Chapter 11
Documenting wishes about the future

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Documenting wishes about the future

INTRODUCTION

11.1 The use of enduring appointments, discussed in the previous chapter, is one way a person can exercise some control over future decisions if they lose capacity. These appointments allow a person to choose a family member or friend in whom they have confidence to make decisions for them when they are unable to do so.

11.2 Another option is to give advance written instructions about particular decisions. ‘Instructional directives’ can be made without appointing a substitute decision maker. They can be used to provide directions about the decision a person wants made in particular circumstances if they lose capacity. These documents are most commonly used to record directions about medical treatment. The legal status of instructional directives is unclear.

11.3 A third possibility is to combine the appointment of an enduring guardian or enduring attorney (financial) with instructions about how to exercise the powers given to the substitute decision maker. These may be ‘binding instructions’, or non-binding indications of wishes or preferences. The legal status of binding instructions is unclear.

11.4 The advantage of combining a personal appointment with an instructional directive is that it allows for the appointment of a trusted person to implement directives in circumstances that have been anticipated and to make decisions about those matters that have not been specifically addressed after bearing in mind any relevant instructions or wishes.

ADVANCE CARE PLANNING

11.5 It is important to distinguish between advance care planning and legal recognition of instructions about future decisions. Advance care planning is often used as a generic term to describe the process of planning for future health and personal care. Advance care planning often takes place within a health or aged care setting and is supported by a planning program that involves trained professionals facilitating a discussion. Contemporary advance care planning programs aim to provide a holistic approach, which supports that person to discuss their values, personal goals and preferences.

11.6 The Commission recognises the importance of the conversations that take place as part of advance care planning. These conversations are crucial in assisting people to form and articulate their views about future decisions. They also ensure that family members and any other people involved in future decision making, such as medical professionals, understand the person’s overarching concerns about future decisions and the goals, values, beliefs and preferences that are important to them.

11.7 While the Commission acknowledges the importance of advance care planning programs, our recommendations deal with the narrower issue of the legal rights of an individual to make arrangements for future decisions through personally appointing a substitute decision maker, making an instructional directive, or a combination of both.

11.8 Advance care planning programs may lead to the use of statutory mechanisms to record instructions or make appointments. This step might help to ensure that instructions are followed or that third parties will recognise the authority of the substitute decision maker.

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1 For example, the Respecting Patient Choices Program at Austin Health.
RESPECTING PATIENT CHOICES PROGRAM

11.9 A well-known example of advance care planning for health care is the Respecting Patient Choices program at Austin Health. The program seeks to ensure that health professionals find out what people want and that systems are in place to ensure a person’s wishes are respected. The five aims of the program are to:
- initiate conversations with adults regarding their views about future medical care
- assist those individuals with advance care planning
- ensure that the plans are clear
- ensure that their plans are available when required
- ensure that their plans are followed appropriately when decisions are required.

11.10 The Respecting Patient Choices program aims to treat advance care planning as an ongoing discussion about values and preferences. The program encourages patients to focus on goals, broader values and beliefs rather than specific treatments or procedure decisions. The rationale behind this is that outcomes or goals are likely to remain stable over time, whereas treatment options and availability are likely to change over time due to technological advances and best practice considerations.

11.11 The Respecting Patient Choices program recommends that individuals undertake a five-step process in order to discuss and document their wishes. The recommended steps are:
- thinking about your future medical care
- planning your care
- choosing someone to speak for you
- writing down your wishes
- informing others of your decisions.

11.12 The identified benefits of advance care planning through the Respecting Patient Choices program are:
- improvement in the quality of care from the perspective of the patient and family
- a reduction in the likelihood of stress, anxiety and depression in surviving relatives.

