



Health and Disabilities Committee

Queensland Law Reform Commission Recommendations on Guardianship Laws Inquiry

Issues Paper

November 2011

This paper aims to encourage public submissions to the Health and Disabilities Committee's inquiry into aspects of Queensland's guardianship laws. It describes the Queensland Law Reform Commission's (QLRC) recommendations that are in the committee's terms of reference, the current law, and issues on which the committee seeks comment. Most of the QLRC recommendations in the committee's terms of reference relate to the operation of advance health directives, decisions to withhold or withdraw a life-sustaining measure, and objection to urgent health care.

Contents

1	Introduction	1
2	Advance health directives	5
3	Common law right to consent or refuse treatment - impact of the guardianship legislation	9
4	Decisions to withhold or withdraw a life-sustaining measure	10
5	Objection by an adult to health care	21
6	Other QLRC recommendations	23
7	Terms of Reference	26
8	Health and Disabilities Committee	27

1 Introduction

1.1 Making a submission – process and key dates

The committee invites individuals and organisations to make submissions on the issues in this paper. Submissions close on Thursday 15 December 2011. Guidelines for making a submission are on the committee's website at www.parliament.qld.gov.au/hdc. Details of where to send submissions are at the end of this paper and on the website.

This paper lists issues for comment at the end of each section; they are intended only as a guide and submissions may address any or all of the issues in the terms of reference.

1.2 Terms of reference

On 26 October 2011 the Legislative Assembly referred to the Health and Disabilities Committee an inquiry into 25 of the QLRC recommendations in its report, *A Review of Queensland's Guardianship Laws* (QLRC Report).

The terms of reference, at the end of this paper, refer to 25 specific QLRC recommendations. The committee is due to report to the Parliament by 31 March 2012. The *Parliament of Queensland Act 2001* requires the responsible Minister to respond to the committee's recommendations within three months of the committee's report being tabled.

1.3 Issues not being considered by the committee

The QLRC report, *A Review of Queensland's Guardianship Laws*, considered a broad range of issues relevant to the *Guardianship and Administration Act 2001* (GAA Act) and the *Powers of Attorney Act 1998* (POA Act) and made over 300 recommendations. The committee is examining only those recommendations that are in its terms of reference. The Queensland Government has tabled its response to approximately half of the QLRC recommendations in the Parliament, and indicated that the remaining QLRC recommendations will involve further discussion with stakeholders before a final response in 2012.¹

Most of the QLRC recommendations that the committee is considering relate to advance health decisions by adults who later have impaired capacity, or decisions by a substitute decision maker on behalf of an adult with impaired capacity. The committee's terms of reference do not include health care decisions in relation to children.

Some of the QLRC recommendations which the committee is examining relate to advance health decisions about end-of-life health care. Decisions which are lawful under the guardianship legislation and under common law are not decisions about euthanasia. Section 238 of the GAA Act explicitly provides that the Act does not authorise, justify or excuse killing a person.

1.4 National policy framework

A National Framework for Advance Care Directives (the National Framework) was published by the Australian Health Ministers' Advisory Council in September 2011. It states that Australia's Health Ministers recognise the need for a standardised national format for advance directives. The framework includes best practice standards for policy and legislation about advance care directives and substitute decision making.² Those standards are noted where relevant in the discussion of the QLRC recommendations in this paper.

The National Framework recognises that:

- under common law the terms of an advance directive must be respected whether or not the person was medically informed of the consequences
- an adult (or substitute decision maker) can consent to treatment options that are offered, but cannot demand treatment that is not medically indicated
- there is a need to protect health providers from civil and criminal liability if they abide by the terms of an advance directive that they believe, in good faith, to be valid
- voluntary euthanasia and physician-assisted suicide are illegal in Australia.³

¹ *Queensland Government initial response to the Queensland Law Reform Commission's Report: A Review of Queensland's Guardianship Laws*, tabled in the Legislative Assembly 11 October 2011, at <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2011/5311T5556.pdf>.

² The Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives*, September 2011, at http://www.ahmac.gov.au/cms_documents/AdvanceCareDirectives2011.pdf.

³ *ibid*, National Framework, p.7.

1.5 Health care decisions when an adult is unable to make their own decisions

Many people are concerned about the potential to lose capacity to make decisions about their health care, and wish to make their decisions clear. This may be done through an advance health directive or appointing an attorney to make decisions on their behalf under guardianship legislation, or by making their wishes clear in some other way, eg. to family.

People are also concerned that, if they lose capacity to make decisions, they will be given health care which they do not want. “Often when people complete (advance directives) they are not seeking to control medical treatment decisions, but hoping to live well and die with dignity in accordance with their personal values.”⁴ Decisions about health care for adults whose capacity is impaired often raise sensitive and complex ethical, legal and clinical issues.

The GAA Act and the POA Act provide the legislative framework for decision making for adults whose capacity is impaired. Health decisions may also be made outside the legislative framework, and the effectiveness of those common law directions is one of the issues discussed in this paper.

⁴ *ibid*, p 1.

1.6 Glossary

Some key terms in the guardianship laws are:

advance health directive	A document in which an adult may give directions about their future health care (including directions to withhold or withdraw life-sustaining measures) and may appoint an attorney/s to make decisions on their behalf if the directions are inadequate.
capacity	Under the guardianship laws, capacity means the adult is capable of <ul style="list-style-type: none"> • understanding the nature and effect of decisions about a matter, and • freely and voluntarily making decisions about the matter, and • communicating the decisions in some way.
enduring document	An enduring power of attorney or an advance health directive.
guardianship laws	The <i>Guardianship and Administration Act 2001</i> and the <i>Powers of Attorney Act 1998</i> are referred to in this paper and the QLRC Report as the ‘guardianship laws’.
good medical practice	Practice for the medical profession in Australia having regard to: <ul style="list-style-type: none"> • the recognised medical standards, practices and procedures of the medical profession in Australia; and • the recognised ethical standards of the medical profession in Australia.
health care	Care or treatment of, or a service or a procedure to diagnose, maintain, or treat the adult’s physical or mental condition that is carried out by, or under the direction or supervision of, a health provider. Health care includes withholding or withdrawal of a life-sustaining measure if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice. It does not include first aid treatment, a non-intrusive examination made for diagnostic purposes (eg visual examination of the mouth and throat) or the administration of a non-prescription pharmaceutical drug that is normally self-administered and it is given for the recommended purpose at recommended dosage.
health matter	A matter relating to health care, other than special health care, of an adult.
health provider	A person who provides health care, or special health care, in the practice of a profession or the ordinary course of business.
life-sustaining measure	Health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation. It includes, but is not limited to: cardiopulmonary resuscitation, assisted ventilation and artificial nutrition and hydration. A blood transfusion is not a life-sustaining measure.
National Framework	<i>A National Framework for Advance Care Directives</i> , Australian Health Ministers’ Advisory Council, September 2011.
special health care	Removal of tissue for donation while the adult is alive, sterilisation, termination of a pregnancy, participation in research, ECT or psychosurgery or other prescribed health care.
substitute decision maker	An appointed guardian, an attorney appointed under an enduring document, or a statutory health attorney (first available, and culturally appropriate of spouse, adult who cares for the person and is not paid, adult who is a close relative or friend and is not a paid carer).
Tribunal	Queensland Civil and Administrative Tribunal.

2 Advance health directives

2.1 Advance health directives

Advance health directives provide direction about the future health care of individuals before they lose capacity to make health care choices. They are a mechanism for an adult to plan ahead about their health care, including making directions about any medical interventions that the adult does not want given if they lose capacity. An advance health directive only comes into effect if an adult has impaired capacity and is unable to make their own decisions (e.g. when unconscious or as a result of brain injury or dementia).

