STANDING COMMITTEE ON LEGISLATION

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 19 SEPTEMBER 2007

Members

Hon Graham Giffard (Chair)
Hon Giz Watson (Deputy Chair)
Hon Peter Collier
Hon Sally Talbot
Hon Helen Morton
(Substitute member for Hon Ken Baston)

Hearing commenced at 10.35 am

BUSH, MS LINDA
Senior Assistant State Solicitor,
State Solicitor's Office.

LE SOUEF, MS SUE
Senior Assistant State Solicitor,
State Solicitor's Office.

CHAIR: On behalf of the committee I would like to welcome you to the meeting. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

CHAIR: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record, and please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public, and I advise you that premature publication or disclosure of public evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. Under the normal procedure for hearings such as this, I would invite you to make opening comments. The committee has discussed this. We have already provided you with a list of questions, and you have seen this morning the revised list of questions, which has been substantially expanded. As the committee is seeking from you evidence on specific issues, the committee proposes to simply go straight into those questions. If at the conclusion of your evidence there is anything you wish to add that has not been addressed, I will invite you to do so. I propose, for the purposes of the transcript, to read the questions we ask you into the transcript. You have a copy of the questions in front of you. The committee will then seek your response to those questions.

Ms Bush: Could I make a comment first?

CHAIR: Yes.

Ms Bush: We have been through the questions we were provided late yesterday afternoon, and ultimately our preference would be to provide you with a detailed written response to the questions.

CHAIR: The committee is happy to receive any further supplementary information you wish to provide.

Ms Bush: We have also already prepared three documents, because it is very important to see this bill against the background of the law of consent. We have prepared an opening statement relating to consent generally, which we would like to hand up. We have also prepared a document relating to the liability of health professionals as it pertains to the protection afforded them under the bill, and a final one-page document which relates to the powers the bill gives to the State Administrative

Tribunal. It is just for ease of reference. It is just that the bill cannot be seen out of context, in particular. If we are able to hand those up -

CHAIR: Yes, the committee is happy to receive them.

Ms Bush: From our point of view it would be very useful for Sue to read the opening statement, just to give you the background -

CHAIR: On consent?

Ms Bush: - on the consent issues, because consent issues are fundamental to every single provision in the bill. The other two documents, in particular the one about the liability of health professionals, will, in great part, answer some of the questions that have been put about clause 110ZK.

CHAIR: All right. The committee will hear your opening statement on the question of consent, and then we will perhaps go into the questions.

Ms Bush: Thank you.

Ms Le Souef: 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 judgements 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 for not only end-of-life decision-making, but also 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.

[10.40 am]

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 directive, 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 judgements about that treatment – (although there is no legal entitlement for a person to demand treatment); and 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 judgements 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.

CHAIR: Thank you for that. I take you now to the first question relating to clause 5(2), and the proposed definition of "life sustaining measure". For the committee, can you please clarify whether the term "life sustaining measure" will include nutrition and hydration and therefore whether people will be able to direct, as part of their treatment decision, that they or the person for whom they are deciding not receive nutrition and hydration.

Ms Le Souef: The term "life sustaining measure" includes artificial nutrition and hydration. Consistent with the principles of personal autonomy that underpin the common law, the bill will enable a person, through an advance health directive and an enduring guardian, a guardian or a person responsible, to refuse artificial nutrition and artificial hydration in the same way as any other medical treatment can be refused. 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. It is also consistent with the views of experienced palliative care specialists from a number of hospitals in Western Australia. 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.

Hon HELEN MORTON: I missed that last little bit. Can you say that last part again?

Ms Le Souef: 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. An enduring guardian could not refuse food and water being provided to a patient on that patient's behalf.

Ms Bush: Nor could a person in an advance health directive refuse the natural provision of food and water but, at the same time, you cannot force a person to eat or drink.

Hon HELEN MORTON: Okay. Can I just give an example so that you can clarify this for me? I am talking about a very specific example, which is my mother. She made a decision to go down the track that she went down. The only way I understood that she could actually terminate her life was to refuse food and water. At the time she then became unconscious I can recall my father saying something like, "Do you think they give her something to drink when we are not here?" I said no, that could not possibly be; that was not what she wanted. You are saying that they, in fact, could have. The nursing staff could have?

Ms Bush: If she were unconscious, she would not be able -

Hon HELEN MORTON: To take it naturally.

Ms Bush: - to take it naturally. If there had been a decision made that she was not to receive artificial nutrition and hydration, that would have to be followed because artificial nutrition and hydration are considered to be treatment whereas the natural provision of food and water depends on whether they can eat or drink by themselves and choose to do so.

Hon HELEN MORTON: If a person is able to refuse it, then they can refuse it?

Ms Le Souef: Yes.

Ms Bush: A person in a nursing home with Alzheimer's, for example, would probably not be able to make decisions about treatment but they would eat and drink naturally - one would expect - unless they chose not to do so at the time.

[10.50 am]

Hon HELEN MORTON: Even if that person had previously stated in an advance health directive that if they were to get severe Alzheimer's disease, they would not want to continue to be maintained by those mechanisms, there is no mechanism by which that person could not be provided with food and water?

Ms Bush: No, there is not. The bill provides that a person who has made an advance health directive may refuse treatment. The definition of "treatment" is such that it extends only to artificial nutrition and hydration, not the natural provision of food and water.

CHAIR: Is any obligation placed on a health professional to offer food and water to a person who is conscious?

Ms Bush: I would have thought that would constitute a necessity of life under the Criminal Code.

CHAIR: I take you now to question 3, which deals with clause 11, proposed sections 110F, L, S, X, ZD, ZG, ZI, ZIA, ZJ and ZK, and clause 12, proposed new section 119 of the Guardianship and Administration Act. That question is as follows -

> The term 'reasonable judgment' is used (in relation to the patient, appointer of an enduring guardian and maker of an advance health directive) throughout the Bill's proposed amendments to the GA Act.
>
> (a) What will that mean?
>
> (b) Will it include somebody who is drunk or drugged or suffering from temporary severe pain?
>
> (c) Who will determine whether a person is unable to make a reasonable judgment about a proposed treatment? Why doesn't the proposed section prescribe who this person must be?

Ms Bush: The first base is section 4 of the Guardianship and Administration Act 1990, which sets out certain principles. One of the principles in subsection 2(b)(ii) is that every person shall be presumed to be capable of "making reasonable judgments in respect of matters relating to his person". Secondly, we need to look at the phrase "reasonable judgement" and how it is included in the bill. It actually relates to a person who is unable to make reasonable judgements in respect of matters relating to his person. We need to see that as a complete phrase. The issue in any particular case is whether a person for whom treatment is contemplated possesses sufficient intellectual capacity to understand the nature and consequences of that treatment. Circumstances will arise in which a person will be able to make reasonable judgements at law about one form of treatment but not about another. It really depends upon the circumstances. You need to look at the facts, and at what treatment is required - is it major surgery, or is it "I have a headache; I would like a Panadol"? The person may not be able to understand the consequences of receiving major surgery, but the person may understand that he has a headache and wants to cure it. You really need to look at each circumstance as to whether the person can give consent. That is the first thing. It is very factual, depending upon the circumstances. It is possible that someone who is drugged or drunk or suffering from temporary severe pain may be unable to make a reasonable judgement about proposed treatment at that time. If the person has an advance health directive, you need to look at the terms of that directive, because the person may say, "Even if I am drunk or drugged, I do not want X treatment." We then need to step back a bit and look at the nature of the condition for which the person needs treatment. It may not be anything associated with alcohol. It may be that the person has had a heart attack and needs to have CPR. The person's advance health directive

may say, “If I have a heart attack” - I am putting this in very simple terms; it probably needs to be more complex - “I do not want to have cardiopulmonary resuscitation.” In that case, it would not matter whether the person was drunk or drugged, or was in severe pain; you could obey the advance health directive.

CHAIR: But the person may well be drunk as well.

Ms Bush: Yes, and it may be that the advance health directive could apply in the circumstances. It may be the case that the treatment is not urgent, and that, subject to the terms of the directive, the health professional can just wait until the drug wears off or the alcohol wears off, because at that time the person may well be competent to make a decision. Until such time, I do not think a health professional could make any assessment as to the competency or not of the patient. Does that answer your question?

CHAIR: Have you addressed paragraph (c) of that question?

Ms Bush: It will be a matter for the health professional to make an assessment at the time, by reference to the patient’s condition, and by reference to any advance health directive, or the conditions imposed by any substitute decision maker.

Hon HELEN MORTON: I have some follow up questions on this. In terms of the health professional, there is a whole raft of people who could make that decision.

Ms Bush: It would be the relevant health professional at the time - the health professional who was to take the treatment action. It could not be a dentist if it was a heart problem.

Hon HELEN MORTON: But it could be the nurse, if the nurse was there at the time, or the doctor, if the doctor was in and out at various times during the day. It could be the doctor, but the rest of the time it could be the nurse. It is not saying that anyone has a superior role to anyone else in terms of making that decision.

Ms Bush: I think in the hospital context you would really be looking at a team effort, so that the treating doctor would be -

Ms Le Souef: It depends on which health professional is providing the treatment, too.

Hon HELEN MORTON: The nurses take responsibility for a lot of the procedural work.

Ms Le Souef: You would expect a nurse to make that assessment if he or she was providing the treatment.

Hon HELEN MORTON: We have talked about a person who is drunk or drugged. I assume that sometimes a person may be on medication - not drugged as in the sense of a person who has taken illegal drugs and has come into an emergency department, or whatever, but on medication - and that medication may make that person less competent to make a decision. Is there anything in the bill that would prevent a decision being made while that person was in a temporary state of incapacity?

Ms Bush: I think that would depend upon the urgency with which the treatment was required. There is no provision in the bill about that. One would expect a health professional to make an assessment at the time of the patient’s condition and about whether there was time to wait for the patient to be able to make a reasonable judgement for himself or herself.

Ms Le Souef: Again, it is subject to the terms of the advance health directive and what has been specified in it.

[11.00 am]

Hon HELEN MORTON: That is assuming that there is not an advance health care directive. This bill enables, in the absence of such, for a health professional to make these decisions and take action because someone is incompetent by virtue of medication that they have been given.