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3 Consultation with Respecting Patient Choices Team—Austin Hospital (6 April 2010); Submission CP 49 (Respecting Patient Choices Program—Austin Health).
4 Submission CP 49 (Respecting Patient Choices Program—Austin Health).
5 Consultation with Respecting Patient Choices Team—Austin Hospital (6 April 2010).
6 Detering et al, ‘The Impact of Advance Care Planning on End of Life Care in Elderly Patients: Randomised Controlled Trial’ (2010) 340:1345 BMJ 5 <http://www.bmj.com/content/340/bmj.c1345.full.pdf>. The Austin Hospital has produced information sheets and pro-forma ‘statement of choice’ forms for both competent and non-competent people. For example, the statement of choice form for a competent person details information such as: the author’s medical condition, choices about CPR and life prolonging treatments, details of medical power of attorney, details about what the author values most in life (eg independence, enjoyable activities, talking to family and friends), future situations the author would find unacceptable in relation to their health, specific treatments they would not want considered, who to involve in discussions about the author’s treatment, other things the author would like known that might assist with decisions about their future medical treatment: see Austin Health, Advance Care Plans Documents : VIC (5 December 2011) Respecting Patient Choices: Advance Care Planning <http://www.respectingpatientchoices.org.au/index.php?option=com_content&view=article&id=55&Itemid=45>.
11.13 The discussion that takes place in the advance care planning process and the resulting Advance Care Plan often lead to the use of formal statutory mechanisms such as an enduring power of attorney (medical treatment) to appoint a substitute decision maker or the completion of a refusal of treatment certificate. These documents are often given to the hospital together with advance planning forms.

**CURRENT LAW**

11.14 The law concerning the ability of people to give binding directions about future medical decisions is complex. In Victoria, two overlapping statutory regimes use different procedures and terminology to achieve similar outcomes. The scope of common law mechanisms\(^{10}\) is unclear, and the manner in which the common law and statutory regimes interact is unknown.

11.15 Since the introduction of the *Medical Treatment Act 1988* (Vic), it has been possible for a person to make a binding future direction about refusing all, or some specified, medical treatment for a current condition. It is also possible to appoint an agent with these powers. It is an offence for a medical practitioner to knowingly give a person medical treatment that falls within a refusal of treatment directive.

11.16 It is also possible to appoint an enduring guardian with the power to make decisions about medical treatment. While a principal can give an enduring guardian directions about the use of their powers, there are no statutory provisions that oblige the enduring guardian to follow the directions.

11.17 It might be possible to make an advance directive about medical treatment at common law. The effect of common law advance directives about medical treatment is unknown in Victoria because neither the High Court nor the Victorian Supreme Court has considered the matter. As the Queensland Law Reform Commission recently noted in its *Review of Queensland’s Guardianship Laws*, only New South Wales and Tasmania rely on common law advance directives regarding treatment decisions.\(^{11}\) The remaining states and territories have legislation dealing with the issue.\(^{12}\) We discuss common law advance directives below.

**INSTRUCTIONS IN ENDURING APPOINTMENTS**

**Enduring guardian**

11.18 When appointing an enduring guardian, the donor may specify the wishes that they require the enduring guardian to take into account when making decisions for them.\(^{13}\) The enduring guardian has a duty to take the wishes of the donor into account as part of the ‘best interests’ consideration.\(^{14}\)

**Enduring attorney (financial)**

11.19 The prescribed form for appointing an enduring attorney (financial) includes a section to specify that the appointment is subject to particular conditions, limitations, and instructions.\(^{15}\)

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10 In the glossary we describe common law as law that derives its authority from the decisions of the courts, rather than from Acts of Parliament.


12 See *Powers of Attorney Act 1998* (Qld) ss 35; *Medical Treatment (Health Directions) 2006* (ACT) ss 7–9; *Natural Death Act (NT)* s 4; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ss 7, Guardianship and Administration Act (WA) ss 110P–110RA, 1105, cited in *A Review of Queensland’s Guardianship Laws*, above n 11, vol 2, 17.

13 Guardianship and Administration Act 1986 (Vic) sch 4 form 1.

14 Ibid ss 35(5), 28(1), 28(2)(e). Although s 28(2)(e) of the Act does not specifically provide that wishes expressed in the instrument making the appointment must be taken into account, it does envisage a consultation process.

