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Department of Justice
Office of the Secretary

Via online submission

Dear colleagues

MIGA submission – Tasmanian advance care directives bill

MIGA appreciates the opportunity to comment on the draft Guardianship and Administration Amendment (Advance Care Directives) Bill 2020 (**the draft bill**).

It follows MIGA's contribution to the Tasmanian Law Reform Institute's Review of the *Guardianship and Administration Act 1995* (Tas).

MIGA's position

MIGA seeks practical and workable regimes for advance care directives (**ACDs**) across the country.

The following are imperatives for an ACD regime

- Increasing ACD use across the community
- Improved accessibility to ACDs by the health profession
- Making sure 'manner and form' requirements do not render otherwise clear ACDs invalid
- Ensuring an ACD validly made in one state or territory is recognised throughout Australia
- Appropriate protections for the health profession who rely on ACDs in good faith
- More targeted education and resources for the health profession and community.

The draft bill is a good start towards a practical and workable ACD regime. Scope for any competent patient to make an ACD, options for voluntary ACD registration and the proposed role of the Public Guardian are important elements.

MIGA considers

- It is necessary to clarify that an ACD validly made at common law remains valid in Tasmania
- There should be scope for a person to appoint a substitute decision-maker via an ACD, without need to appoint them as an enduring guardian.

It also has a number of other proposals to improve the operation of the draft bill, set out below.

MIGA's interest

MIGA is a medical defence organisation and medical / professional indemnity insurer advising, assisting educating and advocating for medical practitioners, medical students, healthcare organisations and privately practising midwives throughout Australia.

With over 36,000 members across the country, MIGA has represented the medical profession for 120 years and the broader healthcare profession for 17 years.

It regularly provides advice and assistance to its members and clients around issues relating to capacity, ACDs, guardianship, substitute decision-making, elder abuse and end of life care. Its risk education to its members and the broader profession covers a range of issues around ACDs and other healthcare decision-making issues.

MIGA's advocacy and engagement work includes a range of issues around ACDs, consent, end of life care and elder abuse. It has contributed to a various reviews on these issues, including the ongoing South Australian Parliamentary Inquiry into end of life issues and the recent Review of the National Framework for Advance Care Directives. It has also contributed to earlier reviews of ACDs and healthcare consent issues more broadly in Tasmania, South Australia, New South Wales, Victoria and Queensland.

Preserving common law ACDs

As set out in its submission to the Tasmanian Law Reform Institute review, MIGA has concerns that a statutory ACD regime can place unnecessary emphasis on form over substance and risk unduly impeding healthcare.

Uncertainty around lawfulness of ACDs and how they operate reflect comparative lack of knowledge. This is not an issue for further legislation, but rather education.

MIGA would prefer that legislation only recognise the existence of ACDs under common law, or otherwise made under statutory schemes in other Australian states, without imposing additional manner or form requirements. Encouraging use of template ACDs developed by governments with input from key stakeholders such as MIGA is to be preferred.

It does not oppose a statutory ACD regime so long as ACDs validly made under the common law continue to be recognised.

This is a position supported by the Tasmanian Law Reform Institute, which in its review report indicated

> *It is not intended that a legislative framework restrict the existing ability of a person to make an ACD at common law.*[1]

It is also reflective of the position in South Australia, the ACD regime on which the draft bill is modelled. A recent review of the South Australian regime recommended

> *The Act should be amended to make it expressly clear that it is not intended to operate to the exclusion of the common law. Directives which meet the common law requirements must be treated as legally valid. In addition, non-statutory directives, irrespective of form or whether they appear in a statutory ACD, should be treated as relevant and highly persuasive, particularly when decisions are being made with regard to medical care and treatment, or personal preferences, at the end of life*.[2]

Appointing decision-makers under an ACD

It is unclear why s 35K(2)(c) of the draft bill precludes use of an ACD to appoint a healthcare decision-maker.

A person should be able to appoint a medical treatment decision-maker in an ACD, as is the case in South Australia and the Northern Territory.

There is no compelling reason why a person should have to appoint an enduring guardian in order to indicate who is to make decisions about their healthcare if and when they cannot do so.

Such a mechanism can assist in clarifying who can make decisions when a person cannot and reducing the scope for disputes between multiple 'default' substitute decision-makers.

Individual bill provisions

Below are a number of proposals directed to improving the draft bill, by reference to amended provisions of the principal act.