Ms Bush: Proposed section 110ZK applies protection to a health professional only if the health professional takes treatment action -

> reasonably believing that the patient is unable to make reasonable judgments in respect of the treatment action;

The health professional would therefore have to make an assessment as to whether the patient was unable to make reasonable judgements in the context of the urgency of the treatment.

Hon HELEN MORTON: This proposed section does not apply to urgency provisions.

Ms Bush: No. If there is an urgent situation, under proposed section 110ZI the health professional may provide treatment without reference to an advance health directive or to a substitute decision maker if it is not practicable to consult.

Hon HELEN MORTON: I am saying that we should forget about the urgency side of it because I understand that. Proposed section 110ZK refers to any treatment by anybody at any time.

Ms Bush: Yes.

Hon HELEN MORTON: The person could be temporarily incompetent by virtue of some medication that has been administered to the patient. The proposed section then goes on to provide a raft of protections for a health practitioner to take that treatment action.

Ms Bush: Yes.

Hon HELEN MORTON: There is nothing in the bill that says that under those circumstances, or if a patient is temporarily incapacitated due to medication, that one should wait until a further treatment action is made.

Ms Bush: If there were something in the bill to that effect, it would still leave the question of interpretation. What is meant by "temporary"?

Ms Le Souef: In that situation we would expect a health professional to make an assessment at that time about whether the incapacity would be temporary and the health professional would ask either an enduring guardian whether they wanted to make a decision on behalf of the patient or whether they wanted to wait.

CHAIR: I take you now to clause 11, which is proposed section 9A of the Guardianship and Administration Act. Why does the bill simply not make provision for the registration of enduring powers of guardianship?

Ms Bush: That was a policy decision, and we are not here to debate policy. The decision was made on the basis that there should be a simple, flexible scheme and that a person making an enduring power of guardianship should not be restricted in any way so that there would be a good take-up rate. It was a policy decision.

Hon PETER COLLIER: Does that reflect other jurisdictions?

Ms Bush: I cannot answer that at the moment because I have not looked at the other jurisdictions in relation to registration for some time. Also, the enduring power of guardianship is to be looked at in the context of the Guardianship and Administration Act. In that act, there is only the ability to appoint a guardian for personal and lifestyle measures. However, from a financial point of view, SAT can appoint an administrator. On the other hand, there is a less restrictive alternative whereby a person can appoint an attorney under an enduring power of attorney. There is no registration for enduring power of attorney in the Guardianship and Administration Act. Similarly, for enduring guardians, who are the counterparts from the personal and lifestyle point of view, to be consistent, there is no provision for registration.

Hon HELEN MORTON: It is a formal process, is it not?

Ms Bush: Yes.

Hon HELEN MORTON: It is a formal process through SAT to either appoint someone as an administrator or a guardian.

Ms Bush: Yes, but not for the appointment of an attorney under an enduring power of attorney. The enduring power of attorney corresponds to the enduring power of guardianship.

Hon HELEN MORTON: Is there a form that someone must fill out?

Ms Bush: For an enduring power of attorney? Yes, there is. It is in the schedule to the Guardianship and Administration Act. It is a formal requirement but it is not in similar terms. The drafting of the formalities relating to enduring powers of attorney is different from the bill.

Hon HELEN MORTON: SAT writes a letter or something - I think I have seen one - that says an appointment has been made for someone to be a guardian or administrator of a person.

Ms Bush: There is an order of appointment. SAT makes those appointments when it determines that a person is unable to make reasonable judgements either about personal and lifestyle affairs generally or specifically, because they can make a full plenary guardianship order or a limited one, and they make an order also from an administration point of view about administration and financial affairs.

Hon HELEN MORTON: Apart from that letter that gets to a person - what did you call it?

Ms Bush: It is a formal order.

Hon HELEN MORTON: Is that order recorded anywhere? Is it recorded as an order?

Ms Bush: It is just like any order. It is accessible at the State Administrative Tribunal. It is not a registration system, but the orders will be accessible. It is an order of the tribunal.

Hon HELEN MORTON: Will this be the same? Will it be accessible?

Ms Bush: An administration order is a different animal from an enduring power of attorney. An enduring power of attorney is a document by which a person appoints an attorney, in writing, to have financial management over that person's affairs. It is not the same as an administration order and it is not required to be registered. It is more informal. It is an expression of a person's wishes, whereas an order for administration or for guardianship made by SAT only occurs when the tribunal determines that a person is incapable of making the relevant decision. The enduring power of attorney is an appointment made by a person who has the full legal capacity about whom he wants to look after his affairs and he or she can decide at the time whether that enduring power of attorney is to come into operation immediately, even though the person is competent - it could be somebody who is physically disabled and cannot get to the bank, for example - or they can elect for that power to come into operation only upon incompetency. If that is the case, the tribunal has to make a finding of incompetency with enduring powers of attorney. An enduring power of guardianship is an instrument by which a person, while he has full legal capacity, can appoint an enduring guardian. However, it is not something with which the tribunal becomes involved unless when the instrument becomes operative on incapacity, there is either a problem or a perceived problem with the appointment.

Hon HELEN MORTON: Can I confirm that the only difference between the two is that for the enduring power of attorney, the incompetence only kicks in once SAT has determined that a person is incompetent, whereas for the enduring power of guardianship, there is no requirement for SAT to determine that a person is incompetent?

Ms Bush: No. I think the reason for the distinction for the enduring power of attorney is because that instrument can become operative immediately, notwithstanding a person's incapacity. I cannot take the reasoning any further than that. The member is correct that there is no requirement for SAT to determine that a person is incompetent.

[11.10 am]

Hon HELEN MORTON: Can that determination be made by any health professional under the circumstances that we have previously discussed?

Ms Bush: There would be an assessment made.

CHAIR: All right. We are still on clause 11, proposed part 9A of the Guardianship and Administration Act 1990. I have another question to ask before we go to question 5. The committee discussed it this morning, and the question is: does the appointee under an enduring power of guardianship have the right to be informed of the actual medical state of the maker of the advance health care directive, including information that would otherwise be considered confidential.

Ms Bush: I am sorry, where is that question?

Hon HELEN MORTON: They are looking for the question. It is not on our list; it is an additional question.

Ms Bush: Sorry, is it a new question?

CHAIR: I am asking you this straight off the bat.

Ms Bush: I am sorry. Could you repeat that question please?

CHAIR: Yes, and then I will go through question at question 5. Perhaps I can ask this independent of the list. My separate question is: does the appointee under an enduring power of guardianship have the right to be informed of the actual medical state of the maker of the advance health directive; including information that would otherwise be considered confidential?

Ms Bush: You are tying-up two things here. An advance health directive and an enduring power of guardianship are different.

Ms Le Souef: They are two separate instruments and I think that you are talking about an appointee of an enduring power of guardianship. You mentioned advance health directives in the same question.

Ms Bush: Are you saying that a person may appoint an enduring guardian and at the same time have an advance health directive. They are two totally different mechanisms.

CHAIR: They are different mechanisms, but can they be in operation at the same time?

Ms Bush: Yes, although there is a clause that gives priority to the advance health directive -

CHAIR: Is it correct to say that a guardian could be appointed and an advance health directive could be in place at the same time?

Ms Bush: A person can appoint an enduring guardian and can also have an advance health directive. To the extent that those powers are inconsistent, priority is given to the advance health directive under proposed section 110ZJ.

CHAIR: If an advance health directive requires that a certain treatment be withdrawn at a certain point and there is a guardian, is it correct to expect that the guardian would then be involved in the decision to withdraw the treatment?

Ms Bush: No, that is not correct. The decision documented in the advance health directive takes priority.

CHAIR: Yes, and the guardian would have no -

Ms Bush: Because that is the personal wish of the person.

CHAIR: If there is an advance health directive in place and an enduring guardian, what role does the guardian play in a situation where a health directive is invoked?

Ms Bush: The enduring guardian may be given plenary powers - all powers relating to all health care. The advance health directive may have a treatment decision that is extremely limited in scope -

CHAIR: Okay.

Ms Bush: - so the extent of the authority may not overlap.

CHAIR: I think I understand where the confusion has arisen. Putting aside the advance health directive, which may be more narrowly defined than the circumstances that a patient is actually in, is an enduring guardian, if required to make a treatment decision, entitled to what would otherwise be considered confidential patient information?

Ms Bush: Yes, because they stand in the shoes of the person - it is as if they were the patient.

CHAIR: I think that was the crux of the question.

Ms Bush: Sorry, I did not understand the question.

CHAIR: I think it was a misleading question because we said the "maker of the advance health care directive" and the maker is also the appointer of the enduring guardian.

Ms Bush: Just by way of correction, it is "appointor" in the bill.

CHAIR: Yes. I will go to the question in front of you. How will the appointor of the enduring guardian be able to revoke the appointment without having to apply to SAT for a revocation?

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.

CHAIR: Or make another one?

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.

Hon HELEN MORTON: Thank you.

CHAIR: I take you to clause 11, proposed section 110B of the Guardianship and Administration act. My question is: Proposed section 110B of the act requires the appointor of an enduring guardian to have full legal capacity when making the appointment. How will this be ensured and who will check that the appointor was at full capacity when making the instrument, especially in an urgent situation?

Ms Le Souef: 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. If urgent treatment is required in these circumstances, then the treatment can be given in any event, as we have said previously.

Hon GIZ WATSON: Is that because it would come under the other section?

Ms Bush: It would come under proposed section 110ZI.

CHAIR: So it is possible under this bill for someone who no longer has "adequate mental capacity" to appoint an enduring guardian.

Hon HELEN MORTON: Without it being known.

Ms Bush: It is possible, just as it is possible for that person to make a will.

CHAIR: Yes.

Hon GIZ WATSON: However, it can be appealed. Another person could take an appeal to SAT?

CHAIR: Yes.

Ms Bush: Yes.

Ms Le Souef: Yes, if there were any concerns about the person's capacity at the time they made the appointment.

CHAIR: You used the term "health professional". Is it restricted to a health professional?

[11.20 am]

Ms Bush: If we are talking about medical treatment, yes. If we are talking about any other lifestyle decision -

CHAIR: What if a brother questioned the enduring power of a guardianship of a sister?

Ms Bush: They would have to bring an application to SAT.