15 Instruments Act 1958 (Vic) ss 123(1), 125ZL. An approved form is a form approved by the Secretary to the Department of Justice under s 125ZL; see Secretary to the Department of Justice (Victoria) ‘The Instruments (Enduring Powers of Attorney) Act 2002—Approved Forms’ in Victoria, *Victoria Government Gazette*, No G 9, 26 February 2004, 384, 437. This corresponds with the Instruments Act 1958 (Vic) s 115(1)(b) which provides that a donor may ‘provide conditions and limitations on, and instructions about, the exercise of the power’.
11.20 The *Instruments Act 1958* (Vic) allows the donor to specify in an enduring power ‘a time from which, circumstance in which, or occasion on which, a power is exercisable’.\(^\text{16}\)

**Enduring attorney (medical treatment)**

11.21 An agent appointed under an enduring power of attorney (medical treatment) may refuse treatment on behalf of the donor by completing a *refusal of treatment certificate*.\(^\text{17}\) The agent may only do so if one of the following two conditions apply:

- The medical treatment would cause unreasonable distress to the patient.
- There are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to their health and wellbeing, would consider the medical treatment unwarranted.\(^\text{18}\)

11.22 At the time of making an appointment, a donor could provide written instructions about medical treatments they would consider unwarranted. While these instructions could help to guide an agent’s decision, it is unlikely that an agent would be legally obliged to follow them.

**REFUSAL OF TREATMENT CERTIFICATES UNDER THE MEDICAL TREATMENT ACT**

**Background to the Medical Treatment Act**

11.23 The Medical Treatment Act provides a statutory scheme for providing advance refusal of medical treatment through a refusal of treatment certificate. The certificate may be given by the person concerned or, if that person becomes ‘incompetent’,\(^\text{19}\) by an agent appointed under an enduring power of attorney (medical treatment) or a guardian (with appropriate powers) appointed by the Victorian Civil and Administrative Tribunal (VCAT).\(^\text{20}\) The Act was a response to the recommendations in the Social Development Committee’s 1987 report, *Inquiring into Options for Dying with Dignity*.\(^\text{21}\) The report noted a significant degree of confusion about the common law right to refuse treatment, and variation in the approach of medical professionals to such refusals.\(^\text{22}\)

11.24 The committee recommended that:

> legislative action clarifying and protecting the existing common law right to refuse medical treatment is desirable and practicable and should be brought about by the enactment of legislation to establish an offence of medical trespass.\(^\text{23}\)

11.25 It recommended that medical trespass be defined as occurring when a medical practitioner carries out or continues a procedure or treatment where a competent and informed patient freely refuses that procedure or treatment. It also recommended that the legislation include protection for medical practitioners from criminal and civil liability if they act in good faith and in accordance with the expressed wishes of the fully informed, competent patient who refuses medical treatment or procedures.\(^\text{24}\)

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\(^\text{16}\) *Instruments Act 1958* (Vic) s 117(1).

\(^\text{17}\) *Medical Treatment Act 1988* (Vic) s 5B.

\(^\text{18}\) Ibid s 5B(2).

\(^\text{19}\) Ibid s 5A(2)(b).

\(^\text{20}\) Ibid s 5A(2)(b).


\(^\text{22}\) Ibid 43.

\(^\text{23}\) Ibid 142.

\(^\text{24}\) Ibid.
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11.26 The Medical Treatment Act was passed in response to these recommendations. The purposes of the Act are to:

- clarify the law relating to the right of patients to refuse medical treatment
- establish a procedure for clearly indicating a decision to refuse medical treatment
- enable an agent to make decisions about medical treatment on behalf of an incompetent person.25

Refusal of treatment certificate by the person concerned

Formal requirements

11.27 In order to be legally effective, a refusal of treatment certificate under the Medical Treatment Act must be set out in a particular form26 and must be witnessed by a registered medical practitioner and one other person, who must each be satisfied that:

- the patient clearly expresses or indicates the decision to refuse medical treatment generally, or medical treatment of a particular kind
- the refusal of treatment relates to a current condition
- the patient’s decision is made voluntarily and without inducement or compulsion
- the patient is sufficiently informed about the nature of their condition to an extent that is reasonably sufficient to enable the patient to make a decision about whether to refuse treatment, and that the patient has appeared to understand the information
- the patient is of sound mind and aged 18 years or older.27

Limitations on refusal of medical treatment certificate

Advance refusal only

11.28 Refusal of treatment certificates made in accordance with the Medical Treatment Act do not provide for advance consent to medical treatment. In contrast, the South Australian, Western Australian and Queensland statutory schemes provide for advance refusal and consent.28

Current condition only

11.29 The refusal of treatment certificate allows treatment to be refused for a current condition only.29 It is not possible to use a certificate to give instructions about treatment for a possible future illness. The five Australian jurisdictions, other than Victoria, that have enacted legislation about advance directives all allow directions about treatment for a future illness.30