The POA Act provides that an advance health directive can:

- give directions about health matters and special health matters for future health care
- appoint one or more eligible attorneys to exercise power for a health matter in the event that directions prove inadequate
- provide terms or information about exercising the attorney's power
- direct that a life-sustaining measure be withheld or withdrawn
- authorise the physical restraint, movement or management of the individual.⁵

2.2 When an advance health directive can not operate

2.2.1 QLRC recommendation 9(3)(b)

The QLRC recommends that the POA Act should be clarified to provide that a direction will not operate if it is uncertain, or if circumstances have changed.

2.2.2 Current law

Section 36 of the POA Act provides for circumstances when an advance health directive operates and can not operate. Section 36(1) provides that an advance health directive operates only when the adult's capacity is impaired, and is as effective as if the adult gave the direction when decisions needed to be made and the adult then had capacity to make decisions.

2.2.3 Clarification of when an advance health directive can not operate

Elsewhere in the POA Act, a health provider is protected from liability if he or she does not follow an advance health directive because a direction is uncertain, or circumstances have changed (s.103). The QLRC considers that similar criteria should be added to s.36 to provide that a direction in an advance health directive will not operate:

- when it is uncertain, or
- if circumstances (such as advances in medical science) have changed, and that if the patient had known about the changes they would have thought their advance health directive was inappropriate.

Issues for comment

- Should the POA Act be amended to clearly state that an advance health directive can not operate if the directive is uncertain or if circumstances have changed to the extent that, had the patient known of the changed circumstances they would think the advance health directive was inappropriate?

⁵ *Powers of Attorney Act 1998*, s 35.

2.3 Ensuring that health providers are aware of advance health directives and enduring powers of attorney

2.3.1 QLRC recommendation 9.11

The QLRC recommended changes to the GAA Act to place an obligation on hospitals and residential aged care and residential disability facilities to help ensure that health providers are aware of advance health directives or enduring powers of attorney for health matters.

2.3.2 Health providers' awareness of advance health directives and enduring powers of attorney

Advance health directives and enduring documents that appoint an attorney for health decisions need to be readily accessible to be fully effective. A directive that is carefully filed but not brought to the attention of health providers or the person who is appointed as an attorney for health matters is of limited practical effect.

The QLRC considered the difficulty of alerting health providers to patients' existing advance health directives. The possible use of a register was examined and rejected. The QLRC concluded that a future nationally consistent electronic health records system could enable advance health directives to be scanned and stored electronically with other health records. This would mean they may come to the attention of health providers in a more obvious and consistent way.

A variety of mechanisms have been implemented to improve health providers' access to advance health directives. They include fridge magnets to alert ambulance officers and others to advance health directives, a "yellow envelope" with health information (and an advance health directive if relevant) about aged care residents when they attend health facilities, and prominently marked sleeves to store an advance health directive in patient files.

The National Framework suggests that a variety of mechanisms be used to record that an advance directive exists so it can be accessed when needed. It notes that recording advance health directives on electronic health records, and including a copy in a coloured sleeve in medical files, is more reliable than registers.⁶

2.3.3 Proposed obligation to ask about advance health directive and inform health providers

The QLRC proposes that the person in charge of a hospital, a residential aged care or residential disability service be required to take reasonable steps to ensure that patients and residents are asked whether they have an advance health directive or enduring power of attorney for health matters. If an enduring document exists, it should be brought to the attention of health providers. The QLRC also recommends a related obligation to advise health providers if the person in charge or others become aware that an enduring document is made, changed or revoked.

Issues for comment

- Would the proposed obligation on health and disability services improve health providers' access to and awareness of advance health directives and enduring powers of attorney?
- What impact would the proposal have on hospitals, residential aged care and residential disability facilities and health providers?

⁶ National Framework, p 35.

2.4 Protection of health providers for non-compliance with an advance health directive

2.4.1 QLRC recommendation 9.18

The QLRC recommends amendments to reinforce the effectiveness of a direction in an advance health directive. The amendments would limit the circumstances in which a health provider could legitimately ignore a direction in an advance health directive. The most significant part of the recommendation is to omit the current protection for a health provider who ignores a valid direction because of their belief that it is inconsistent with good medical practice.

2.4.2 Current law

The POA Act (s.103) currently allows a health provider to avoid liability for not following a valid advance health directive in three situations:

- the direction is uncertain (a health provider has reasonable grounds to believe that a direction is uncertain only if he or she has consulted with any attorney who is appointed under an advance health directive)
- the circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate
- the health provider believes the advance health directive is inconsistent with good medical practice.

2.4.3 Direction uncertain

The POA Act currently requires that health providers consult with an attorney appointed under an advance health directive if the health provider believes that a direction in an advance health directive is uncertain. The QLRC considers that the same consultation requirement should also apply to an attorney appointed under an enduring power of attorney.

2.4.4 Directive inconsistent with good medical practice

The reference to 'good medical practice' was not included in the original POA Bill 1997, rather it was an amendment proposed in the Legislative Assembly. The amendment was proposed because of concern that the Bill would have required health providers to *provide* health care that is inconsistent with good medical practice. No other Australian jurisdiction protects a health provider from liability if they do not comply with a valid advance health directive because it is considered to be inconsistent with good medical practice.

The QLRC considers the current law to be inconsistent with respecting a person's autonomous choice and seriously undermines the right to self-determination.⁷ It received evidence which identified that s.103 of the POA Act gives health providers "...greater scope not to act in accordance with an adult's directions than would be the case at common law".⁸ The QLRC also received evidence expressing the view that the discretion afforded to health providers about whether or not they should act in accordance with an advance health directive, may be desirable.⁹

Currently, health care can be given despite an adult's express refusal in an advance health directive, if the health provider believes that the advance health directive is inconsistent with good medical practice. The protection in s.103 raises a fundamental question about the operation of advance health directives. Their purpose and value is to record an adult's choices and directions about health care, including refusing health care, however directions can be ignored on the basis of a health provider's belief that it is inconsistent with good medical practice. This defence for non-compliance with an advance direction has not been recognised at common law.¹⁰

⁷ QLRC *A Review of Queensland's Guardianship Laws*, (QLRC report) Vol 2 p 77.

⁸ QLRC report, Vol 2 p 74.

⁹ QLRC report, Vol 2 p 75.

¹⁰ White, B & Willmott, L, *Rethinking Life-Sustaining Measures: Questions for Queensland*, 2005 p 46.

2.4.5 Changed circumstances

The QLRC considers that it is appropriate for a health provider to be protected if circumstances have changed to the extent that the terms of a direction are inappropriate. However, it recommends that the changed circumstances should be viewed from the adult's perspective rather than the health provider's. It therefore recommends that the protection for health providers apply if circumstances have changed to the extent that *if the adult had known about the change in circumstances, they would have considered* the advance health directive inappropriate.¹¹

2.4.6 Summary of QLRC recommendation

The QLRC recommends changes to the protection for a health provider who does not follow a valid advance health directive to:

- provide that a health provider must consult with any attorney appointed for health matters under an enduring power of attorney before forming a belief that a direction is uncertain (this would be consistent with the current provision about consultation with an attorney appointed under an advance health directive)
- make changed circumstances a valid reason for non-compliance with an advance health directive only if the adult would have considered their advance health directive inappropriate had they known of the changed circumstances
- omit the current protection for a health provider who does not comply with an advance health directive because he or she considers it inconsistent with good medical practice.