CHAIR: Would they be able to do that in relation to proposed section 110K? I think you indicated in your answer that if a health professional became concerned about the validity of the guardianship -

Ms Bush: That is in the context of medical treatment, not in the context of the -

CHAIR: Yes, validity per se.

Ms Bush: But yes; a brother could do that too, yes. Anybody with a proper interest could, I am sorry.

CHAIR: No, I just thought you were saying it was restricted to that.

Ms Bush: No, it is not restricted to the health professional; it is anybody with a proper interest, so it could be a sibling.

Ms Le Souef: We can refer you to proposed section 110J in that context, which says -

> A person who, in the opinion of the State Administrative Tribunal, has a proper interest . . . may apply to the Tribunal . . .

CHAIR: All right. In clause 11, proposed section 110E of the Guardianship and Administration Act, this proposed section provides that an enduring power of guardianship is not valid unless it is prepared in the correct way. The question is: how will this be ensured and who will check that the instrument meets the formal requirements, especially in an urgent situation?

Ms Bush: Again, there is no provision for an enduring power of guardianship to be checked at the time it is made, but it should be apparent from the form as to whether it has been completed correctly; so, all of the spaces have been filled in with the relevant signature of the appointor and the witnesses and also the signatures of acceptance of the enduring guardian or guardians and the substitute guardian or guardians. The bill again proceeds on the basis that the document is valid if on its face it meets those formal requirements.

Hon HELEN MORTON: But you are saying it can be revoked verbally; you do not actually have to do anything to the form so much as to revoke it.

Ms Bush: Yes.

Hon HELEN MORTON: Can a new form or a new enduring power of guardianship be put in place verbally?

Ms Bush: No. The bill requires the formal -

Hon HELEN MORTON: The only way is if they actually go through that formal process.

Ms Bush: That is correct, yes. Like an enduring power of attorney, there have to be written formalities.

CHAIR: Still on clause 11 of the bill, proposed section 110G of the Guardianship and Administration Act; that proposed section provides that an enduring power of guardianship may limit the functions of the enduring guardian, the circumstances in which the enduring guardian may act or include directions about how the enduring guardian is to perform any functions. Who will check the original instrument to ensure that the enduring guardian is acting within the power he or she has been given?

Ms Bush: If a person is concerned at the manner in which the enduring guardian is acting, then that person will have to bring an application to the State Administrative Tribunal.

CHAIR: I assume from that answer that notwithstanding the difficulties that are involved in that, that would apply equally in an emergency situation.

Ms Bush: Proposed section 110ZI would apply if it is not practicable for the health professional to -

Hon HELEN MORTON: Check?

Ms Bush: - to check whether there is an enduring guardian.

CHAIR: But assume that there is an enduring guardian, the question with respect to acting within the power they have been given I think you answered before.

Ms Bush: Yes, I think you just have -

CHAIR: Because you said if it is in conflict with the advance health directives or something like that.

Ms Bush: Yes. I think one of the principles is that a person who appoints an enduring guardian trusts that person. It may transpire that that trust is misplaced, just as with an enduring power of attorney the appointment of the attorney could be misplaced and there may be abuse. I think the bill proceeds on the basis that a person will be appointing somebody who he or she thinks will act in his or her best interests from a position of trust.

CHAIR: Question 9, on proposed sections 110O and 110ZA of the Guardianship and Administration Act states that the committee understands that proposed sections 110O and 110ZA

will allow for instruments made in other jurisdictions to be recognised in Western Australia as enduring powers of guardianship and statutory advance health directives, respectively, provided that those instruments correspond sufficiently with the form and effect of the Western Australian documents. Will the Western Australian instruments be recognised in other jurisdictions; and what will happen when a person travels to another jurisdiction? Will that jurisdiction's laws with respect to health directives and substituted decision-making apply to that person?

Ms Le Souef: I think the answer to that, the first part anyway, is that it depends on the law that applies in the other jurisdictions and we cannot answer that off the top of our heads today without going back to the specific legislation.

Ms Bush: Yes. I cannot remember whether there is any reciprocity in the legislation in other jurisdictions.

Ms Le Souef: There may be in some of them, but we are just -

CHAIR: Could I ask you to take question 9 then on notice and provide answers to the committee on that?

Ms Le Souef: Yes, certainly.

CHAIR: Thank you.

Ms Bush: It must be said, of course, that this state cannot compel another state to recognise -

CHAIR: Yes, within sort of the bounds of our Constitution we are asking.

Ms Bush: Yes.

CHAIR: So I will go to the tenth question on clause 11, proposed sections 110Q of the Guardianship and Administration Act. Proposed section 110Q of the GA Act will require statutory advance health directives to comply with formal, statutory requirements. How will compliance with the statutory requirements be ensured?

Ms Bush: I think the response is the same as for the enduring forms of guardianship. There is no provision in the bill for the checking of compliance with the statutory requirements. Again, it should be apparent from the form as to whether it has been completed correctly and there has been compliance with the requirements. I would add, of course, also that it is intended that explanatory notes will accompany the forms, both for the advance health directive and the enduring power of guardianship to assist a person in completing the form correctly.

Hon HELEN MORTON: Can I just for my own benefit get you to confirm that any advance health directive in whatever format is equally legal.

Ms Bush: No. For a statutory advance health directive it has to be in the form of or substantially in the form of the form which is to be prescribed in the regulations, which have not yet been drafted.

Hon HELEN MORTON: Okay, but if a person has not actually gone to the trouble of filling out one of those and doing the work that is necessary to do it, but still writes on the back of an envelope, "This is what I want to have happen under these circumstances" and signs it or witnesses it or whatever, that has an equal legal status in terms of ensuring that that is followed through, and that if anybody does not comply with it, then they are in breach.

Ms Bush: Yes, it does, as a common law advance health directive, yes.

CHAIR: And that is not affected by this.

Ms Bush: No. There is a provision in the bill; proposed section 110ZB preserves the common law.

[11.30 am]

CHAIR: Still on that proposed section, we understand that the government intends to develop a pro forma document that could form the basis of a statutory advance health care directive. Is the

pro forma document likely to be prescribed in regulations and are you able to tell the committee your views on the pro forma document being prescribed in the Guardianship and Administration Act?

Ms Le Souef: Proposed section 110Q(1)(a) provides that an advance health directive must be in the form or substantially in the form prescribed by the regulations. If this bill passes, parliamentary counsel, on instruction from the State Solicitor's Office, will draft the form. In consideration in detail in the Legislative Assembly on 12 September 2006, the Attorney General also agreed to an education package and said -

> I have a very open mind . . . I want to make sure that we get all the input from everyone who has an interest to make sure that it is made very easy for people to be able to go through and tick a box, if need be, so that we can really empower people to make their own decisions in a very simple form.

Ms Bush: I would also add that the instructions from our office will be based on instructions from the Attorney General.

CHAIR: In terms of?

Ms Bush: We cannot make policy. We will implement policy and we will provide instructions to parliamentary counsel.

CHAIR: Are you in any position to advise the committee on the second element of that question, that is, actually prescribing it in the act? Do you see any great consequences of that?

Ms Bush: Prescribing it in the -

CHAIR: The act itself rather than the regulations.

Ms Bush: 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 regulations, because if there is a problem, then it is far easier to amend without going through the complete legislative process.

CHAIR: We move now to clause 11 of the bill and to proposed section 110R of the Guardianship and Administration Act. In order for a treatment decision in a statutory advance health care directive to be valid, proposed section 110R of the Guardianship and Administration Act will require the maker of the directive to have made the decision voluntarily and understanding the nature and consequences of the decision. How will this be ensured? What are your views on requiring the maker of the directive to consult a health or legal professional before making the directive? Would you support a requirement for a medical doctor to either countersign a directive or certify that the maker was of the required understanding when making the directive?

Ms Le Souef: There is no provision in the bill that ensures that a treatment decision in an advance health directive is made voluntarily and that the maker understood the nature of the decision and the consequences of making it. Again, should a health professional have any concerns, an application could be make to the State Administrative Tribunal under proposed section 110W. Consultation with and certification by a health professional or a legal professional is a policy issue. We should note, however, that any such requirements would result in a less accessible and flexible scheme and would compromise principles of self-determination and freedom of choice.

CHAIR: Clause 11, proposed section 110RA of the Guardianship and Administration Act, allows for, but does not require, statutory advance health directives to be registered. What was the rationale for this? Who would be expected to maintain the register? What are your views on the suggestion that statutory advance health directives must be registered in order to be valid and binding, and in that way, people inquiring into the existence or validity of directives can quickly

and simply check the register? Is the registered intended to be available to only a limited group of people, for instance, the makers of the directives, the enduring guardians, guardians or the persons responsible?

Ms Bush: The register is only for advance health directives. There is no intention for a register for enduring guardianship. I do not think there could be a register for persons responsible, because they are in a list of priority of persons. There could not be one person registered. It also depends on whether one of those persons is available and willing to make a decision. I do not think it would work for a person responsible. In any event, the policy is that there should be a register just for advance health directives. 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. As you are probably aware, this proposed section is subject to a proposal for amendment in the Legislative Council. It was drafted on the run in the Legislative Assembly because it was not a provision that was in the bill that was initially put before the Assembly. I have Supplementary Notice Paper 149, which is dated 16 August 2007, but it does contain an amendment of proposed section 110RA and also introduces proposed section 110ZAA, which provides that details of establishing and maintaining the register will be prescribed by way of regulation.

CHAIR: That is the change?

Ms Bush: Yes. Initially, there was no clause at all requiring registration. As a result of debate in the lower house, proposed section 110RA was introduced without reference to parliamentary counsel.

CHAIR: These legislators!

Ms Bush: Yes, I must take responsibility for that, I am afraid. Once it was referred to parliamentary counsel, the proposed section was drafted properly. After due consideration, it was considered necessary to make a provision dealing with giving a regulation-making power to deal with the detail of the register. That is by way of background.

CHAIR: That is the only change, so proposed section 110RA would otherwise be as it appears in the bill?

Ms Bush: Proposed section 110RA will be deleted and it is place it would just read -

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

It is still a voluntary registration, not a compulsory registration, yes. The intention is still there but it is worded better.

Hon HELEN MORTON: Who will have access to the register? Will all health professionals have access to the register?