Must receive information about nature of condition

11.30 The requirement that the patient receives medical information about their condition is also unique to Victoria. This matter appears linked to the Medical Treatment Act requirement that the refusal of treatment certificate be made in relation to a current

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25 Medical Treatment Act 1988 (Vic) s 1.
26 Ibid s 5(2).
27 Medical Treatments Act 1988 (Vic) s 5(1).
28 Powers of Attorney Act 1998 (Qld) s 35; Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7; Guardianship and Administration Act 1990 (WA) ss 110P–110R.
29 Medical Treatment Act 1988 (Vic) s 5(1)(a).
30 The legislative schemes in South Australia, the Northern Territory and Queensland provide that the directive can only operate in particular circumstances relating to the type, level and stage of the illness, level of consciousness or level of awareness and chances of recovery: see Natural Death Act 1988 (NT) s 4, Powers of Attorney Act 1998 (Qld) s 36G; Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 7. For an informative overview and critique of the differences between the legislative schemes in different Australian jurisdictions, see Lindy Willmott, ‘Advance Directives and the Promotion of Autonomy: A Comparative Australian Statutory Analysis’ (2010) 17 Journal of Law and Medicine 556.
condition. The statutory schemes in Queensland, South Australia, the Australian Capital Territory and the Northern Territory do not require that medical information be provided.\textsuperscript{31} While there has been little case law about advance directives at common law, the case of \textit{Hunter and New England Area Health Service v A},\textsuperscript{32} discussed below, suggests that lack of prior information does not necessarily mean that an advance directive at common law is invalid.

\textbf{Cannot be made in relation to palliative care}

11.31 A refusal of treatment certificate does not allow a person, or their agent or guardian, to refuse palliative care. The Medical Treatment Act permits the refusal of ‘medical treatment’ in defined circumstances but that term specifically excludes ‘palliative care’.\textsuperscript{33} Palliative care is defined as including ‘reasonable medical procedures for the relief of pain, suffering and discomfort’ or ‘the reasonable provision of food and water’.\textsuperscript{34}

11.32 There has been litigation about the boundary between ‘medical treatment’ and ‘palliative care’. In the leading case, Justice Morris concluded that a guardian could refuse artificial nutrition and hydration via percutaneous endoscopic gastrostomy (PEG) for a person with dementia who had not been conscious for three years because it was medical treatment rather than palliative care.\textsuperscript{35} There have been no attempts to amend the Medical Treatment Act since this decision was delivered in 2003.

\textbf{Psychiatric treatment}

11.33 The Commission is not aware of the extent to which either refusal of treatment certificates under the Medical Treatment Act, or instructional directives at common law, are completed in relation to psychiatric treatment. On its face, the definition of ‘medical treatment’ in section 3 of the Medical Treatment Act encompasses psychiatric treatment and there is no reason why a certificate could not be completed to refuse future psychiatric treatment in relation to an individual’s current condition.

11.34 There appears to be no reported case law in Victoria explaining how the provisions of the Medical Treatment Act interact with the treatment provisions of the \textit{Mental Health Act 1986} (Vic). However, it is likely that if a person comes within the involuntary treatment provisions of the latter Act, the determinations of the authorised psychiatrist concerning psychiatric treatment would override any refusal of treatment certificate.

\textbf{COMMON LAW MEDICAL TREATMENT ADVANCE DIRECTIVES}

11.35 While it is possible to give a statutory advance directive about refusal of medical treatment, this mechanism is available only in the limited circumstances covered by the Medical Treatment Act. It may also be possible to make an advance directive refusing medical treatment at common law but the legal effect in Victoria of such directives is unclear.

\textsuperscript{31} Medical Treatment (Health Directions Act) 2006 (ACT); Natural Death Act 1988 (NT); Powers of Attorney Act 1998 (Qld); Consent to Medical Treatment and Palliative Care Act 1995 (SA). The Western Australian statutory position is confusing. One of the requirements for a valid advance care directive is that the maker is encouraged to seek legal and medical advice but the statute goes on to say that the validity of an advance health directive is not affected by a failure to comply with this requirement: Guardianship and Administration Act 1990 (WA) s 110Q(1)(b), (2). See also Lindy Willmott, ‘Advance Directives and the Promotion of Autonomy: A Comparative Australian Statutory Analysis’ (2010) 17 Journal of Law and Medicine 556, 569–71.