Issues for comment

- Should a health provider be required to consult with an attorney appointed under an enduring power of attorney before forming a reasonable belief that a direction in an advance health directive is uncertain (consistent with the current legislation, to consult with an attorney appointed under an advance health directive)?
- Should the protection for a health provider who does not follow a direction in an advance health directive because of changed circumstances be modified so that it is a valid reason only if the adult would have thought their direction to be inappropriate if they had known of the change in circumstances?
- Should the protection for a health provider who does not follow a direction in an advance health directive because he or she believes it is inconsistent with good medical practice be omitted?

¹¹ QLRC Report, Vol 2, p 87.

3 Common law right to consent or refuse treatment - impact of the guardianship legislation

3.1 QLRC recommendations 9.26, 9.27 and 9.28

The QLRC recommends amendments to the POA Act and the GAA Act to ensure that an adult's common law rights to exercise control of their future health care are clear. It notes that the continued operation of common law rights was originally intended and reflected in s.39 of the POA Act. However some doubt has arisen about the effect of the guardianship legislation on common law decisions. The QLRC therefore recommends adding provisions to both Acts to clarify that nothing in the Act affects the operation at common law of an adult's consent to, or refusal of, health care given at a time when the adult had capacity to make decisions about the matter.

3.2 Common law consent or refusal of health care

A patient's consent to health care is generally required at common law. In addition, the common law recognises that an adult with capacity may refuse health care, even if the refusal may lead to the adult's death. A common law 'advance directive' is one made other than under legislation such as the POA Act. The common law does not place limits on when a direction about health care can operate. Provided the adult had capacity at the time they made a direction about health care, a common law direction is likely to be valid consent or refusal of health care. The effect of a common law directive to refuse health care was summarised in *Hunter and New England Area Health Service v A*.¹²

*A person may make an 'advance care directive': a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive.*¹³

Advance care planning and directions about health care are often made in discussion with health providers and family, and are not necessarily formalised in a statutory advance health directive. The QLRC considers it important that the law should reflect actual practice, and that the guardianship legislation does not affect what would otherwise be recognised at common law as effective consent to, or refusal of health care.¹⁴

The National Framework also recommends that legislation regulating advance directives should preserve the common law.¹⁵

Issues for comment

- Should the guardianship legislation be amended to ensure that common law rights to consent to or refuse health care are not affected by the legislation?

¹² [2009] NSWSC 761 at paragraph 40.

¹³ 'battery' – in effect, a physical assault.

¹⁴ QLRC Report Vol 2, pp 106-7.

¹⁵ National Framework, p.25.

4 Decisions to withhold or withdraw a life-sustaining measure

4.1 Overview of QLRC recommendations about withholding or withdrawing a life-sustaining measure

The QLRC made 16 recommendations about withholding or withdrawing life-sustaining measures, 12 of which are in the committee's terms of reference. Most of the QLRC recommendations are to remove limitations on the operation of advance decisions by a competent adult or on decisions made on their behalf by a substitute decision maker. Those recommendations are underpinned by recognition of a competent adult's autonomy to make health care choices that will continue to be respected if the adult's decision making capacity is later impaired. The National Framework also emphasises respect for an adult's autonomy and entitlement to make decisions about personal and health matters.¹⁶

The QLRC recommendations which the committee is examining would:

- amend the definition of *health care* to remove a limitations on the operation of an advance health directive or on a substitute decision maker's consent to withhold or withdraw a life-sustaining measure
- amend the definition of *life-sustaining measure* so that it no longer excludes blood transfusions
- remove limitations (in s.36(2) of the POA Act) on the circumstances when an advance health directive to withhold or withdraw a life-sustaining measure can operate
- remove limitations (in s.66A of the GAA Act) on the circumstances when a substitute decision maker's consent to withholding or withdrawing a life-sustaining measure can operate (majority recommendation)
- provide a process to resolve differences in view between a health provider and a substitute decision maker about consent to withholding or withdrawing a life-sustaining measure (minority recommendation)
- allow a medically futile life-sustaining measure to be withheld without consent (majority recommendation)
- allow a medically futile life-sustaining measure to be either withheld or withdrawn without consent (minority recommendation)
- clarify that a health provider who withholds or withdraws a life-sustaining measure in accordance with the legislation is not criminally liable, and retain provisions that the legislation does not authorise euthanasia.

4.2 When decisions to withhold or withdraw a life-sustaining measure are made

The circumstances in which decisions to withhold or withdraw a life-sustaining measure are made are diverse. For example:

- a 40 year old woman with terminal cancer decides that, if she contracts an infection, she does not want antibiotics or other life-sustaining measures
- a 64 year old man decides soon after diagnosis with dementia, and while he has capacity to make decisions, that he does not want any treatment other than palliative care once he does not have capacity to make decisions about health care
- a middle aged woman with chronic heart disease, diabetes, emphysema and progressive renal failure decides that, if she has another cardiac arrest, she does not want to be resuscitated
- a young man suffers catastrophic head injuries in a car accident and after initial treatment and artificial ventilation is pronounced brain dead; after consultation with health providers his family decide that artificial ventilation should be stopped

¹⁶ National Framework, p.14 ff.

4.3 Definition of *health care*

4.3.1 QLRC recommendation 11.1

The QLRC recommends omitting from the definition of *health care* the reference to commencement or continuation of a life-sustaining measure. The relevant part of the definition of *health care* is below.¹⁷ The QLRC recommends omitting the words underlined below.

5 Health care

- (1) **Health care**, of an adult, is care or treatment of, or a service or a procedure for, the adult—
 - (a) to diagnose, maintain, or treat the adult's physical or mental condition; and
 - (b) carried out by, or under the direction or supervision of, a health provider.
- (2) **Health care**, of an adult, includes withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.

[NB: subsection (3) of the definition is not reproduced here]

4.3.2 Why amend the definition of *health care*?

The QLRC considers that it is inappropriate to impose a limitation on the operation of directions in an advance health directive or a decision of a substitute decision maker in a statutory definition.¹⁸ The limitations on the operation of directions or decisions that the QLRC identifies are that:

- while a substitute decision maker may exercise powers for a health matter, they may consent to the withholding or withdrawing of a life-sustaining measure only if the commencement or continuation of the measure would be inconsistent with good medical practice
- a direction in an advance health directive to withhold or withdraw a life-sustaining measure will be an effective direction only if commencing or continuing the measure would be inconsistent with good medical practice. If it would not be inconsistent with good medical practice to commence or continue the measure, the withholding or withdrawing of it will not be *health care* and therefore not a matter on which an advance health directive can give a direction.¹⁹

The QLRC considers that locating these limitations in a definition, separated from other more obvious limitations on withholding or withdrawing of a life-sustaining measure, makes the legislation more difficult for users. Users of the legislation need to be easily able to identify limitations on decisions to identify the validity of a direction in an advance health directive, or consent by a substitute decision maker.²⁰

In addition the QLRC states that the definition has a significant impact on the offence in s.79 of the GAA Act. Section 79 provides that it is an offence to carry out health care on an adult with impaired capacity unless it has been authorised or consented to in a way specified in the section.²¹ Because the offence in s.79 applies to *health care* as defined in the Act, it does not apply to the withholding or withdrawing of a life-sustaining measure where it would not be inconsistent with good medical practice to commence or continue the measure. “As a result, if a health provider withheld or withdrew a life-sustaining measure without authorisation or consent and the commencement or continuation of the measure would not be inconsistent with good medical practice, the health provider would not commit an offence under section 79.”²²

¹⁷ See Schedule 2 of both the GAA Act and the POA Act.