Ms Bush: That has not been determined as yet; that will be prescribed by the regulations, but I anticipate that it would have to be a health professional who was providing treatment who would need to have access to the register.

Hon HELEN MORTON: You said that some people might not want to register because of sensitive material.

Ms Bush: That is correct.

Hon HELEN MORTON: However, those who do register will do it on the basis that they are prepared to register and allow it to be more known.

[11.40 am]

Ms Bush: Yes, possibly; but the policy has not yet been -

Hon HELEN MORTON: But I am thinking that family members or other important and responsible people around that person might be concerned. What would be the problem with them having access to the register as well?

Hon GIZ WATSON: The person might not want them to know.

Ms Bush: With respect, I think it is a policy decision, and that policy has not yet been thought through.

Hon GIZ WATSON: I would assume if it is a question of personal autonomy, then there is no reason you should provide it to - you might be encouraged to provide it to other family members, but -

Ms Bush: Yes. It may be that the policy is that the fact of the existence of an advance health directive is registered, but not the content, for example.

Hon HELEN MORTON: I am thinking about the fact that the health professionals will have access to it when they need to, if they are to -

Ms Bush: That is correct, yes.

Hon HELEN MORTON: - have a look at what is there, but there are so many protections for health professionals. Part of what I am interested in is who is actually going to monitor the health professionals' adherence to that advance care directive.

Ms Bush: Yes, I understand that. Under clause 110ZK, the health professional has to act reasonably and in good faith. I would have -

Hon HELEN MORTON: With all due respect, when the person has died, it is too late to say "oops".

Ms Bush: It is, yes.

Hon GIZ WATSON: You might have a court case about it.

CHAIR: I think what we are leading towards is the notion that, in the same way as SAT can allow people who have a, I think, sufficient interest - was that the test that we -

Ms Bush: A proper interest, yes.

CHAIR: A proper interest -

Hon HELEN MORTON: Yes -

CHAIR: I think what Hon Helen Morton was talking about -

Hon HELEN MORTON: - as long as there is someone with a proper interest.

CHAIR: If someone has a proper interest, why should they not be allowed to look at what is contained in the register? I think that is the sort of approach that is being proposed.

Ms Bush: Yes, I am sure that that is what policy will probably dictate, but I cannot speak with authority in relation to that.

Hon GIZ WATSON: With regard to this register, if it is put in place by regulations, would it then constitute constructed 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.

Hon HELEN MORTON: Over there are the emergency and urgency provisions, so we are not talking about things like in the emergency department of a hospital or something like that; we are talking about somebody over here that is not falling into that category of emergency or urgency.

Ms Bush: It would be whatever is reasonable in the circumstances. I would like to draw to your attention, as well, that the protection afforded by 110ZK is in the context of a civil tort in trespass, a civil action in trespass, and the criminal prosecution for assault. It does not provide a defence to an action in negligence.

Hon HELEN MORTON: No, I understand that.

Ms Bush: There would be the normal negligence principles. Of course, you know, we have got reasonableness as well in that context, but - sorry, I was not sure whether you were aware of that.

Hon HELEN MORTON: Yes.

Hon GIZ WATSON: Can I just follow up?

CHAIR: Yes.

Hon GIZ WATSON: Because this seems to me a fundamental issue in terms of if there is not a register - but I appreciate this provision is going to be there - that it is obviously a lot easier for a medical professional to say, "I didn't have time to check and I didn't know how to check, or who to check with," whereas if you have a formal register, in the same way as you do, say, with organ donors, then it makes it a lot more sense that there would be an obligation, then, on the healthcare professional to check that register.

Ms Bush: Yes.

Hon GIZ WATSON: I do not know whether you could tell us now, but maybe you could tell us if, in the other states where this has been operational, whether such registers have been set up, because also it would seem to me that the logical thing would be to build on an existing register, like the organ donors register, and to have it national, so that - perhaps you cannot give that answer now, but I would be interested to know if they have already done it and had it operational in other states. Is that how it works?

Ms Bush: I am not aware of the practice in other states, if there are registers. I just want to make it clear that the register will only be for the statutory advance health directives. There could be a common law health directive and the protection does extend to common law as well as statutory directives.

Hon GIZ WATSON: Sure.

Ms Bush: It is sort of not quite -

CHAIR: We are talking about the directives under this bill.

Hon GIZ WATSON: Under this bill.

Ms Bush: Yes.

CHAIR: But I think that the committee would be interested to know, if you could assist us in the answer to that question of Hon Giz Watson.

Ms Bush: As to the operation of registers in other states?

CHAIR: Yes.

Ms Bush: Yes.

CHAIR: If you could take that on notice for us.

Hon GIZ WATSON: Yes.

CHAIR: We would appreciate the answer to that. We will go then to question 14 -

> Proposed section 110S(3) of the GA Act provides that a treatment decision in a statutory advance health directive would not operate if there or have been circumstances which the maker of the directive would not have anticipated when making the directive and those circumstances would have caused the maker to change his or her mind about the treatment decision.
>
> (a) Who is required to determine whether such circumstances exist or have arisen? Why doesn't the proposed section prescribe who the person must be?
>
> (b) What would be the consequences for the person making the determination if he or she is incorrect?

Ms Bush: It would be for the health professional to assess the circumstances, and then the health professional can take into account the considerations in 110S(4) in coming to that assessment. So you look at when the directive was made, the maker's age at the time, were they very young, would they have understood the implications - I am paraphrasing somewhat - whether there has been a review of the decision, and the nature of the condition for which the treatment is required and the consequences of providing or not providing that treatment. That will take into account whether new medications and new treatment have come into being since the treatment decision was given - was made in the directive - but it would be a matter for the health professional who proposes to give the treatment to assess the circumstances.

CHAIR: So you would not see a role for the guardian there?

Ms Bush: Well -

CHAIR: There are kind of two elements to it: there are the things that you have discussed, but there is also the guardian, who, one assumes, if they know that person very well and they know what their wishes might be across a whole range of things -

Ms Bush: In those -

CHAIR: - who then learn of either new technologies or new consequences for how they are going to end up after this treatment, they may well be the person in the best position to say, "Look, I know this person and I know they would not want that treatment", even though there is nothing in the health directive that covers the issues that you are now saying that they are confronting.

Ms Bush: If it is known that the person had changed their mind and they could have informed their enduring guardian. The guardian is not relevant because a guardian is only appointed on incapacity. So if they advised the 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.

[11.50 am]

Hon GIZ WATSON: Would there be any advantage in making that explicit in the bill? We are envisaging a situation in which a person has both made an advance health directive and appointed a guardian. I would not have thought that it would be unreasonable to put in the bill that in the event of the existence of an enduring guardian, his or her views are also considered.

Ms Bush: It would not be the enduring guardian's views; it is any information that he or she has about the maker's views. I think that is what you meant.

Hon GIZ WATSON: Is there any problem with explicitly stating that rather than assuming that it will be taken into consideration?

Ms Le Souef: An order of priority is set out in the bill.

Hon GIZ WATSON: We are contemplating a situation in which there is an advance health directive but the medical professional says that if the person knew what the medical professional now knows, he or she might not have made that particular directive. If a patient has made the provision to appoint somebody who might have additional information that would be useful in the decision-making process, would not more assurance be provided if any information that that person had had to be taken into account?

Ms Bush: I would think that that person's views would be taken into account in any event.

Hon HELEN MORTON: The views of who?

Ms Bush: An enduring guardian or any other family member or friend.

Hon GIZ WATSON: Taken into account when?

Ms Le Souef: We are looking at proposed section 110S(3).

Ms Bush: I think Ms Watson is asking whether it should be specified in proposed section 110S(4) that if there is an enduring guardian, any information that he or she has that could shed light on a situation should be taken into account. Again, that is a policy decision; however, I can no reason that proposed section 110S(4) could not be extended.

Hon GIZ WATSON: I note that proposed section 110S(4) has paragraphs (a), (b), (c) and (d). It states that these matters must be taken into account and includes those paragraphs. Often legislation contains "and any relevant matter". Is there a specific reason that that language has not been used?

Ms Bush: It is not necessary because of the word "include". The words "any other matter" would cover the field, so we do need the word "include". It would cover any information given by an enduring guardian, but it does not specifically say so.

Hon GIZ WATSON: We do not need "or" anymore?

Ms Bush: That is a drafting decision. It is already implicit in proposed section 110S(4). However, it is not explicit.

CHAIR: Proposed section 110S(4) is predicated on the fact that an advance health directive is at least 10 years old.

Ms Bush: Those matters have to be taken into account if a directive is at least 10 years old, but they may be taken into account if the directive has been around for a shorter period.

CHAIR: Where in the bill is that stated?

Ms Bush: I refer to proposed section 110S(5).

CHAIR: I refer to treatment decision by persons responsible for patients. The bill lists who might be responsible in proposed sections 110S(3) and (4). When asked about who is required to determine whether such circumstances exist, your answer was primarily the health professional. What role do you see for responsible persons in those circumstances?

Ms Bush: Again, they could fall within proposed section 110S(4). It is a policy decision about how far the health professional has to go. I think for all practical purposes, the health professional would consult the family. Having said that, a patient would personally appoint an enduring guardian because he or she wants that person to make a decision and not any other person. You cannot cross boundaries as if there was no enduring guardian.

CHAIR: In the absence of an enduring guardian and where there is a responsible person who knew the patient intimately, it is almost unimaginable that a health professional would not be required to talk to that person about a new scenario.

Ms Bush: We have to be careful that proposed section 110S(4) is not too prescriptive or imposes too many burdens, otherwise treatment may never be given.

CHAIR: I am talking about someone who may sit by the patient's bedside day in and day out and who might be not be an enduring guardian but who is very much a responsible person. I would have thought that this bill would require a health professional to consult with that person at the very least about new scenarios the patient is presented with.

Ms Bush: I think it would depend on the ambit of the provisions from a policy point of view.

CHAIR: Is there an obligation? I did not think that it explicitly said the health professional, but your answer -

Ms Bush: There is no obligation on a health professional to take into account -

CHAIR: But does it explicitly say that it is the health professional?

Ms Bush: The circumstances in proposed section 110S(4) must be taken into account if an advance health directive is at least 10 years old. They may be taken into account if the directive has been in existence for a shorter period. There is an obligation in proposed section 110S(4) to consider those issues.