\textsuperscript{32} Hunter and New England Area Health Service v A (2009) 74 NSWLR 88, 94.

\textsuperscript{33} Medical Treatment Act 1988 (Vic) s 3.

\textsuperscript{34} Ibid s 3.

\textsuperscript{35} Re BWV; Ex parte Gardner (2003) 7 VR 487. See also Brightwater Care Group (Inc) v Rossiter [2009] WASC 229 [35]; Adult Guardian v Langham (2006) 1 Qd R 1 [32].
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Hunter and New England Area Health Service v A

11.36 The 2009 New South Wales Supreme Court decision in Hunter and New England Area Health Service v A (Hunter) appears to be the first occasion in which an Australian superior court has directly considered the effect of an advance directive at common law. In Hunter, Justice McDougall determined that the common law allows a competent adult to make an advance directive refusing life-sustaining medical treatment. While of persuasive authority, this decision is not binding on Victorian courts.

11.37 Hunter was a decision about the legal effect of a document completed by a competent adult providing advance refusal to kidney dialysis. Justice McDougall granted the declarations sought by the hospital that the document was a valid advance care directive and that it would be justified in complying with his wishes as expressed in the directive. Justice McDougall recognised that there is a possible conflict between two interests that are recognised by the common law: a competent adult’s right of autonomy or self-determination—the right to control his or her own body—and the interest of the state in protecting and preserving the lives and health of its citizens. However, in line with authorities from the United Kingdom, Canada and the United States, he determined that ‘whenever there is a conflict between a capable adult’s exercise of the right of self-determination and the State’s interest in preserving life, the right of the individual must prevail’.

Is the advance directive valid?

11.38 English and Australian courts have identified two requirements for a common law advance directive to be valid. First, the adult must have capacity at the time the advance directive is given, and secondly, the adult must have acted without undue influence or other legally invalidating factors. Capacity is a two-limbed test. It requires that the person making the directive has capacity to make the directive and is able to communicate the decision in some way. Capacity is not a fixed state but rather operates on a sliding scale; a person may have capacity in relation to some decisions but not others. The determination as to whether a person has capacity to make a particular decision ‘must take into account the importance of the decision’. The question is ‘whether that person suffers from some impairment or disturbance of mental functioning so as to render him or her incapable of making the decision’.

Is the advance directive operative?

11.39 In order to have legal effect, the adult who made the directive must have intended it to apply to the particular situation that has arisen. This requires a consideration of the scope of the decision. For example, an advance directive not to resuscitate if the person is in the final stages of terminal cancer would not apply if the person who

37 Ibid.
40 Re T (Adult: Refusal of Treatment) [1992] 4 All ER 649 provides guidance as to what is considered undue influence or other vitiating factors. The Court of Appeal held that Mr T’s refusal of future blood transfusions was invalid because it was made under undue influence from his mother who, as a practising Jehovah’s Witness, rejected the use of blood transfusions as a medical treatment. Factors identified as relevant to a consideration of whether undue influence was present included: the strength of will of the person, as a person who is tired, in pain or depressed may be less able to resist the imposition of someone else’s will; the strength of the relationship of the ‘persuader’ to the patient and the holding of strong religious beliefs by the persuader that would require refusal of the treatment. Lord Donaldson MR and Butler-Sloss LJ considered that religious beliefs may be especially powerful influences and that the combination of very strong religious belief held by the ‘persuader’ and a close relationship between them and the patient should alert doctors to the possibility of undue influence.
41 Hunter and New England Area Health Service v A (2009) 74 NSWLR 88, 93.
42 Ibid.
43 Ibid 94.
made the directive stops breathing following an electric shock.\textsuperscript{44} In *Hunter*, Justice McDougall also accepts that an advance directive will be invalid if it is the result of a misrepresentation or undue influence.\textsuperscript{45} However, as we note above, Justice McDougall expressly rejects the absence of, or failure to provide, adequate information as invalidating advance refusal of treatment.\textsuperscript{46}

**INTERACTION BETWEEN THE MEDICAL TREATMENT ACT AND COMMON LAW**

11.40 The Medical Treatment Act does not alter, and clearly seeks to preserve, any existing common law rights by providing that ‘the Act does not affect any right of a person under any other law to refuse medical treatment’.\textsuperscript{37} The legislation in Western Australia\textsuperscript{48} and Queensland\textsuperscript{49} goes a step further in recognising the existence of a parallel common law right by expressly preserving the common law on advance directives.