¹⁸ QLRC Report, Vol 2, p 175.

¹⁹ QLRC Report, Vol 2, p 173.

²⁰ *ibid*, Vol 2, p 174.

²¹ The QLRC recommendation about s.79 is discussed below.

²² QLRC Report, Vol 2, p.175.

Issues for comment

- Should any limitations on the effect of decisions about health care be more clearly stated in the body of the Act, rather than in a definition?
- Should it be an offence to withhold or withdraw a life-sustaining measure without consent or authorisation when continuation or commencement of the life-sustaining measure would not be inconsistent with good medical practice?

4.4 Definition of *life-sustaining measure*

4.4.1 QLRC recommendation 11.2

The QLRC recommends omitting from the definition of *life-sustaining measure* the current exclusion of blood transfusions.

4.4.2 Current law

The current definition of a *life-sustaining measure* excludes blood transfusions. The policy reasons for excluding it were not described in the Explanatory Notes or the second reading speech when the POA Bill was introduced in the Parliament in 1997. The QLRC assumes that blood transfusions are excluded from the definition because the limitations in the guardianship laws on the operation of a direction to withhold or withdraw a life-sustaining measure are considered to be too restrictive to apply to refusal of a blood transfusion.²³

4.4.3 Why remove the exclusion of blood transfusions from the definition of a *life-sustaining measure*?

The QLRC considers that the legislation about a direction to refuse a blood transfusion should be transparent, and included in the body of the legislation rather than in a definition.²⁴ The QLRC has therefore recommended that the provision which excludes blood transfusions from the definition of a *life-sustaining measure* should be omitted, with the result that a blood transfusion would be a *life-sustaining measure*.

While the guardianship legislation does not place limits on an adult's advance health directive to refuse a blood transfusion, the legislation limits the circumstances in which an adult can use an advance health directive to refuse other measures designed to sustain life. (QLRC recommendation 11.3, outlined below, also deals with limits on the operation of an advance direction.)

4.5 Direction in advance health directive to withhold or withdraw a life-sustaining measure

4.5.1 QLRC recommendation 11.3

The QLRC recommended that the limitations on when a direction to withhold or withdraw a life-sustaining measure can operate (s.36(2), POA Act) should be removed. The QLRC considered the current limitations to be inconsistent with an adult's autonomy.

²³ The limitations on operation of an advance health directive, particularly s.36 of the POA Act are discussed further below in relation to QLRC recommendation 11.3.

²⁴ QLRC Report, Vol 2, p 178.

4.5.2 Current law

Section 36(2) of the POA Act limits the circumstances in which a direction in an advance health directive to withhold or withdraw life-sustaining measure can operate. A direction can not operate unless the adult is in one of the following categories:

- has a terminal condition and the treating doctor and another doctor consider the patient may reasonably be expected to die within one year
- is in a persistent vegetative state, with severe and irreversible brain damage which allows some bodily functions to continue, e.g. breathing
- is permanently unconscious (in a coma) with brain damage so severe that there is no reasonable prospect of regaining consciousness, or
- there is no reasonable prospect of recovery to the extent that life can be sustained without continued life-sustaining measures.

In addition, if the direction in an advance health directive is to withhold or withdraw artificial hydration or nutrition, it can not operate unless:

- the commencement or continuation of artificial hydration or nutrition would be inconsistent with good medical practice; and
- the adult has no reasonable prospect of regaining capacity for health matters.

4.5.3 Why remove the limitations on when a direction or decision can operate?

The QLRC considered the requirement that a direction to withhold or withdraw a life-sustaining measure can not operate unless the patient is one of the four conditions above is “an unjustified limitation on the autonomy of an adult and should be omitted.”²⁵

There may be circumstances where none of these four patient conditions applies, yet the adult does not want any life-sustaining measures. A competent adult patient may, at common law, refuse health care that is offered, even if refusal may result in the patient’s death. In a submission to the QLRC the then Adult Guardian commented that it is inconsistent that a person who has capacity can refuse a life-sustaining measure regardless of the circumstances, but once they lose capacity (e.g. become unconsciousness) and if they rely on an advance health directive, their refusal only operates if one of the conditions in s.36(2) applies.²⁶

The QLRC considers that the limits on when a life-sustaining measure can be effectively refused fail to recognise the importance of self-determination and choice made by an adult at a time when they had capacity to decide.

The QLRC considered the importance of safeguards to prevent the risk that an advance health directive may operate in (irreversible) circumstances that were not contemplated when the adult made the directive, or risks such as a directive being made by a vulnerable adult under pressure. It concluded that it was desirable to implement other safeguards that respond more directly to the risks, and which do not conflict with an adult’s autonomy to make decisions. The QLRC made recommendations (only one is within the committee’s terms of reference) to:

- tighten the test for capacity to make an advance health directive (s.42, POA)
- require an approved form for advance health directives that encourages consideration of unforeseen circumstances
- stipulate that a direction would not operate if the direction is uncertain, or circumstances have changed to the extent that the adult would have considered the direction inappropriate (recommendation 9.3(b) above)

²⁵ *ibid*, p 190.

²⁶ *ibid*, pp 186-187.

- enable the Supreme Court and the Tribunal to decide whether a direction in an advance health directive is operative and make a declaration to that effect.²⁷

4.6 Withholding or withdrawing artificial nutrition or hydration

4.6.1 Artificial nutrition and artificial hydration

The potential need for artificial nutrition or hydration may arise when an adult has difficulty swallowing. Artificial nutrition may be provided through a nasogastric tube or a gastrostomy tube into the stomach through the abdominal wall (a PEG – percutaneous endoscopic gastrostomy). Artificial hydration is commonly provided by intravenous infusion.

4.6.2 Current law

As noted above, the guardianship legislation places additional limitations on whether a direction in an advance health directive to withhold or withdraw artificial nutrition or hydration can operate. A direction can not operate unless the health provider considers that to commence or continue artificial hydration or nutrition would be inconsistent with good medical practice, and the adult has no reasonable prospect of regaining capacity.

A direction in an advance health directive to withhold or withdraw any other life-sustaining measure (for example, artificial ventilation) is not limited in the same way as a direction about withholding or withdrawing artificial nutrition or hydration.

4.6.3 Should the limits on a decision to withhold or withdraw artificial nutrition or hydration be different from the limits on other life-sustaining measures?

In the leading Australian case on withholding or withdrawing artificial nutrition or hydration, Morris J agreed with this analysis by Margaret Somerville of the ethics of a decision to withhold or withdraw artificial nutrition or hydration:²⁸

One such request by patients that healthcare professionals and families often find difficult to respect – and which some people vehemently oppose implementing – is that to withdraw artificial hydration and nutrition when a person’s life is dependent on them. Images of a person dying of dehydration and starvation come to mind. This situation can be viewed differently, however, if we think of a terminally ill person as suffering from a failed alimentary system and the withdrawal of artificial hydration and nutrition as withdrawal of artificial alimentary system support. In short, respecting a refusal of [artificial nutrition and hydration] is no different from accepting a person’s refusal of respiratory support for a failed respiratory system. We have tended to see these situations differently because of values and symbolism attached to the provision of food and drink for those in our care, We have wrongly equated artificial hydration and nutrition (a medical life-support treatment) with natural food and drink and, thereby, have mistakenly equated the withholding of them. I hasten to add that I am not suggesting we are always justified in withholding or withdrawing artificial hydration and nutrition. Rather, the basis on which this decision should be made is the ethics of the withholding or withdrawing of artificial life-support treatment, not that of food and water.²⁹

The QLRC considered the case law and the submissions it received. It considered that there is no justification for the guardianship legislation to treat artificial nutrition and hydration differently to other life-sustaining measures.³⁰

²⁷ *ibid*, pp 189-190.