Hon HELEN MORTON: I seek clarification. The chairman's questioning is around "by whom". You are saying "by the health professional", although that is not made explicit. The chairman is saying "by others". There is nothing in the bill that states by whom these things must be taken into account to make sure that those things are considered appropriately. Even though a patient might be seeing a medical practitioner on a regular basis, he or she may have spoken to another person about new developments in that area. It might not be that the medical practitioner has the latest information that the patient is interested in.

Ms Bush: That is it correct, yes.

Hon HELEN MORTON: The question is still unresolved as to how that determination is made and by whom.

Ms Bush: I think what are you saying is: should a policy decision be made to include another category in proposed section 110S(4)? Is that correct?

CHAIR: I will offer a hypothetical scenario. A person collapses at home and goes into a coma. The person does not have an enduring guardian. The person's family sits with the person around the clock. The treating health professional says that as the person is in a declining state, he wishes to withdraw treatment to allow the person to peacefully leave this earth. If the family - say the husband or the wife - says no, would the health professional then make that decision himself, or would he be required, under this bill, to be directed by that responsible person?
[12 noon]

Ms Bush: No, a person cannot demand treatment. There is no legal entitlement for the person to demand treatment.

CHAIR: If in the health professional's view the machine needs to be turned off, then the health professional may well prevail?

Ms Le Souef: If, in the health professional's view the treatment is no longer clinically indicated, then there is no obligation to continue providing that treatment.

CHAIR: When you say "clinically indicated", if that machine keeps that person alive, is that a clinical indication?

Ms Bush: Not per se, no.

CHAIR: It just keeps them in a coma?

The Witnesses: Yes.

CHAIR: They would go on things like brain activity to say that there is nothing there?

Ms Bush: I do not know. I do not think that is within the scope of our -

Ms Le Souef: It is not within our expertise.

CHAIR: No worries.

Hon HELEN MORTON: I am actually looking at it from a slightly different perspective; that is, in 10 years or five years or even in two years, a whole raft of new treatment opportunities will be developed. This person may have made a very clear statement, such as: "I just want to go peacefully. Do not involve me or intervene in any of these ways." However, the doctor says, "The person with the advance health directive did not know two years ago that we can now do this, that and the other. Therefore, that means that I can keep this person going and try these new things."

Ms Bush: He would be justified in not following the treatment decision in the advance healthcare directive, yes. Bringing us back to proposed section 110S, because the scenario that the chairman put before was really more of a person responsible scenario in which there is no guardian, these conditions are specific to a change of circumstances in relation to advance health directives, yes.

Hon HELEN MORTON: However, circumstances also apply. If I wrote out an advance health directive saying, "Under these circumstances, if I become brain-dead or if I have Alzheimer's", but I can also include - tell me if, in fact, this is not correct - circumstances, such as the fact that I do not have a house to live in or that the rest of my family have already died before me and I do not have anybody. I can describe the circumstances in my advance care directive to which I want it to apply, so that, as I understand it, the circumstances are not specific to health or medical circumstances. It is left open for me to describe any circumstances that I want to describe in that advance health directive.

Hon GIZ WATSON: John Howard gets re-elected - just pull the plug!

CHAIR: Just inject me.

Ms Le Souef: I think technically that is correct, but there is a risk with that type of directive in that it could be too vague.

Hon HELEN MORTON: I do not disagree with you, but that is how it is written at the moment. To be honest, I always understood it more as relating to non-health and non-medical circumstances than I ever read it to be wholly and solely around health and medical circumstances. Therefore, when we get further into the document and we talk about protections for a medical practitioner - even if the circumstances do not exist that we describe - I will not talk about health and medical circumstances. I will talk about the circumstances that the person who has written the directive out has described; that is, "Under these circumstances, please let me go; do not intervene," which may not have anything to do with new inventions in health and medicine.

Hon GIZ WATSON: Would that not be outside the scope of this act? Because it is in the context of consent to medical treatment, I would have thought that any court would interpret it -

Ms Le Souef: Also, that does not really fit with proposed section 110S(3)(a), the circumstances that "the maker of the directive did not anticipate at the time of making the directive", and proposed section 110S(3)(b), "would have caused the maker to change his or her mind about the treatment decision". It would have to affect the directive, so I would have thought that in that context, they are more likely to be medical circumstances.

Hon GIZ WATSON: Again, would it be possible to make it more explicit? I think what Helen is saying is that if the intent is to prescribe matters to do with your health, then if there is any doubt about it, would you not -

Ms Le Souef: I wonder if we could consider that further. Could that be a question on notice?

Hon GIZ WATSON: Yes.

CHAIR: We will move on to the next question, which you have partly addressed but there might be an opportunity to address the bill a bit further here. Under proposed section 110S(4) of the Guardianship and Administration Act, if a statutory advance health directive has been in place for more than 10 years, a question arises about whether it carries as much weight as it did when it was first written. Why was the 10-year mark chosen as the point of reference? What do you use on requiring directives to be reviewed regularly; for example, if directives were only valid for up to five years and would they need to be remade after that point? That is a new one, is it not?

Ms Bush: It was just a policy decision to choose 10 years. It was debated in the lower house - it will be recorded in *Hansard* - but I cannot recall, at this stage, the pros and cons for that particular year. I do not even know whether it was voted on.

Ms Le Souef: I think it was in the context of the debate about mandatory review of advance health directives within a particular number of years. That was the outcome of that debate.

Ms Bush: We are not able to answer part (b) of the question.

Hon HELEN MORTON: The advance health directive is still in place, even if it is after 10 years; it is just saying that it has to be reviewed at 10 years.

Ms Le Souef: Yes, it is just that those factors must be taken into account in proposed section 110S(4) when an advance health directive is older than 10 years.

Hon HELEN MORTON: I recall listening to a number of people comment in the debate that people might forget that they did it 10, 15 or 20 years ago, and that no reminder would come out saying, "Hey, guess what? Ten years ago you signed this. Are you still of this view?" I imagine that if somebody registered a directive many years ago, and they do not remember it now, there would be no reminder coming to them in any way, shape or form. The practitioner who might have to deal with that situation is obliged to follow that advance care directive at the time, taking into account the things that we have already talked about, even though it was written 20 years ago.

Ms Le Souef: Yes.

Ms Bush: Yes, that is correct, but it is a personal document. I think it is for makers, while they are competent, to not have a lapse of memory and forget about their directives. They have to take responsibility for their own health care, if they want to plan ahead. Even if the directives were registered, it would not really be feasible for reminders to be sent out; it would not be practical. I think that this is a personal document; it is a personal decision.

CHAIR: Okay. I will take you to the sixteenth question, clause 11. Proposed sections 110S(6) and 110Z of the Guardianship and Administration Act provide that a treatment decision in a statutory 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. You have addressed these issues, but this is a further opportunity to address these questions. 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? What would the

consequences be for a person who incorrectly determined that a treatment decision was revoked because the maker changed his or her mind?

[12.10 pm]

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. It certainly would be in the interests of the maker to notify the hospital if they have put their advance health directive on the hospital file; the general practitioner, if it is on a doctor's file; or the register, if they have registered it. It would really be the responsibility of the maker to inform. On application by a person with a proper interest, the State Administrative Tribunal under proposed section 110Z may make a declaration that a treatment decision in an advance health directive is deemed to have been revoked under proposed section 110S(6), if there is any doubt about it. Where a health professional incorrectly determines that a treatment decision has been revoked, he or she will have protection under proposed section 110ZK - again, provided that the conditions of proposed section 110ZK have been met. The operation of proposed section 110ZK is dealt with in detail in the additional document we have provided to the committee.

CHAIR: Okay. We now go to proposed section 110ZB of the Guardianship and Administration Act. It provides that the statutory advance health directives that will be introduced under the bill will not affect people's common law entitlements to make treatment decisions for their own future treatment. What are the similarities and differences - if you have not already addressed them - between statutory and common law advance health directives? There is also a question that I think you have already answered, but I will ask it again: are common law advance health directives binding?

Ms Le Souef: At common law, a legally competent adult may indicate in an advance health directive, either in writing or orally, the type of health care he or she wants or does not want in the event of subsequent incapacity. The conditions for valid statutory and common law advance health directives are similar. The conditions for a refusal of treatment at common law were stated by the English Court of Appeal, in Re T, to be that a person must be competent at the time of the decision; must know, in broad terms, about the nature and effects of the procedure; must have anticipated and intended the refusal to apply to the circumstances that subsequently arise; and must be free from undue influence when making the decision. Common law advance health directives are binding at law. Those conditions are similar to the requirements set out in the bill, as the committee knows.

CHAIR: Thank you. Proposed section 110ZD of the Guardianship and Administration Act sets out circumstances in which a person responsible may make a treatment decision on behalf of a person who is unable to make a reasonable judgement. The proposed section also lists, in order of priority, who can be a person responsible. Among other things, the person responsible must also be of full legal capacity. The committee has a number of questions. Does the health professional who is proposing a particular treatment have to go through the list and decide each time whether the person is a person responsible? Why does the proposed section not prescribe that the health professional is the person who must determine these matters? If, for example, the person who is to be treated has no spouse or de facto partner, but has two children who are equally eligible to be the person responsible in a particular instance, how would the person responsible be chosen from the two children? A person who is a near relative of a person who is to be treated is only eligible to be the person responsible if he or she maintains a close personal relationship with the patient; that is, the person must have frequent contact of a personal nature with the patient, and he or she must take a genuine interest in the patient's welfare. How is the health professional to know whether a person's relationship with the patient meets the requirements of such a close personal relationship? Is proposed section 110ZD dependent on the existence of a valid advance health directive? How

will the bill ensure that the person responsible will act in the best interests of the patient when making the treatment decisions? In answering that question, I ask you to turn your mind to whether there are any consequences or sanctions for persons responsible acting in that way. Thank you.

Ms Le Souef: Starting with the first question, yes, a health professional who is proposing treatment would have to go through the list each time a person presents for treatment, and decide who is the appropriate person responsible from the list. The health professional would at least have to make some reasonable inquiries about persons potentially on the list.

Ms Bush: 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. 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.