**REFUSAL OF TREATMENT CERTIFICATES AND SUBSTITUTE DECISION MAKERS**

11.41 The *Guardianship and Administration Act 1986* (G&A Act) provides that if a refusal of treatment certificate under the Medical Treatment Act is in force, treatment contrary to the certificate cannot be performed.\textsuperscript{50} This means that a guardian, or any other substitute decision maker, cannot provide legally effective consent to medical treatment if a refusal of treatment certificate is in place about that treatment.

**COMMON LAW ADVANCE DIRECTIVES REFUSING LIFE-SUSTAINING TREATMENT AND SUBSTITUTE DECISION MAKERS**

11.42 The ability of a guardian, or any other substitute decision maker, to provide legally effective consent to medical treatment that is contrary to the wishes expressed by a person in a common law advance directive is unclear.

11.43 As outlined above, it may be possible to make an advance directive about medical treatment that is enforceable at common law. There have not been any cases concerning the relationship between common law advance directives about medical treatment and a statutory substitute decision-making regime such as that created by the G&A Act.\textsuperscript{51} Consequently, it is unclear whether a common law advance directive is binding on a substitute decision maker or is merely one of the matters that must be taken into account in determining the best interests of the patient.

11.44 The Public Advocate appears to be of the view that a common law advance directive is merely one matter that a substitute decision maker must consider when deciding what would be in the best interests of the patient.\textsuperscript{52}

\textsuperscript{44} This example of the way in which the scope of an advance directive may be limited is based on the example provided by Lindy Willmott, ‘Advance Directives to Withhold Life-Sustaining Treatment: Eroding Autonomy through Statutory Reform’ (2007) 10(2) *Rinders Journal of Law Reform* 287, 296.

\textsuperscript{45} *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 94. McDougall J refers to *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, 662–3. 668 in which Lord Donaldson MR and Butler-Sloss LJ suggest that the scope of Ms T’s refusal to a blood transfusion was limited. She believed that there would be effective alternatives to blood transfusion and that it was unlikely that it would be necessary to transfuse her. In reality, there were not adequate alternatives and the chances of transfusion were high.

\textsuperscript{46} *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 94.


\textsuperscript{48} *Guardianship and Administration Act 1990* (WA) ss 110ZB.

\textsuperscript{49} *Powers of Attorney Act 1988* (Qld) ss 39. However, this attempt to preserve the common law on advance directives in Queensland was probably ineffective due to a drafting error. See Lindy Willmott, ‘Advance Directives to Withhold Life-Sustaining Treatment: Eroding Autonomy through Statutory Reform’ (2007) 10(2) *Rinders Journal of Law Reform* 287, 293–4.

\textsuperscript{50} *Guardianship and Administration Act 1986* (Vic) ss 41. However, under the Medical Treatment Act 1988 (Vic) ss 5C–5D VCAT can overturn a refusal of treatment certificate made by an agent. For further detail see Chapter 13 Medical treatment.

\textsuperscript{51} See *H Ltd v J & Another* [2010] SASC176.

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11.45 If common law advance directives are not legally binding, then a substitute decision maker under the G&A Act would only need to consider it as part of the best interests evaluation, which requires the person responsible to take a number of factors into account including ‘the wishes of the patient, so far as they can be ascertained’.  

EXPOSURE DRAFT MENTAL HEALTH BILL

11.46 The former Minister for Mental Health released an Exposure Draft Mental Health Bill 2010 for public comment in October 2010. The Exposure Draft Mental Health Bill 2010 included provision for people to make advance statements that specify ‘their wishes and preferences in the event that their capacity to make decisions is significantly impaired by a mental illness which requires treatment’.  

11.47 The Victorian Government is currently considering revised policy for the new Act—taking into account all feedback on the Exposure Draft Bill—in preparation for drafting a Bill for introduction to Parliament.