²⁸ Morris J, in *Re BWV; Ex parte Gardner* (2003) 7 VR 506, cited in QLRC Report Vol 2, pp 191-2.

²⁹ Somerville, M *The Ethical Canary, Science, Society and the Human Spirit* (2000) 163, cited in QLRC Report vol 2, p 191-2.

³⁰ QLRC Report, Vol 2, p194.

Issues for comment

- Should the limitations on when a direction in an advance health directive to withhold or withdraw a life-sustaining measure can operate be omitted?
- Should the limitations on a direction to withhold or withdraw artificial nutrition or hydration be treated differently to other life-sustaining measures?

4.7 Consent to withholding or withdrawing a life-sustaining measure by a substitute decision maker

4.7.1 QLRC recommendations 11.4, 11.5 and 11.6

A majority of the QLRC recommends that the limitation which applies to a substitute decision maker's decision to withhold or withdraw a life-sustaining measure should be removed. This recommendation is related to recommendation 11.1 about the definition of *health care*, and part of recommendation 11.3 above about a decision in an advance health directive to withhold or withdraw a life-sustaining measure. A minority of the QLRC recommended that instead the law be amended to create a mechanism to resolve different views by a substitute decision maker and a health provider.

4.7.2 Current law

Section 66A of the GAA Act limits the circumstances when consent by a substitute decision maker to withholding or withdrawing a life-sustaining measure can operate. A substitute decision maker's consent can not operate unless the adult's health provider reasonably considers the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.

4.7.3 Inconsistent with good medical practice

The definition of good medical practice is summarised in the glossary, and refers to recognised Australian medical and ethical standards. The QLRC notes that the parliament has no control over 'recognised medical standards' in Australia, and if standards and ethics change over time, different practices may result, which nevertheless comply with the Act. It may also be difficult to determine what constitutes good medical practice, due to the lack of comprehensive recognised medical standards for withholding or withdrawing a life-sustaining measure.³¹

For a substitute decision maker's consent to withholding or withdrawing a life-sustaining measure to be effective, the health provider must be reasonably satisfied that to commence or continue the measure would be *inconsistent* with good medical practice. The QLRC report quotes the former tribunal's explanation of the test of inconsistency with good medical practice in *Re HG*:

*This test will not be satisfied just because the withholding or withdrawing of the measure is consistent with good medical practice. More must be demonstrated. There must be evidence that the provision of the measure is inconsistent with good medical practice. Therefore, if there was evidence that there were two medically and ethically acceptable treatment options, one being the provision of the measure, the test in the legislation is not satisfied and consent could not be given to the withholding or withdrawing of the measure.*³²

The QLRC notes the serious nature of a decision to withhold or withdraw a life-sustaining measure. It assumes that the limitations on consent in s.66A are intended as a safeguard against inappropriate decision making about end of life care. However it suggests the current law can result in a stalemate where the substitute decision maker considers that a life-sustaining measure should be withheld or

³¹ QLRC Report, Vol 2, p 206.

³² [2006] QGAAT 26, cited in QLRC Report Vol 2, p 205.

withdrawn and the health provider does not consider that commencement or continuation of the measure would be *inconsistent* with good medical practice (using the test described above).³³

4.7.4 Differing views on whether a life-sustaining measure should be withheld or withdrawn

Where there are differing views on whether a life-sustaining measure should be withheld or withdrawn, or commenced or continued, the QLRC suggests the issue is how best to achieve two goals:

- that an adult is not deprived of life-sustaining measures because of poor decision making, and
- that an adult is not subjected to life-sustaining measures in a way that is inconsistent with the principles in the legislation.

4.7.5 Safeguard that adult guardian may make decision – majority QLRC recommendation

The majority of the QLRC consider that the adult guardian's existing powers to make decisions if a substitute decision maker refuses to make a decision, or makes a decision that is contrary to the health care principle (in s.43, GAA Act) are adequate to protect adults with impaired capacity against decisions that are contrary to the health care principle. The QLRC nevertheless agrees that it is desirable to include a specific provision to draw the adult guardian's powers to the attention of health providers. Given the view that s.43 provides adequate safeguards, the majority of the QLRC recommend that s.66A should be omitted (QLRC recommendation 11.4).

To highlight the adult guardian's powers to make a decision, the QLRC recommends a new provision to enable a health provider, the person in charge of a health facility or an interested person to inform the adult guardian if a substitute decision maker refuses to make a decision, or if a decision is made that is believed to be inconsistent with the health care principle. The proposed provision would apply to any decision about a health matter (QLRC recommendation 11.5).

4.7.6 Safeguard – legislation to specify process to refer to the adult guardian or for substitute decision maker consent to apply - QLRC minority recommendation

One member of the QLRC did not support this recommendation to omit s.66A. Instead the minority recommendation is that the legislation set out a process for circumstances when the health provider and the substitute decision maker have different views about consent to withholding or withdrawing a life-sustaining measure. It proposes that if the substitute decision maker's consent does not operate under s.66A, then the health provider or the adult guardian should refer the decision to the adult guardian within two days. If the referral is not made, the substitute decision maker's consent would be effective. If the adult guardian is the guardian for the person, they would be required to apply to the Tribunal for a declaration that the withholding or withdrawing of the life-sustaining measure is a valid exercise of power.

Issues for comment

- Should the limitations on operation of a substitute decision maker's consent to withhold or withdraw a life-sustaining measure be omitted?
- Alternatively, if a substitute decision maker's consent can not operate under s.66A of the GAA Act, should the legislation allow the health provider to refer the decision to the adult guardian to make a decision (if the adult guardian is the guardian for the adult, for the Tribunal to make a decision)?

³³ QLRC Report, Vol 2, p 211.

4.8 Consent to withhold or withdraw a life-sustaining measure that is medically futile

4.8.1 QLRC recommendations 11.7 and 11.8

The QLRC considers that generally consent should be required both to withhold and to withdraw a life-sustaining measure. It recognises some difficulty with requiring consent to withhold a futile life-sustaining measure. The majority of the QLRC recommends that consent should not be required to withhold a life-sustaining measure that is medically futile.

It recommends amendment of the guardianship legislation so that “withholding a life-sustaining measure” does *not* include commencing a life-sustaining measure if the health provider reasonably considers that commencing the measure would not be consistent with good medical practice (QLRC recommendation 11.7).

A minority recommendation proposes withholding or withdrawing a life-sustaining measure should not be treated differently in the legislation, and that consent should not be required to withdraw a medically futile life-sustaining measure that has been commenced. The recommendation proposes that “the withdrawal of a life-sustaining measure” does *not* include the discontinuing of a life-sustaining measure if the health provider reasonably considers that continuing the measure would not be consistent with good medical practice.

4.8.2 Current law

Section 79 of the GAA Act makes it an offence to carry out health care of an adult with impaired capacity unless:

- the GAA Act or another Act allows it without consent
- consent is given under the GAA Act or another Act
- it is authorised by the Supreme Court.

At common law, a medical practitioner is not required to seek consent to not provide (i.e. to withhold) treatment that is not considered clinically appropriate. A competent patient is not entitled to insist on the provision of treatment that is not offered. The QLRC notes that there is a tension between the consent requirements in the GAA Act and the common law.