[12.20 pm]

Therefore, it is the health professional in those circumstances. I am not sure if that is clearer. It is referring again to this whole area of consent. This is the consent to medical treatment that we are talking about throughout the bill except in the limited circumstance of an enduring guardian being able to make personal and lifestyle decisions for completeness. The focus of the bill, and virtually all the provisions, is on who can consent to medical treatment because a health professional cannot give treatment except in emergencies without consent.

Hon HELEN MORTON: Can I ask for a little bit of clarification about that? One of the points in your opening document was quite specific to what you were just saying but I was not sure of it. At the third paragraph you state 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. If the patient is incompetent?

Ms Bush: A person who is competent can refuse consent however irrational that is. For whatever reason they want, it does not matter. Where you have got an incompetent person currently – as mentioned on the first page of that document - that person may have, while competent, written out or orally expressed their views, which would constitute a common law advance health directive. If they have not done that or if the common law directive does not apply to the circumstances that have arisen, there still has to be consent.

Hon HELEN MORTON: Except for an emergency.

Ms Bush: Except for emergencies. Leaving emergencies aside -

Hon HELEN MORTON: There is no circumstance other than an emergency under which a health professional can take action without somebody else consenting.

Ms Bush: That is correct. The only mechanism at the moment for substitute decision making is the appointment by the State Administrative Tribunal of a guardian, and that occurs once the person has already lost decision-making ability. Because a lot of decisions were required in the medical context, it was thought that the least restrictive alternative to appointing a full-blown guardian or getting an order was to introduce section 119, which is the "person responsible". It has a list of people, in priority, to whom a doctor could go for consent. It is the least restrictive alternative. The thinking behind the Guardianship and Administration Act is to consider the least restrictive alternative because an order is quite an extreme step to take.

Hon HELEN MORTON: In terms of this opening statement, that is the current situation?

Ms Bush: On the first page, yes. Those three dot points. The current situation is where a person lacks the capacity to make a decision at the time the treatment is required.

Hon HELEN MORTON: If this bill is passed, does that change the situation that says that under no circumstances other than in an emergency can a health professional take treatment action without getting consent from another person?

Ms Bush: It does not change the position. All it does is expand the mechanisms for consent so that a person can have a statutory advance health directive or appoint their own enduring guardian.

Ms Le Souef: It clarifies the identity of those substitute decision makers.

Hon HELEN MORTON: I will come back to this again.

Ms Bush: All it does is expand the mechanisms for consent so that by giving a person their own choice as to what treatment they would like - say by an advance health directive - or who they trust to make the decision for them in the event that they lose capacity. The "person responsible" is just a rewording to be consistent with the rest of the bill in relation to what is currently in section 119. Those people do not have a name; it was thought better to call the person the "person responsible" rather than people who are in the list in whatever section it is. It is for ease of reference. Consent is vital; it is the fundamental principle underlying this bill.

I do not know whether we have answered all the parts of question 18. Part (c) - it does not specify who has priority if you have two siblings. The policy behind it is that, given the nature of family relationships, it was necessary to retain some flexibility in identifying the person. The person also has to be ready, willing and able to make the decision. That is under clause 110ZD(2). The person has to be of full legal capacity, reasonably available and willing to make a treatment decision in respect of the treatment which is proposed. That is all we can say. It does not give any guidance as to priority.

Hon GIZ WATSON: How would you resolve that? It provides some clarity but you cannot provide absolute clarity.

Ms Bush: We were discussing this. What happens if you say that it is the elder of two? That is fine but what if there are twins?

Hon GIZ WATSON: There is still an older one, let me tell you. We have twins in our family! Twenty minutes!

Ms Le Souef: There is also no rational basis for saying that it is the elder of two siblings.

Hon HELEN MORTON: I do not think that is a rational basis. I would hate to think that my eldest brother got some say over me!

CHAIR: I cannot imagine your elder brother having any say over you, Helen!

Ms Bush: There is no reference. It is very hard to differentiate.

Hon HELEN MORTON: I was going to say that whether, somehow or other, it was determined while the person was competent, but that just does not happen.

Ms Bush: Well then, you see, they should be appointing an enduring guardian because they do not want the elder brother to make the decisions.

Hon GIZ WATSON: That is the answer - get in early!

Ms Bush: Or they do not want any family member at all to make the decisions.

CHAIR: That could be the beginning and the end of the advance health directive, could it not, by simply appointing a guardian and saying that it is up to him - leaving all other details to the guardian?

Ms Bush: Again, I think we have to differentiate between the advance health directive, the enduring guardian and the "person responsible". The "person responsible" only makes the decision in the absence of an advance health directive. They are three distinct cases.

CHAIR: They avoid the person who is responsible by appointing a guardian?

Ms Le Souef: An enduring power of guardianship, yes.

Ms Bush: An enduring guardian.

CHAIR: That is all they have to do.

Ms Le Souef: That is really one of the most important aspects of this bill.

Ms Bush: There is going to be a comprehensive education package in relation to these provisions. From an enduring guardianship point of view, there has been a lot of support over many years for a person to be able to appoint an enduring guardian rather than to have to go to SAT. Somebody has to make a formal application to SAT with all the issues of medical documents etc to have an order. People want to be able to appoint somebody to make all personal and lifestyle decisions for them. There has been no opposition to that concept over many years. It is something that is seen as quite vital for people's future care. We see this as quite an important part of this bill - this ability to appoint an enduring guardian - because there is then clarity, whereas, of course, with an advance health directive, unless it is very specific there could be uncertainty. I think it is recommended that a person do appoint an enduring guardian and in the enduring guardianship they could actually impose conditions on the enduring guardian.

[12.30 pm]

CHAIR: The committee will have a short break for half an hour. We would like to see you back in half an hour. We can only sit until two o'clock today because members have other commitments. We would like to have you back for another hour to see how much progress we can make on the remaining questions.

Ms Bush: I will need to check my commitments because I am currently an Acting Supreme Court Registrar. I have come here today because I have been an instructing officer for the bill. I have been seconded from the office until the end of the year. I will have to check my diary back at the court because I have formal commitments.

CHAIR: Do you mean between one o'clock and two o'clock?

Ms Bush: I am fine today, but I have court commitments on other days.

CHAIR: If we do not get through the questions today, we will liaise with you about alternative times or about providing correspondence to the committee. The committee has not discussed what it might do if, at the conclusion of this hearing, we have not dealt with a list of questions. We certainly will not ask you to give the committee a commitment today about any future hearing dates.

Proceedings suspended from 12.30 to 1.05 pm

CHAIR: Before the break, we were on question 18. Was there any other aspect on question 18 that you needed to finish off on, or has it been addressed?

Ms Bush: The answer to 18(e) is no. I think we explained earlier that the person responsible is independent of an advance health directive. In answer to 18(f), again, there is no provision to ensure that a person responsible will act in the best interests of the patient, but the person responsible is required to act in the best interests of the patient. One hopes that the list of people includes those who would, in the normal course, act in the best interests of the patient.

CHAIR: If they do not, does it rely on the Criminal Code?

Ms Bush: It would be a breach of fiduciary duty. It is not related to the Criminal Code.

CHAIR: What are the consequences of that?

Ms Bush: Of not acting in the patient's best interests?

CHAIR: Yes.

Ms Bush: I think we had better put that on notice, if that is okay.

CHAIR: Question 19 relates to proposed part 9D of the Guardianship and Administration Act. Firstly, what is meant by the term "reasonable" in relation to health professionals and other variations of it that are contained in proposed part 9D? Secondly, does it refer to any benchmarks or standards? Thirdly, will proposed section 110ZK, which appears in proposed part 9D, be too subjective?

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.

Hon PETER COLLIER: Is that a commonly used term?

Ms Bush: It is a legal term.

Hon GIZ WATSON: Can you give the reference of where that is defined?

Ms Bush: It is proposed section 110ZK.

Ms Le Souef: It is not defined.

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.

Hon PETER COLLIER: From my perspective, it appears to give enormous discretionary powers to the health practitioners. Are you saying that it is a legal term?

Ms Bush: Yes. 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.

Hon PETER COLLIER: Would one person's interpretation of "reasonably" be the same as that of another person?

Ms Bush: The objective standards would ultimately have to be decided by a court. Those terms are not usually defined because they are given legal meaning.

Hon HELEN MORTON: I do not know whether the questions I want to ask are covered by the prepared questions. I am interested in the issue of the protections that are provided to health professionals in proposed section 110ZK. I need to understand whether this is still consistent with

your opening statement that under no circumstances can any health professional take any treatment action without getting consent from another person unless it is in an emergency and an advance health care directive does not exist.

Ms Bush: I cannot answer that by saying either "yes" or "no" because proposed section 110ZK deems certain consents valid. We have dealt with this in detail in the paper we handed up on the liability of health professionals.

Hon HELEN MORTON: Unfortunately I have not had time to read it.

Ms Bush: I understand that.

Hon HELEN MORTON: I do not know whether to ask you questions about it or to read it and come back to it later.

Ms Bush: That might be wise.

Ms Le Souef: We would be happy to provide follow-up information if you have any further question after reading that because it is quite a comprehensive document about the liability of health professionals.

Ms Bush: Essentially we are looking at valid consents, which are definitely valid, and certain consents that are deemed valid by proposed section 110ZK for the circumstances set out in proposed section 110ZK. However, the paper goes into some detail about proposed section 110ZK and other proposed sections that relate to protection, and it provides examples. There are more questions about proposed section 110ZK later.

CHAIR: We will go now to question 20, which is still on proposed part 9D of the Guardianship and Administration Act. I think you have probably covered this in part, but I will ask it again. If treatment decisions made under the bill are to be binding, what protections are there for health professionals who refuse to implement a treatment decision on the grounds that the decision is not reasonable in the circumstances or does not accord with best practice or goes against their own beliefs? I do not think you have addressed the question that relates to beliefs at this point, but you have probably addressed the issue of best practice, in part at least.

Ms Le Souef: There would not be any protection for health professionals in that situation.

CHAIR: In relation to their own beliefs, or all those things?

Ms Bush: All of those things.

Ms Le Souef: I think we have previously said that it is a fundamental legal principle that a health professional may not give treatment in the absence of consent, even if the decision is inconsistent with good medical practice or in a situation when the health professional has a conscientious objection to the decision. The health professional cannot ignore the wishes of the patient.

