZJ) the validity or application of a common law directive to proposed treatment had direct implications for whether or not it is open to a substitute decision maker to make a treatment decision. Such a result could be achieved by vesting the Tribunal with the jurisdiction to determine whether a substitute decision maker was empowered to make a particular treatment decision - if the substitute decision maker's power was dependent upon the validity and application of a common law directive, determining the extent of the substitute decision maker's power would necessarily (unless the directive and the substitute decision maker's proposed decision were to the same effect) require the Tribunal to assess the validity and operation of the directive.
APPENDIX 7
SUPPLEMENTARY NOTICE PAPER NO 149, ISSUE NO 4,
DATED 16 AUGUST 2007 - MARKED-UP VERSION OF
AFFECTED CLAUSES
APPENDIX 7

SUPPLEMENTARY NOTICE PAPER NO 149, ISSUE NO 4, DATED 16 AUGUST 2007 - MARKED-UP VERSION OF AFFECTED CLAUSES

“11. Parts 9A to 9D inserted

After section 110 the following Parts are inserted —

“...

110RA. Register for advance health directives

(1) A register for advance health directives will be established.

(2) An advance health directive may be registered.

110RA. Registration of advance health directive

An advance health directive may be registered in the register referred to in section 110ZAA.

Division 2 — Operation of advance health directive

1108. Operation generally

(1) A treatment decision in an advance health directive operates in respect of the treatment to which it applies —

(a) at any time the maker of the directive is unable to make reasonable judgments in respect of that treatment; and

(b) as if —

(i) the treatment decision had been made by the maker at that time; and

(ii) the maker were of full legal capacity.

(2) Subject to subsection (3), a treatment decision in an advance health directive operates only in the circumstances specified in the directive.

(3) Subject to subsection (4), a treatment decision in an advance health directive does not operate if circumstances exist or have arisen that —

(a) the maker of the directive did not anticipate at the time of making the directive; and
would have caused the maker to change his or her mind about the treatment decision.

(4) In determining whether or not subsection (3) applies in relation to a treatment decision that is in an advance health directive made more than 10 years before the time at which the treatment decision would otherwise operate, the matters that must be taken into account include the following—

(a) the maker’s age at the time of the directive was made and at the time the treatment decision would otherwise operate;

(b) the period that has elapsed between those times;

(c) whether the maker reviewed the treatment decision at any time during that period and, if so, the period that has elapsed between the time of the last such review and the time at which the treatment decision would otherwise operate;

(d) the nature of the condition for which the maker needs treatment, the nature of that treatment and the consequences of providing and not providing that treatment.

(5) Subsection (4) does not prevent a matter referred to in subsection (4)(a) to (d) being taken into account in determining whether or not subsection (3) applies in relation to any other treatment decision if it is relevant to do so.

(6) Subject to section 110T, a treatment decision in an advance health directive is taken to have been revoked if the maker of the directive has changed his or her mind about the treatment decision since making the directive.

...
(c) the contents of the register;
(d) who may apply for registration;
(e) the procedure for registration, including the alteration and removal of entries in the register;
(f) who may have access to the register;
(g) the procedure for accessing the register;
(h) the fees payable in respect of matters connected with the register and registration.

110ZR. Common law preserved

This Part does not affect the common law relating to a person’s entitlement to make treatment decisions in respect of the person’s future treatment.

Part 9C Persons responsible for patients

Division 1 — Preliminary matters

110ZC. Terms used in this Part

In this Part—

“advance health directive” includes a directive given by a person under the common law containing treatment decisions in respect of the person’s future treatment;

“patient” means a person who needs treatment.

110ZC. Meaning of “patient”

In this Part—

“patient” means a person who needs treatment.
110ZIA. Urgent treatment after attempted suicide

(1) Subsection (2) applies if—

(a) a patient needs urgent treatment; and

(b) the patient is unable to make reasonable judgments in respect of the treatment; and

(c) the health professional who proposes to provide the treatment reasonably suspects that the patient has attempted to commit suicide and needs the treatment as a consequence.

(2) The health professional may provide the treatment to the patient despite—

(a) that the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment; or

(b) that the patient’s guardian or enduring guardian or the person responsible for the patient under section 110ZD has made such a treatment decision in relation to the patient.

110ZI. Order of priority of persons who may make treatment decision in relation to patient

(1) Subject to section 110ZI, this section applies if a patient is unable to make reasonable judgments in respect of any treatment proposed to be provided to the patient.

(2) If the patient has made an advance health directive containing a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided in accordance with the treatment decision.

(2) If a patient has made an advance health directive containing a treatment decision in respect of—

(a) refusal of the treatment, whether or not that treatment is provided must be decided in accordance with the treatment decision; or

(b) requesting the treatment, the health professional must take that treatment decision into account in determining whether or not that treatment is provided.

(3) If—

(a) subsection (2) does not apply; and

(b) the patient has an enduring guardian who—

(i) is authorised to make a treatment decision in respect of the treatment; and
(ii) is reasonably available; and

(iii) is willing to make a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided by the enduring guardian.

(4) If —

(a) subsections (2) and (3) do not apply; and

(b) the patient has a guardian who —

(i) is authorised to make a treatment decision in respect of the treatment; and

(ii) is reasonably available; and

(iii) is willing to make a treatment decision in respect of the treatment, whether or not the treatment is provided to the patient must be decided by the guardian.

(5) If —

(a) subsections (2) to (4) do not apply; and

(b) there is a person responsible for the patient under section 110ZD,

whether or not the treatment is provided to the patient must be decided by the person responsible.

..."