The QLRC notes that because *health care* includes withholding or withdrawing a life-sustaining measure, it appears that unless the withholding or withdrawing of a life-sustaining measure is authorised, s.79 requires consent. If a substitute decision maker is not willing to consent to the withholding or withdrawing of a life-sustaining measure that is futile, or has become futile, it appears that the current law may enable a substitute decision maker to effectively insist on commencement or continuation of a life-sustaining measure, even though it may be medically futile. It would require a decision of the adult guardian, the Tribunal or the Supreme Court to resolve.³⁴

It appears that the current law may require a health provider to explain medically futile life-sustaining measures to a substitute decision maker, in order to obtain their consent to withhold those measures. One submission to the QLRC suggested that consent should not be required to not do something that is “not deemed good medical practice, not clinically indicated, and not in the patient’s interests”.³⁵

4.8.3 Should consent be required to withhold a medically futile life-sustaining measure?

The QLRC considers that consent should not be required with withhold (not offer) a life-sustaining measure that is medically futile. To require information about a life-sustaining measure to be given to the adult’s substitute decision maker so that their consent could be obtained to withhold the

³⁴ QLRC Report, Vol 2 pp223-4.

³⁵ *ibid* Vol 2, p.237.

measure would suggest to a patient's family that there is valid choice of treatment to be made, when this is not the case.³⁶

4.8.4 Should consent be required to withdraw a medically futile life-sustaining measure? QLRC majority recommendation

A majority of the QLRC considers that it should not be possible for a health provider to withdraw a futile life-sustaining measure without consent. They consider it creates too great a risk that a health provider may incorrectly form the view that the life-sustaining measure is futile and withdraw it without the opportunity to test that view.

Consent should be required from the substitute decision maker, the adult guardian or the Tribunal. If the substitute decision maker refuses to make a decision or makes a decision that is contrary to the health care principle, the QLRC has recommended referral to the adult guardian. If the adult guardian does not consider that the substitute decision maker is acting contrary to the health care principle in not consenting to withdrawal of the measure, the health provider may apply to the Tribunal for its consent to withdraw the life-sustaining measure.

4.8.5 Should consent be required to withdraw a medically futile life-sustaining measure? QLRC minority recommendation

One QLRC member did not consider there was justification for treating the withholding and withdrawing of life-sustaining measures differently, and that consent should not be required to withdraw a futile life-sustaining measure. The minority argument includes:

- that any duty to provide health care should depend on the nature of the health care and the circumstances of the adult, not on whether the health care has initially been provided or not provided at all.
- to distinguish between the withholding and the withdrawing of life-sustaining measures is inconsistent with the common law and the position in other jurisdictions.

Issues for comment

- Should consent be required to withhold (not commence) a medically futile life-sustaining measure?
- Should consent be required to withdraw a medically futile life-sustaining measure that has been commenced?

4.9 Consent to withholding or withdrawing a life-sustaining measure if the adult has previously objected

4.9.1 QLRC Recommendations 11.9 and 11.10

The QLRC recommends excluding 'withholding or withdrawing a life-sustaining measure' from the definition of *health care* for the purpose of s.67 of the GAA Act, regarding the effect of an adult's objection on a substitute decision maker's consent to withhold or withdraw a life-sustaining measure (Recommendation 11.9). The QLRC considers that this would restore s.67 to its original purpose.³⁷

The QLRC also recommends enabling the adult guardian to give consent to withholding or withdrawing a life-sustaining measure where the health provider knows that the adult objects, rather than the substitute decision maker giving consent. (Recommendation 11.10)

³⁶ *ibid*, p.237.

³⁷ QLRC Report, Vol 2, p249.

4.9.2 Current law – objection to withholding or withdrawing of life-sustaining measure in non-urgent circumstances

Section 67 of the GAA Act states the effect of an adult's advance objection to *health care* when a decision is made by a substitute decision maker.³⁸ In circumstances other than an emergency, a substitute decision maker's consent to withholding or withdrawing a life-sustaining measure or the commencement or continuation of a life-sustaining measure is not effective if the health provider knows that the adult objects to the health care.

However, under s.67 (2) the substitute decision maker's consent will prevail over an adult's objection to health care if:

- the adult has no or minimal understanding of what the health care involves or why it is required; and
- the health care is likely to cause the adult no distress or only temporary distress that is outweighed by the benefit to the adult.

Under common law, an adult may object to health care while he or she has capacity. Because *health care* is defined to include withholding or withdrawing a life-sustaining measure, an objection to health care could be an objection to the commencement or continuation of a life-sustaining measure, or to the withholding or withdrawing of a life-sustaining measure.

The requirements in s.67(2) did not apply to the withholding or withdrawing of life-sustaining measure when the GAA Act was originally enacted. They came about as a result of an amendment in 2002 which extended the definition of *health care* to include the withholding or withdrawing of a life-sustaining measure.

4.9.3 What effect should an adult's prior objection to withholding or withdrawing a life-sustaining measure have on substitute decision maker consent?

The QLRC considers that the requirements in s.67(2) are appropriate to consent to the provision of health care, so that consent by a substitute decision maker is not effective if the health provider knows that the adult objects to the health care. However, the QLRC does not consider this to be appropriate for a decision about the withholding or withdrawing of a life-sustaining measure.

The QLRC recommends that a substitute decision maker should not generally be able to give an effective consent to the withholding or withdrawing of a life-sustaining measure if the health provider knows that the adult objects. In those circumstances the QLRC recommends that the adult guardian should be able to give consent, to ensure that an independent decision is made.

The QLRC recommends that a new section be added to the GAA Act with the following effect:

67A Effect of an adult's objection to the withholding or withdrawal of a life-sustaining measure

- (1) Generally, the consent of an adult's guardian or attorney to the withholding or withdrawal of a life-sustaining measure for the adult does not operate if the health provider knows, or ought reasonably to know, the adult objects to the withholding or withdrawal of the measure.
- (2) If an adult objects to the withholding or withdrawal of a life-sustaining measure—
 - (a) the adult guardian may consent to the withholding or withdrawal of a life-sustaining measure for the adult; and
 - (b) the adult guardian's consent is effective despite the adult's objection.
- (3) The adult guardian may exercise power under subsection (2) whether or not the adult guardian is the adult's guardian or attorney.

³⁸ A direction in an advance health directive must be dealt with in accordance with the directive.

(3) In this section—

attorney means an attorney under an enduring document or a statutory health attorney.

object, by an adult, to the withholding or withdrawal of a life-sustaining measure means—

- (a) the adult indicates the adult does not wish to have the life-sustaining measure withheld or withdrawn; or
- (b) the adult previously indicated the adult did not wish to have the life-sustaining measure withheld or withdrawn and since then the adult has not indicated otherwise.

Issues for comment

- Should ‘withholding or withdrawing a life-sustaining measure’ be omitted from the definition of health care for the purpose of s.67 of the GAA Act?
- Should the proposed new s.67A (above) be added to the GAA Act?

4.10 Potential criminal responsibility for withholding or withdrawing a life-sustaining measure

4.10.1 QLRC Recommendations 11.15 and 11.16

The QLRC recommended that the Criminal Code be amended to remove doubt that a health provider is not criminally responsible for the death of a person because they withhold or withdraw a life-sustaining measure in accordance with the GAA Act. The QLRC also recommended retaining s.238 of the GAA Act.