Ms Bush: The wishes would normally be the refusal of treatment because a patient cannot demand treatment. The question is probably geared to when a patient refuses treatment in circumstances when the health professional thinks the patient ought to have it. I think that is the context of the question.

CHAIR: When you say that the patient cannot demand treatment, does that mean that the patient cannot demand any treatment whatsoever?

Ms Bush: That is correct.

CHAIR: That answers the question, in my mind at least.

Ms Bush: A patient cannot demand treatment and a doctor cannot force treatment upon a patient. That goes against the whole idea of consent and the expression of a person's wishes.

CHAIR: Moving to proposed section 110ZJ of the Guardianship and Administration Act, during the second reading speech in the Legislative Council it was said that the bill will not change the

position at common law whereby a health professional is under no obligation to provide treatment that is not clinically indicated, and will not permit euthanasia. How do you reconcile this policy statement with the requirement of health professionals to comply with the treatment decision that has been made?

Ms Le Souef: I think we have answered that in the previous answer.

Ms Bush: I have an additional comment on question 21. Even with consent, a health professional cannot do that which is unlawful. Therefore, he cannot commit euthanasia because euthanasia is unlawful under the Criminal Code.

CHAIR: That will prevent a health professional from having to comply with the decision?

Ms Bush: Yes. Consent can only be given to something that is lawful.

Hon HELEN MORTON: I am trying to remember the conversation we had earlier today. Does this bill, and in particular proposed section 110ZK, give a greater range of protection to medical practitioners than is currently available?

Ms Bush: It does in so far as it deems certain consents valid in certain circumstances that are specified. There are issues about a doctor acting reasonably and in good faith.

CHAIR: And lawfully.

Ms Bush: Yes. It does extend the protection when it is reasonable for doctors to act in a certain way. Valid consent will be deemed to have been given.

Hon HELEN MORTON: Is it reasonable to say that if the protection is extended in one direction, it is reduced in another? If the protection is extended to the health professionals, is it then reduced to the patient?

Ms Bush: I do not think so because of the concept of reasonableness and good faith. There are obligations placed on a doctor to comply with those requirements.

Ms Le Souef: We are trying to think of an example of when that might apply. Perhaps it would apply to a situation whereby a patient goes into an emergency department without an advance health directive and a doctor makes reasonable inquiries but is unable to determine the existence of an advance health directive and treats the patient on the basis of consent from another person. Subsequently an advance health directive is identified and a direction in the advance health directive is to refuse the particular treatment that had been administered. I am trying to think how, under those circumstances, the protection to the patient would have been diminished.

Ms Bush: The doctor would be protected if he acted reasonably and in good faith and with the consent of a substitute decision maker, and he did not know that there was an advance health directive. It would protect a doctor in those circumstances when he had made all reasonable inquiries but was unaware of the advance health directive and went ahead and gave the treatment with the consent of the substitute decision maker who was next on the priority list. The doctor would be protected in that circumstance.

Hon HELEN MORTON: Can I give you another circumstance? This is a real one. I have brought a copy of it along, but I will not bother reading it to you. It relates to a mental health patient who is legally incompetent to make a decision. The guardian of that patient has been saying she does not want her brother to be moved from one place to another. More than one medical practitioner decided that it would be a good idea for the patient to be moved from one place to another. Against the wishes of the guardian, the patient was moved under the authority that the doctor knows what is best for the patient. When the guardian found out that that had happened, she went to the second place, which was a hospital. The guardian was told that the patient would stay for only a short time for an assessment. However, when the guardian went to the patient's original place, she discovered that all of the patient's belongings had been sent with the patient to the hospital. She collected the belongings, took him out of the hospital that day and took him home.

She then wrote to the Premier and whoever else to complain about the treatment. That is an example of a situation where, retrospectively, it would have been possible in some way or another - I have seen these things happen - for the medical practitioner to have found some protection for having made that decision against the wishes of the people concerned.

Ms Bush: Are we looking at the Mental Health Act or the Guardianship and Administration Act? I cannot speak with authority about the Mental Health Act.

Hon HELEN MORTON: If someone is deemed legally incompetent under the Mental Health Act, is that a different circumstance entirely?

Ms Bush: I cannot assist the member with the Mental Health Act because it has specific provisions about the movement of people who are either voluntary or involuntary patients.

Hon HELEN MORTON: This case is nothing to do with being an involuntary patient. The patient was not deemed involuntary.

Ms Bush: We are probably talking about a guardian who has been appointed under the Guardianship and Administration Act. Proposed section 110ZK relates only to the treatment of a patient and not the movement of a patient.

Hon HELEN MORTON: The movement was to get a form of treatment, which was an assessment.

Ms Bush: I do not think that proposed section 110ZK covers that. It refers only to taking treatment action, which is defined in proposed section 110ZK(1) and means -

(a) to commence or continue any treatment of a patient; or

(b) to not commence or to discontinue any treatment of a patient.

It does not enable a person to be moved for the purpose of treatment. I would have thought that it was a matter for the guardian to deal generally with personal lifestyle decision as to whether the person should be moved for treatment. If the doctor was aware of the guardian's views, the guardian would not have given consent to the removal of the person, regardless of proposed section 110ZK, because that comes into operation when a doctor, notwithstanding being reasonable and acting in good faith, gives treatment when the consent is invalid. Proposed section 110ZK does not apply to that circumstance.

Hon HELEN MORTON: Can I just be clear then that we are referring to treatment. I might have assumed something here.

Ms Bush: Treatment is defined -

Hon HELEN MORTON: At the very beginning. Does the definition of "treatment" at the beginning of the bill apply?

Ms Bush: Yes.

Hon HELEN MORTON: "Treatment" is proposed to mean -

(a) medical or surgical treatment, including -

(i) a life sustaining measure; and

(ii) palliative care;

or

(b) dental treatment; or

(c) other health care;

"treatment decision", in relation to a person, means a decision to consent or refuse consent to the commencement or continuation of any treatment of the person.

Ms Bush: Yes, that is correct. Those definitions apply.

Hon HELEN MORTON: What is "other health care"?

Ms Bush: That would include podiatry, physiotherapy, optometry and any other health care.

Hon HELEN MORTON: Would it include a mental health assessment?

Ms Bush: It is the giving of the health assessment; it is not the removal of the person for the purpose of getting an assessment. The treatment is the actual treatment given. It is the treatment taken. If an appointed guardian has plenary powers, that guardian has a choice of where the patient can live.

CHAIR: A guardian could not insist that a patient be maintained at a facility that they did not have control over?

Ms Bush: A guardian could consent to a patient being put into a home. That is the whole purpose of having a guardian.

CHAIR: If the owners of a home said that they were withdrawing treatment, it might be a treatment facility but not a hospital.

Hon HELEN MORTON: Let us make it clear that the patient went back, and so whatever was being provided to the patient at that place could be and continued to be provided.

Ms Bush: A guardian stands in the shoes of the represented person. If it is a plenary guardianship, it relates to all aspects of life. It is under the Guardianship and Administration Act. There are specific provisions in that act that specify some of the powers of the guardian.

Hon HELEN MORTON: A lot of my concerns about this proposed section of the bill relate to its applicability to people with a mental illness. You said something today that I never even would have imagined; that is, this part of the bill may not be applicable to people with a mental illness.

Ms Bush: It depends on whether under the Mental Health Act there is a provision for involuntary patients. If that is the case, I think they are under the jurisdiction of -

Hon HELEN MORTON: The Chief Psychiatrist.

Ms Le Souef: There are provisions in the Mental Health Act that deal with the treatment of mental health patients. I believe that they are involuntary patients.

Ms Bush: I think it is the Chief Psychiatrist. The Mental Health Act has a different regime from the Guardianship and Administration Act.

Hon HELEN MORTON: Only if the patient is an involuntary patient. When the patients are voluntary, they are not.

Ms Bush: I cannot answer that off the top of my head.

CHAIR: You can take that question on notice.

Question 22 relates to proposed section 110ZJ of the Guardianship and Administration Act. That proposed section applies if the patient is unable to - I probably need to ask if you have anything to add to the answers you have already given in this respect - make reasonable judgements in respect of any treatment proposed to be provided to the patient. In terms of the treatment decisions that may be made, is the bill really allowing for reactive decision making in the sense that it will only allow people to consent or refuse consent to future treatment that is first identified by a health professional?

[1.30 pm]

Ms Bush: Proposed section 110ZJ is not a substantive provision about consent. It does not give any authority to consent or to refuse consent. It only gives an order of priority as to who has priority to give consent. The priority is the advance health directive, an enduring guardian, a

guardian and then a person responsible. The answer to your question is that treatment cannot be demanded, but proposed section 110ZJ really does not relate to who can demand treatment and who cannot, and who is authorised to give consent. It is purely a priority provision; that is all that it does. The authority to give consent is in the other provisions in the bill: under part 9A, enduring powers of guardianship; part 9B, advance health directives; and part 9C, persons responsible for patients. All that proposed section 110ZJ does is to prioritise the decision-making. However, the answer to the question is that treatment cannot be demanded, but it is probably not relevant, in fact, to proposed section 110ZJ, substantively.

CHAIR: All right. Question 23, again, deals with proposed section 110ZJ. I think that this is a new question for you today. The Australian Christian Lobby suggested that an independent expert be required to provide a second opinion on the diagnosis of a condition before an advance health directive would apply. Do you have any views on that suggestion? Would your views change if the same requirement was placed on all other forms of treatment decision; that is, if the decision was made by an enduring guardian, a guardian or a person responsible?

Ms Le Souef: We do not think that we are in a position to answer that; it is a question concerning policy.

CHAIR: All right, I will go to question 24: proposed section 110ZJ will determine the order of priority of treatment decisions and is expressly made subject to proposed section 110ZI of the Guardianship and Administration Act, which allows for health professionals to provide urgent treatment in the absence of a treatment decision. Should the proposed section also be expressly made subject to proposed section 110ZIA of the Guardianship and Administration Act, urgent treatment after attempted suicide?

Ms Bush: Can we have that as a question on notice please?

CHAIR: Yes. I will move to question 25, which deals with proposed sections 110ZK and 110ZL of the Guardianship and Administration Act. Under the bill, it is proposed that a health professional who treats a patient according to a valid treatment decision consenting to the treatment will have a defence to civil trespass and criminal assault. A health professional who refrains from treating a patient based on a valid treatment decision refusing consent of the treatment is also protected. Can you confirm which clauses of the bill, and the operative words in those clauses, which provide for this protection?