NATIONAL FRAMEWORK FOR ADVANCE CARE DIRECTIVES

11.48 In 2009, the Australian Health Ministers Council requested the Clinical, Technical and Ethical Principal Committee to develop nationally consistent best practice guidelines for the use and application of advance care directives within the broader context of advance care planning.  

11.49 Following consultation on a draft National Framework for Advance Care Directives, a post-consultation draft was released in April 2011, and a final report in September 2011.  

11.50 The National Framework includes a Code for Ethical Behaviour and a set of Best Practice Standards. It also suggests common terminology to describe advance care directives.

11.51 The Commission’s recommendations about advance care directives are consistent with the overall policy objectives of the National Framework for Advance Care Directives.

COMMUNITY RESPONSES

INSTRUCTIONAL MEDICAL DIRECTIVES

11.52 In the consultation paper, the Commission identified a number of specific problems associated with medical instructional directives made either through a refusal of treatment certificate under the Medical Treatment Act or at common law. Those problems are:

• uncertainty about the status of common law advance directives

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53 Guardianship and Administration Act 1986 (Vic) s 38(1)(a).
55 Department of Health (Victoria), Exposure Draft Mental Health Bill 2010 (Vic) cl 154. The Exposure Draft Mental Health Bill 2010 cl 154 provides that advance statements are not legally binding on third parties. A person making decisions about the treatment of the patient is permitted to make decisions that are inconsistent with the wishes and preferences expressed in the advance statement. The decision maker must have regard to a valid advance statement made by the patient. If they make a decision that is inconsistent with the wishes and the preferences the patient expressed in the advance statement, the decision maker must record the reasons for doing so and provide information about the circumstances and reasons to the patient, the Mental Health Commissioner, the nominated person and the authorised psychiatrist (where they did not make the decision).
59 Ibid 14–42.
60 Ibid 9.
• a refusal of treatment certificate under the Medical Treatment Act may only be made in limited circumstances—for a current condition

• uncertainty about whether common law advance directives are binding on substitute decision makers or merely provide non-binding guidance to them in reaching a decision

• difficulties in identifying that an advance directive exists, which means they might not be followed

• lack of community and professional awareness about common law advance directives and refusal of treatment certificates

• instructional directives, such as a refusal of treatment certificate, may not provide an accurate reflection of a person’s wishes because their views may change over time, and because of changes in medical treatment options

• uncertainty about whether the current law allows a person to give an enduring guardian binding directions.

11.53 One option advanced in the consultation paper was to broaden and clarify the statutory right to make instructional medical directives in order to provide people with increased certainty that their instructions would be followed if they lost capacity in the future. The Commission noted that this change is preferable because the status of common law advance directives is unclear and the medical profession is more likely to recognise directions about medical treatment made in accordance with a statutory scheme.

11.54 The majority of submissions that commented on this issue supported this option.61 The principal reasons given in support were:

• to provide increased certainty that the person’s wishes will be followed,62 to deal with uncertainty about the status of common law directives and to overcome confusion about the current system63

• to overcome practical problems that might cause doctors not to follow a directive, such as concerns about the validity or currency of the directive or whether the person completely understood the implications of the directive64

• to reduce the burden on family members to make decisions about medical care65


11.55 Many of the submissions that supported this reform option commented on the importance of retaining any existing common law rights to make advance directives. This would provide a safety net for situations not envisaged by the statutory provisions.68

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61 For eg Submissions CP 13 (Dying with Dignity Victoria), CP 22 (Alzheimer’s Australia Vic), CP 33 (Eastern Health), CP 35 (Ursula Smith), CP 37 (Mildura Base Hospital), CP 43 (Alfred Health), CP 50 (Margaret Brown), CP 55 (Office of the Health Services Commissioner), CP 63 (Shih-Ning-Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)), CP 65 (Council on the Ageing) Victoria), CP 66 (Victorian Equal Opportunity and Human Rights Commission), CP 68 (Australian Nursing Federation), CP 71 (Seniors Rights Victoria), CP 73 (Victoria Legal Aid), CP 77 (Law Institute of Victoria), CP 75 (Federation of Community Legal Centres (Victoria)) and CP 78 (Mental Health Legal Centre).

62 For eg, Submissions CP 55 (Office of the Health Services Commissioner) and CP 35 (Ursula Smith).

63 For eg, Submissions CP 63 (Shih-Ning-Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)) and CP 71 (Seniors Rights Victoria).