4.10.2 Current law

The guardianship legislation provides that a person carrying out health care on an adult with impaired capacity is not liable for an act or omission to any greater extent than if it had occurred with the consent of the adult (if they had capacity to consent).³⁹

However, the operation of these sections is limited by s.238 of the GAA Act (and s.37 of the POA Act) which provides:

238 Act does not authorise euthanasia or affect particular provisions of Criminal Code

To remove doubt it is declared that nothing in this Act—

- (a) authorises, justifies or excuses killing a person; or
- (b) affects the Criminal Code, section 284 or chapter 28.

4.10.3 Clarification of criminal responsibility

The QLRC report discusses the interaction of the guardianship legislation and the Criminal Code and notes that there is some uncertainty whether a health provider who withholds or withdraws a life-sustaining measure in accordance with the guardianship legislation could be criminally responsible. In *Re HG*⁴⁰ the Tribunal suggested that criminal responsibility required legislative clarification.

The QLRC recommends amendment to the Criminal Code to ensure clarity about criminal responsibility. The QLRC also recommends that s.238 of the GAA Act and s.37 of the POA Act be retained.

³⁹ S.80 GAA Act & s 101 POA Act.

⁴⁰ [2006] QGAAT 26, cited in QLRC Report Vol 2, p.260.

Issues for comment

- Should the Criminal Code be amended to remove any doubt that a health provider who withholds or withdraws a life-sustaining measure in accordance with the guardianship legislation is not criminally responsible?

5 Objection by an adult to health care

5.1 QLRC recommendations 12.6, 12.7 and 12.8

5.1.1 Urgent health care - imminent risk to life or health

The QLRC recommends amending the current authority to provide health care without consent to an adult whose capacity is impaired to meet an imminent risk to life or health, so that it applies only if it is not reasonably practicable to get consent from someone who could give consent under the guardianship legislation (e.g. a spouse) (QLRC recommendation 12.6). It also recommends limiting the authority to provide health care without consent to meet an imminent risk to life or health if the health provider knows that the adult refused the health care at a time when the adult had capacity to make decisions (QLRC recommendation 12.7).

5.1.2 Urgent health care – prevent significant pain or distress

In addition, the QLRC recommended that urgent health care without consent to prevent pain or distress should not be authorised if the health provider knows that the adult objected to the health care in an advance health directive or otherwise when they had capacity to make decisions about health care (QLRC recommendation 12.8).

5.2 Current law – urgent health care without consent

Health care as defined for the legislation generally includes withholding or withdrawing a life-sustaining measure. However, for the purpose of s. 63 of the GAA Act, (Urgent health care) *health care* does not include withholding or withdrawing of life-sustaining measures (s.63(5)).

Section 63 of the GAA Act generally authorises a health provider to deliver urgent health care without consent if an adult has impaired capacity (e.g. is unconscious) if either:

- the health care should be provided urgently to meet imminent risk to the adult’s life or health, or
- the health care should be provided urgently to prevent significant pain or distress to the adult and it is not reasonably possible to get consent from a person who may give it under the GAA Act of the POA Act (e.g. a spouse, or an attorney).

That general authorisation to provide urgent health care without consent does not apply if the health provider knows the adult has objected to the health care. The legal effect of an adult’s objection differs, depending on whether it is to meet an imminent risk to life or health, or is to prevent significant pain or distress.

5.2.1 Imminent risk to life or health

Section 63(2) of the GAA Act provides that urgent health care may not be carried out without consent if the health provider knows the adult objects to the health care in an advance health directive (s.63(2)). If the adult had objected to the health care, but not in an advance health directive, the health care could be carried out, despite the adult’s objection.

5.2.2 Urgent health care to meet significant pain or distress

Under s. 63(3), urgent health care may not be provided without consent if the health provider knows the adult has objected (not necessarily via an advance health directive). However, the health care may be provided without consent if:

- the adult has minimal or no understanding of what the health care involves or why it is required, and
- the health care is likely to cause no distress or temporary distress that is outweighed by the benefits of the health care.

5.3 Clarification of authority to provide health care without consent to an adult with impaired capacity to meet an imminent risk to life or health

The QLRC recommendation 12.6 would create consistent requirements for urgent health care without consent, whether the health care was to meet an imminent risk to life or health, or to prevent significant pain or distress. Urgent health care to meet an imminent risk to life or health could be provided without consent to an adult with impaired capacity, only if it was not reasonably practicable to obtain consent from a person who could consent under the guardianship laws. Currently if an adult arrived unconscious at a hospital emergency department and health care was necessary to keep them alive, no consent is required. The proposed amendment would mean that if the adult was accompanied by their spouse, the spouse's consent would be required to provide health care.

5.4 Adult's prior objection to urgent health care to prevent significant pain or distress

The QLRC considered that health care to prevent significant pain or distress should not be provided without consent if the adult objects to the health care in an advance health directive, or otherwise objected at a time when he or she had capacity to make decisions.

Like some other QLRC recommendations, this would give recognition to an adult's right to make choices about health care when he or she has capacity to do so.

The QLRC recommendation (12-8) is to amend s.63(3) of the GAA Act so that urgent health care may be provided without consent to prevent significant pain or distress, unless:

- the adult objects in an advance health directive, or
- at a time when the adult had capacity to make decisions, he or she refused the health care.

Issues for comment

- Should the authority to provide urgent health care without consent to meet an imminent risk to life or health be clarified so that it is consistent with the authority to provide health care without consent to prevent significant pain or distress, that is, where it is not reasonably practicable to get consent from a person who could give it under the guardianship legislation?
- Should it be possible to provide health care without consent to meet an imminent risk to life or health if the health provider knows that the adult objects to the health care in an advance health directive or refused the health care at a time when the adult had capacity to make decisions about health care.

It also recommends limiting the authority to provide health care without consent in an emergency if the health provider knows that the adult refused the health care at a time when the adult had capacity to make decisions. (QLRC recommendation 12.7)

6 Other QLRC recommendations

6.1 Registration of an enduring power of attorney

6.1.1 QLRC recommendation 16.15

The QLRC considered whether registration of enduring powers of attorney should be required, and the possible features of a registration system. It concluded that the legislation should not require registration of enduring powers of attorney and recommended (16.15) that the POA Act should not be amended to require all enduring powers of attorney be registered.

6.1.2 Current registration requirements

In Queensland, registration is not generally required by the POA Act, unless a land transaction is taking place under the enduring power of attorney. Similar registration requirements apply in New South Wales and the ACT. The Northern Territory, Tasmania and the United Kingdom require enduring powers of attorney to be registered. South Australia has a voluntary system for registration of health directives.

Some believe that a registration system would overcome difficulties in verifying whether an enduring power of attorney exists, and minimise the potential for fraud or abuse by verifying an attorney's authority. One suggestion to the QLRC was that a central register could facilitate access to information about an appointed attorney to assist in making urgent health decisions.

Conversely, registration systems can be resource intensive and increase the burden of advance planning and expense on families. There is also a risk that concerns about privacy of information may discourage people from making an enduring power of attorney if registration was mandatory.

6.1.3 Would registration of enduring powers of attorney be effective?

The QLRC's examination noted that a compulsory registration system for enduring powers of attorney would ensure that they are known about, enable third parties (eg. financial institutions and health providers) to inquire of a register, and may help to expose multiple documents with incompatible powers. However, the QLRC noted that a registration system may be limited in its capacity to ensure the validity of a registered instrument and would not necessarily detect fraud or abuse. Other disadvantages of a registration system are privacy concerns and costs, and the increased complexity such a system would impose on those who wish to make an enduring power of attorney.⁴¹

The QLRC concluded that compulsory registration may make enduring powers of attorney less attractive as an advance planning tool, and recommended that there not be a compulsory system.