Ms Bush: I think that we need to refer you to the paper we have given, because that explains in detail about how the bill provides for a valid consent and how the bill deems certain consents to be valid, even though, ultimately, they are invalid. I think that it would be worth - unless you want us to go through the paper with you - it is quite detailed.

Hon GIZ WATSON: Let us read it and see.

CHAIR: Do people insist on that now?

Hon GIZ WATSON: No.

CHAIR: If issues arise out of that, we can always get back to you with more specific matters.

Ms Bush: We just need to stress that you can have a valid consent, which is definitely valid, and a consent which is deemed valid. You get the protection under both. I think that we have explained it reasonably carefully, but we can always come back.

CHAIR: I will move on to proposed section 110ZK of the Guardianship and Administration Act. Proposed section 110ZK(2)(a) appears to protect health professionals who treat a person who they reasonably believe to be unable to make reasonable judgements in respect of the treatment and relying in good faith on a purported treatment decision. Can you tell the committee what is meant by good faith in this case? How will the health professional know whether a valid statutory advance health care directive exists and what it states? What are the consequences if the health

professional was wrong in their belief as to a person's judgement and their reliance on a purported treatment decision? Who would decide whether the health professional was wrong in these respects?

Ms Le Souef: We would like to refer you back to the paper that we provided on liability of health professionals, again, in the context of this question. We have some further comments to make here. Proposed section 110ZK applies where 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 subsection (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, is not authorised in the making of the treatment decision. The proposed section will provide an appropriate measure of protection for health professionals from civil actions and trespass, and criminal prosecutions for assault. It will not provide a defence to an action in negligence.

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 of 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.

That was actually answering another question as well.

Ms Bush: I think that is relevant to question 27 too.

Ms Le Souef: We answered questions 26 and 27 together.

CHAIR: Yes.

Hon HELEN MORTON: This is a main area for me, but there is the matter of reading the paper first.

Ms Bush: I think that it would be wise to read the paper first. With proposed section 110ZK, all of the subsections have to be read as a whole. You cannot isolate subsection (3) from subsection (2); they have to be read as a whole.

CHAIR: I think, just in terms of question 27, essentially you are saying to us that so long as they make reasonable efforts to find out the status of any health care directives -

Ms Le Souef: Reasonable inquiries, yes.

CHAIR: Reasonable inquiries, and they act in good faith in the interests of the patient, this will afford them all protection, essentially.

Ms Le Souef: Appropriate protection.

Ms Bush: In relation to trespass and assault, yes.

CHAIR: However, within that broad umbrella, in relation to trespass and assault, that is your answer?

Ms Bush: That is correct.

Hon HELEN MORTON: You are saying that they have made reasonable inquiries; that is your sort of benchmark or guideline for covering most of the things that sit in here. Do they have to have

made reasonable inquiries to see whether the guardianship is invalid or has been revoked? If the guardianship order or enduring power of guardianship is invalid or has been revoked, would they need to make reasonable inquiries about that?

Ms Bush: The guardianship order cannot be revoked; it can only be brought to an end by the State Administrative Tribunal.

Hon HELEN MORTON: Yes. Sorry, just that proposed section 110ZK(3)(b) says that subsection (2) applies; that is, they are deemed to have consent - I am understanding that that is what that means - even if what purports to be an advance health directive, guardianship order or enduring power of guardianship is invalid or has been revoked. So, the measure for that would be the extent to which they have inquired?

Ms Bush: Yes, as long as they have relied in good faith on what is purportedly a treatment decision, in either of those circumstances, then they will have protection. So, good faith means they will have to make reasonable inquiries.

Hon HELEN MORTON: To have found out whether it has been revoked?

Ms Bush: Yes. Factually, it is difficult to say what those inquiries would entail, because it would depend on the circumstances. For example, if a person turned up and said, "I am a guardian", then they would have an order; an enduring guardian ought to have the enduring power of guardianship.

[1.40 pm]

Hon HELEN MORTON: They might not have it.

Ms Bush: I find it hard to imagine that a court would want a health professional to actually go to the State Administrative Tribunal and ask if the guardianship order was still on foot. I think they would have to ask the person if it was still a valid order. They could ask: Is this guardianship order still on foot? Has this enduring power of guardianship been revoked? There really are no other inquiries that they could make, especially about the latter - the enduring power of guardianship. I know these answers are probably not satisfactory, but it is very difficult from a legal point of view to say what would be "in good faith" in all of the circumstances. You need to address specific circumstances.

Hon HELEN MORTON: What about the circumstances in which the treatment decision - this is the one I was referring to before, where I understood the circumstances to be broader than just health - in fact do not exist or have never even arisen? That is at point (e). Are they still deemed to have consent even if the circumstances that somebody went to the effort of describing in their advance care directive don't exist or have never arisen? Are they still deemed to have consent?

Ms Bush: Yes, if they reasonably think that the circumstances exist at the time the treatment is required. For example, an enduring guardian might say they have authority in these circumstances to give consent. It is then whether it is reasonable, in the circumstances, to rely on what the enduring guardian has said, rather than seeing the document.

Hon HELEN MORTON: Sorry, but that seems to confuse the statement you made earlier on, that if there is an advance care directive that describes the circumstances, then the enduring guardian does not have a say.

Ms Bush: I am talking about the circumstance where we just have an enduring guardian; not an advance health directive.

Hon HELEN MORTON: I see.

Ms Bush: Would you like us to think further about examples for you?

Hon HELEN MORTON: What I would really like is to somehow or other think of some different ways to write this section!

Ms Bush: A lot of thought was given to drafting that clause.

Ms Le Souef: It was very difficult.

Ms Bush: It was very difficult to draft.

CHAIR: I can imagine.

Hon HELEN MORTON: This is the point at which I want to ask: has the balance moved? Has it reduced the protection of the patient in order to enhance the protection of the practitioner?

Ms Bush: Can we have that question on notice? I would like to give it more thought. I cannot answer it at the moment. I would prefer to think about it.

CHAIR: In my mind, I would add, is that an either/or scenario? Is the enhancement of one necessarily at the expense of the other?

Ms Bush: Yes.

CHAIR: I have another question that you have only just seen today. My own view is that you have probably addressed it a number of times. I refer you to question 28. Is there anything that you would add to the proposition that we were talking about in proposed section 110ZK. The Coalition for the Defence of Human Life suggested that a health professional should not be required to take treatment action to give effect to a treatment decision if the treatment decision (a) is made with the intention of ending the patient's life, or (2) - (a) or (2), you know what I mean - (2) will have the effect of ending the patient's life and is not in accordance with good medical practice.

Ms Bush: We have answered (a) because any treatment given with the intention of ending a patient's life is unlawful.

CHAIR: Yes.

Ms Bush: Point (2) - proposed section 110ZL deals with the situation where treatment is given - such as palliative care - which does not have the intention of ending a patient's life, but the effect is to do so. Proposed section 110ZL is referred to in the paper on the liability of health professionals. As far as good medical practice is concerned, in the context of advance health directives, a decision is a matter of choice for the patient. It does not have to be in accordance with good medical practice. It is their choice. It may be an irrational decision, but it is still their choice to make it.

As far as a substitute decision-maker is concerned, that decision maker must act in the best interests of the patient. The best interests may not necessarily coincide with good medical practice. For example, a health professional might say that the refusal of blood products by a Jehovah's Witness is not consistent with good medical practice. However, the patient would say that it is in their best interests to, for example, refuse a blood transfusion.

CHAIR: Earlier, you alluded to a proposed amendment - in the supplementary notice paper. Are there any other proposed amendments that you are aware of?

Ms Le Souef: No.

Ms Bush: On our instructions, they are the only amendments which Hon Sue Ellery intends to move at this time.

CHAIR: Do members have any further questions?

Hon HELEN MORTON: Can you indicate whether the bill was originally intended as a bill for the terminally ill and that changed along the way, or was it always intended that the bill would not necessarily be focused on people who are terminally ill?

Ms Bush: Initially the discussion paper which was put out sought comments on medical treatment for the dying. However, in the context of the bill and given that consent was required for all treatment, it was considered necessary to deal with all medical treatment. To have a complete

scheme, we needed to deal with all health care and not just medical treatment for the dying - again, because of this background of consent.

Hon HELEN MORTON: However, by the time it was drafted, it was definitely a bill for all medical consent.

Ms Bush: When the discussion paper was put out, the content of the bill was not discussed but medical treatment for the dying was an area which would have been more controversial than other treatment.

Hon HELEN MORTON: Some of the other states have legislation specific to treatment of the terminally ill, or whatever words are used.

Ms Bush: That is in the context of their equivalent of advance health directives. The other jurisdictions, where there are guardians, enduring guardians or persons responsible, they are given authority in relation to all health care -

Ms Le Souef: That has been a very important part of this bill.

Ms Bush: - and not just for the terminally ill.

Hon HELEN MORTON: Sorry, say that again.

Ms Le Souef: The enduring power of guardianship was always - the discussion paper included a section on the introduction of enduring power of guardianship. It was never just about decision-making at the end of life.

CHAIR: Is there anything that you want to add to the information that you have already given us today?

Ms Le Souef: I do not think so.

Ms Bush: No.

Ms Le Souef: No, thank you.

CHAIR: Thank you both very much for your time and for the evidence you have given today. You have been of great assistance to the committee. Without going back through my notes now, I am aware that you have taken a note of those matters taken on notice and that you will be providing the committee with further information. The committee will now discuss the evidence that we have received today and if there is a need to contact you again, we will be in touch. You will receive a transcript of today’s proceedings. I explained the status of that transcript earlier. Thank you very much for your attendance today.

Ms Bush: Do you have a time frame in relation to a response for these questions on notice? We know that you have a limited time -

Hon PETER COLLIER: Five o’clock today is fine!

Ms Bush: Sorry?

Hon GIZ WATSON: He is joking!

CHAIR: Yes. We are under the hammer with the reporting time frame and would very much appreciate your getting it back to us as soon as possible.

Ms Le Souef: We will do that.

Ms Bush: Thank you.

CHAIR: I am sure that you will; thank you!

Hearing concluded at 1.51 pm