- **Long title and s 5 - Objects of Act** – change both to read "*to* ***recognise*** ~~*enable*~~ *the giving of advance care directives*" - it is important to ensure there is no doubt that ACDs already in existence in Tasmania, validly made under the common law, continue to be recognised and followed
- **Section 3 – definition of "*advance care directive*"** – change to read "*means an advance care directive* ***recognised*** ~~*given*~~ *under Part 5A that is in force*" – as indicated above, it is important to ensure that ACDs

[1] Tasmanian Law Reform Institute, *Review of the Guardianship and Administration Act 1995 (Tas)* (Final Report, No 26, December 2018), para 5.5.13

[2] W Lacey, *Report on the review of the Advance Care Directives Act 2013* (SA) (June 2019), recommendation 3

already in existence, and which are validly made under the common law, continue to be recognised in Tasmania

- **Section 35B(c) – Principles to be observed** - "*a person is, in the absence of evidence or a law of the State to the contrary, to be presumed to have decision making ability in respect of decisions about his or her health care*"
    - A presumption of decision-making ability is appropriate for adults, but not for children where their decision making ability depends on having "*sufficient maturity*" (see s 35E(5), which is consistent with the common law[3])
    - The provision should be amended to apply to adults only – if this does not occur there would be the unintended consequence of a child of any age being presumed to have sufficient maturity to make decisions about all aspects of their healthcare
- **Section 35D - Meaning of health care** – given s 35C(4) clarifying that a reference in the draft bill to "*health care*" is taken include a reference to withdrawing or withholding health care, for the avoidance of confusion it would be helpful to include a reference to that provision as a note under s 35D(1)
- **Section 35E(2) – Decision making ability**
    - The requirement for a person assessing decision-making ability to be 'satisfied' of impaired decision-making ability is too high a standard, and potentially inconsistent with clinical approaches to assessment of decision-making ability
    - The provision should be changed to read

        … unless a person or body considering that ability ***reasonably believes*** ~~*is satisfied*~~ *that the adult has impaired decision making ability in respect of the decision*.
- **Section 35G(1) - Giving an advance care directive**
    - An additional requirement to both understand what an ACD is, and the consequences of giving one, is inappropriate and unnecessary
    - Scope for making an ACD should be based on decision making ability only, not additional tests which may cause confusion, particularly for health practitioners assessing ACDs when they come into effect
    - There should be no scope, however unintentional, to undermine the validity of an ACD made by a person with decision making ability
    - This sub-section should be removed from the final bill
- **Section 35H(1) – Requirements for advance care directive - form**
    - As set out above, ACDs validly made under the common law, both previously and into the future, should continue to be recognised
    - To ensure there is no confusion around this issue, s 35ZH of the draft bill, modified to refer specifically to the common law around ACDs being unaffected, should be referred to under sub-section (1)
- **Section 35H(3)(d) – Requirements for advance care directive – minor errors**
    - There is potential for uncertainty and differing views over what constitutes a "*minor error … that does not affect the ability to understand the wishes and instructions of the person who gave the advance care directive …* "
    - Consensus guidance on this issue should be developed by the Tasmanian Government, with input from key stakeholders such as MIGA
- **Section 35H(3)(g) – Requirements for advance care directive – religious, social or moral grounds**
    - The reference to ACDs or their provisions not being invalid merely because they are based "*solely on religious, moral or social grounds*" has the potent to cause confusion where instructions are based on a range of factors
    - The reference to "*solely*" should be removed

[3] *Department of Health and Community Services (NT) v JWB (Marion's case)*(1992) 175 CLR 218, endorsing *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112

- **Section 35K – Provisions that cannot be included in advance care directives**
  - Section 35K(2)(a)(iii) - invalidity of an ACD on grounds that it would cause a health practitioner to contravene "*a professional standard or code of conduct*" applying to them could be read too narrowly to exclude professional guidance or other good healthcare practice not expressed in a document described as a standard or code of conduct
  - This can be addressed by amending s 35K(2)(a)(iii) to read

    ... an advance care directive cannot include provisions … that would, if given effect, cause a health practitioner or other person to contravene a professional standard or code of conduct applying to the health practitioner or person, ***or otherwise contravene good health care practice.***
  - Section 35K(3) – it is unclear why a professional standard or code of conduct does not include one prepared by a hospital, clinic, hospice, nursing home or other place which regulates the provision of healthcare or other services at that place if it is consistent with good healthcare practice
  - Intention to avoid health services from relying on standards or codes which go beyond or are at odds with good healthcare practice is appropriate, but it cannot be permitted to cause confusion around the validity of a health service codes and standards which are consistent with broadly accepted healthcare
  - This issue can be dealt with by amending s 35K(3) to read

    … a reference to a professional standard or code of conduct does not include a reference to a standard or code of conduct that –

    (a) is prepared by or on behalf of a hospital, clinic, hospice, nursing home or any other place at which health care is provided to a person; and

    (b) regulates the provision of health care or other services at that place,~~.~~

    (c) is inconsistent with standards or codes of conduct applying across the relevant health care profession or otherwise representing good health care practice.