The QLRC's conclusion is consistent with that reached in a South Australian review of advance health directives.⁴² South Australia has a voluntary registration system for health directives. The review reported that between 1999 and 2004 there were no requests for information about a registered advance directive from medical or ambulance staff. The South Australian review also concluded that the benefits of a register do not outweigh the impositions.⁴³

The National Framework suggests that registers (of health directives) are not recommended; they are expensive to establish and operate, and evidence indicates that they are not effective in ensuring that a directive is found when needed.⁴⁴

⁴¹ QLRC report, vol 3, pp185-6.

⁴² *Advance Health Directives: Planning ahead; your health, your money, your life*, Second Report of the Review of South Australia's Advance Directives, Stage 2. Proposals for implementation and communication strategies, at http://www.agd.sa.gov.au/news/pdfs/2009/Stage_2_report_final.pdf.

⁴³ *ibid*, pp 37 – 40.

⁴⁴ National Framework, p 35.

Issues for comment

- Is it appropriate that registration of enduring powers of attorney is not required?

6.2 Appointment of a litigation guardian

6.2.1 QLRC recommendations 28.1 and 28.2

The QLRC considered how to ensure that legal action can be commenced or continued if no-one is willing to be appointed as litigation guardian for a person who does not have legal capacity. The QLRC recommended that generally, a person should not be appointed as a litigation guardian without their consent, and that the Public Trustee or the Adult Guardian could be appointed by the court without their consent.

6.2.2 Current law – appointment of litigation guardian

Currently, the *Uniform Civil Procedures Rules 1999* provide that a court may appoint a litigation guardian, and may remove a litigation guardian or substitute another person in the interests of the person who does not have capacity. The *Public Trustee Act 1978* requires the public trustee's consent to any appointment of the public trustee.

In the Northern Territory, South Australia and Victoria consent is not required when the court appoints individuals to act as litigation guardian. In the ACT, Tasmania and New South Wales, the court cannot appoint an individual as litigation guardian without their consent.

6.2.3 Role of litigation guardian and QLRC views

A litigation guardian can start or defend proceedings for a person who lacks capacity. The litigation guardian is personally liable for the costs of legal representation and for costs awarded against the plaintiff, when they represent the plaintiff. A litigation guardian is primarily liable for the costs of the legal representatives engaged by the litigation guardian. While a litigation guardian can be reimbursed from the estate of the person they represent, this may be problematic.

Without a litigation guardian, a person without capacity can not have their case heard before the courts. If a litigation guardian is appointed when they have not consented to the appointment, they might not act in the best interests of the person they represent.

The QLRC noted the significant financial and administrative burden associated with acting as litigation guardian, and the risk that a person with impaired capacity may not be represented well or at all if no-one agrees to appointment. On balance, the QLRC suggests that the Public Trustee is suitable as a litigation guardian of last resort, and that the potential burden on the Public Trustee is outweighed by the need to safeguard the interests of adults with impaired capacity.

The QLRC therefore proposes amendment to s.27 of the *Public Trustee Act 1978* to provide that the Public Trustee's consent be no longer required under rule 95 of the *Uniform Civil Procedures Rules 1999*. In addition, it recommends an amendment to the *Uniform Civil Procedure Rules 1999* to provide that a court may appoint a person as litigation guardian for a legally incapacitated person only if the person consents to being appointed. In addition it recommends that a court may, without consent, appoint as litigation guardian:

- the Public Trustee, for a proceeding relating to the adult's financial or property matters
- the Adult Guardian, for any other proceeding.

Issues for comment

- Should the courts have the ability to appoint, without consent, the Public Trustee or the Adult Guardian as a litigation guardian of last resort for a person who does not have capacity?
- What are the main costs and benefits of appointment of the Public Trustee or the Adult Guardian as a litigation guardian?
- Should the court be able to appoint another person as a litigation guardian without their consent?

6.3 Charging of fees by the Adult Guardian

6.3.1 QLRC recommendation 29.1

The QLRC examined whether fees or commissions should be charged for guardianship services provided by the Adult Guardian. The QLRC recommended retaining the status quo so that no fee is charged for guardianship services.

6.3.2 No fees currently charged

Fees are not charged by the Adult Guardian. Most guardianship services are provided on behalf of vulnerable people, often with low incomes. Other Australian jurisdictions do not charge fees for guardianship services.⁴⁵

6.3.3 Should fees be charged?

Most submissions received by the QLRC did not support the introduction of fees for guardianship services. One submission suggested there would be a case for fees when an adult appoints the Adult Guardian under an enduring power of attorney or advance health directive. The submission argued that the situation differs when the Tribunal appoints the Adult Guardian for a person.⁴⁶

After examining the introduction of fees, the QLRC recommended that there should be no change to current arrangements for the Adult Guardian in relation to fees or commissions when the Adult Guardian:

- acts as a guardian under the GAA Act, or as attorney or statutory health attorney under the POA Act
- exercises power to make decisions about health matters under ss. 42 or 43 of the GAA Act, or functions proposed by the QLRC recommendation (11-5 – see discussion above) that some health care decisions or a failure to make a decision may be referred to the Adult Guardian
- is taken to be an attorney under s.196 of the GAA Act during the suspension of an enduring power of attorney.

Issues for comment

- Should the Adult Guardian charge fees for guardianship services?
- What are the main costs and benefits of continuing with current arrangements, and of introducing fees?

⁴⁵ QLRC Report, Vol 4, p 415.

⁴⁶ QLRC Report, Vol 4, pp 417-419.

7 Terms of Reference

“To inquire and report on the following recommendations from the QLRC report *Review of Queensland’s Guardianship Laws*:

- Recommendations 9.3 (second part (b) of recommendation only), 9.11, 9.18, 9.26, 9.27 and 9.28 – which deal with advance health directives;
- Recommendations 11.1-11.10 (inclusive), 11.15 and 11.16 – which deal with withholding or withdrawing life-sustaining measures;
- Recommendations 12.6, 12.7 and 12.8 – which deal with the effect of an adult’s objection to health care;
- Recommendation 16.15 – which deals with the issue of registering an enduring power of attorney
- Recommendations 28.1 and 28.2 – which deals with the appointment of the Adult Guardian or the Public Trustee as litigation guardian; and
- Recommendation 29.1 – which deals with the remuneration of the Adult Guardian.

In undertaking this inquiry, the committee will consider:

- the Queensland Law Reform Commission’s Report;
- other Australian and international jurisdictions;
- the impact on adults with impaired decision-making capacity and their families;
- the impact on health providers and medical professionals; and
- cost/benefit analysis of implementing any recommendations.

The committee will take public submissions and consult with adults who may be involved in the guardianship system, their families, health and disability providers and medical professionals (including professional bodies); and advocacy and peak bodies.

Further, that the committee report to the Parliament by 31 March 2012.”

8 Health and Disabilities Committee

Members

Ms Lindy Nelson-Carr MP, Chair, Member for Mundingburra

Mr Mark McArdle MP, Deputy-Chair, Member for Caloundra

Mrs Liz Cunningham MP, Member for Gladstone

Ms Tracy Davis MP, Member for Aspley

Ms Mandy Johnstone MP, Member for Townsville

Mrs Christine Smith MP, Member for Burleigh

Secretariat

Ms Sue Cawcutt Research Director

Ms Emily Nagle Principal Research Officer

Ms Tamara Vitale Executive Assistant

Mail Research Director
 Health and Disabilities Committee
 Parliament House
 BRISBANE Qld 4000

Email hdc@parliament.qld.gov.au

Phone (07) 3406 7688