- **Section 35L – Binding and non-binding provisions** – for the avoidance of doubt, there should be a note under s 35L(1) referring to obligations in ss 35P(1)(b) and 35R(1)(b) on both health practitioners and persons responsible to comply with non-binding ACD provisions so far as is reasonably practicable

- **Section 35O(2) – When things can happen under an advance care directive**
  - Requiring a health practitioner to only provide care under ACD if person "*has*" impaired decision making ability is too high a standard, implying certainty
  - To better reflect the reality of decision making ability and clinical assessment processes, the provision should be amended to read

    A health practitioner may only provide health care pursuant to a consent granted under an advance care directive if, at the relevant time, the ***health practitioner reasonably believes the*** *person who gave the advance care directive has impaired decision making ability in respect of the health care decision*.

- **Section 35Q – Requirement to make reasonable inquiries as to advance care directive**
  - It is generally impracticable and unreasonable to require health practitioners to make inquiries in emergency situations to determine if a person has given an ACD
  - It is important that health practitioners making split second decisions in emergency situations are not burdened by uncertainty around what are reasonable efforts to locate an ACD in that situation
  - The Tasmanian Law Reform Institute's review report recommended that the obligation to make reasonable inquiries as to an ACD should not arise in circumstances of "*urgent health care and treatment*"[4]
  - Section 35Q(2) should be changed to read

    Except in an emergency situation, *before a health practitioner provides health care to a person … the health practitioner must make reasonable efforts …*

[4] Tasmanian Law Reform Institute, *Review of the Guardianship and Administration Act 1995 (Tas)* (Final Report, No 26, December 2018), recommendation 5.8

- **Section 35S – Circumstances where health practitioners may not be compelled to provide particular health care**
  - It is unclear why under s 35S(6) the Guardianship and Administration Board should be notified of a health practitioner's decision to refuse to comply with the provision of an ACD on the grounds of conscientious objection
  - No other healthcare regime requires such notification
  - Professional obligations ensure that the care of patients is not impeded where a practitioner has a conscientious objection[5]
  - Inclusion of a notification provision for conscientious objection could be seen as a punitive measure for those who have conscientious objections
  - This requirement in s 35S(6) should be removed from the final bill
- **Section 35Z – Protection from liability practitioner protection** – to avoid confusion and unduly narrow readings of what may constitute "*disciplinary proceedings*", s 35Z(2) should be amended to read

  … reference to the civil liability of a person includes a reference to liability arising under disciplinary ~~proceedings,~~ ***regulatory, administrative*** *or similar proceedings*.
- **Section 35ZB – Persons who may apply to the Public Guardian** – given it is often a hospital or other health service which makes applications to a public guardian, guardianship board or tribunal, the class of "*eligible persons*" under s 35ZB able to make applications relating to ACDs should include

  hospitals and other health services where a person who gave the advance care directive is receiving, or is proposed to receive, health care
- **Section 35ZH – Other legal rights not affected**
  - As set out above, there should be an additional provision included in s 35ZH to the effect of "*For the avoidance of doubt, this Part does not affect the ability of a person to make an advance care directive or its equivalent under common law*"
  - It is important to preserve both the parens patriae jurisdiction of the Supreme Court, and jurisdiction provided to the Family Court and Federal Circuit Court for healthcare decisions
  - References to "*treatment*" only, and not to the broader concept of "*health care*" have the potential to create confusion and lead to unduly narrow interpretations of "*treatment*"
  - Both ss 35ZH(3) and 35ZH(4) should also include reference to "*health care*"
  - For the avoidance of doubt, although matters involving the family law jurisdiction in this context are more likely to be heard in the Family Court, it would be prudent to include reference to the Federal Circuit Court in ss 35ZH(3) and 35ZH(4) as a court which may exercise jurisdiction.

Next steps

MIGA looks forward to engaging further with the Department further around these issues, including the development of regulations and guidance, and other reform initiatives relating to healthcare consent.

If you have any questions or would like to discuss, please contact Timothy Bowen, 02 8905 3400 / timothy.bowen@miga.com.au.

Yours sincerely

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[5] See for example Medical Board of Australia, *Good medical practice: a code of conduct for doctors in Australia* (October 2020), cls 3.4.6 and 3.4.7