64 For eg, Submission CP 63 (Shih-Ning-Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)).

65 For eg, Submission 65 (Council on the Ageing).


67 Submission CP 63 (Shih-Ning-Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)) and CP 65 (Council on the Ageing).

68 For eg, Submission CP 73 (Victoria Legal Aid).
Some of the submissions that supported broadening the statutory right to make instructional medical directives supported all three possible changes raised in the consultation paper:

- allowing refusal for future as well as current conditions
- allowing advance consent as well as advance refusal
- removing the requirement that exists under the Medical Treatment Act that the person making the certificate must receive information about the nature of their condition.  

Other responses that, in principle, supported broadening the statutory right to make instructional medical directives expressed concern about the suggestion that the requirement to receive information might be removed. The importance of basing medical decisions on informed consent was emphasised.

One submission, which argued against a requirement that an individual should have to be provided with information about their condition or treatment options, suggested adopting the Western Australian approach as a compromise. There the legislation encourages a person to obtain advice before completing a directive but failure to obtain this advice does not invalidate the directive.

A number of submissions did not favour broadening and clarifying the right to make instructional medical directives. The main concerns expressed were that:

- statutory instructional directives might be used to provide for euthanasia or assisted suicide
- people may make decisions about future treatments for hypothetical situations without supporting information or knowledge of outcomes and that directives for future events cannot be adequately informed
- it could require health providers to act in a way that is inconsistent with their conscience
- it may not take into account the needs of others in the circumstances

Several submissions expressed a preference for relying upon enduring substitute decision makers to make decisions about medical treatment rather than giving binding legal status to written directions about future treatment.

The Public Advocate preferred retaining the refusal of treatment certificate scheme and suggested that legislation should require substitute decision makers to consider any advance directive signed by the patient.

The submission from the Respecting Patient Choices Program emphasised that its approach in assisting people to develop advance care plans is to focus more on...
desired patient outcomes than treatments’.79 It expressed concern that the proposal to broaden and clarify the statutory right to make instructional medical directives ‘may undermine current understanding and acceptance of advance care planning by presenting a rather “black and white” view of blanket acceptance or refusal of specific treatments’.80 It suggested that:

It would be more productive for a person to state their desired outcomes in terms of what level of physical and mental function they would consider an acceptable outcome, so that in the event of an actual condition, their agent would be able to discuss treatment options and likely outcomes with the treating team and make decisions accordingly.81

INSTRUCTIONAL PSYCHIATRIC DIRECTIVES

11.63 The Mental Health Legal Centre expressed a preference for the introduction of ‘comprehensive advance directive legislation … which does not separate psychiatric from non-psychiatric medical treatment directives’.82

11.64 It also submitted that advance directives should ‘have equal legislative recognition and consistent enforceability and implementation whether under guardianship or mental health laws’.83

11.65 Victoria Legal Aid supported retaining a distinction between psychiatric and non-psychiatric treatment. It submitted that:

The law currently distinguishes between psychiatric and non-psychiatric medical treatment decisions, and VLA believes this distinction should be maintained. However, it is important for consistency’s sake that the law relating to instructional medical directives be considered alongside the proposals and recommendations in the mental health law reforms.84

INSTRUCTIONAL DIRECTIVES—PERSONAL, LIFESTYLE, FINANCIAL

11.66 A significant number of submissions supported an ability to make instructional directives about matters other than medical treatment.85

11.67 The advantages identified for providing legislative recognition of instructional directives on lifestyle or financial matters were:

• it allows older people to document their wishes with more confidence that these wishes will be taken into account86
• it may reduce family conflict87
• it maximises individual autonomy in accordance with the principles of the Convention88
• matters other than medical treatment may be very important to people.89
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11.68 Many matters were identified as appropriate for inclusion in an instructional directive. Specific examples include:

- preferences for support, accommodation and residential care
- preferences that financial assets are used to provide a superior level of care rather than preserved for inheritance
- lifestyle, including religious and cultural considerations
- preferences about who the person wishes to have contact with.

11.69 A number of submissions supported the idea that people should be able to include directions about whatever is most important to them. The Mental Health Legal Centre suggested that documents for providing instructions should not be overly prescriptive, but rather should allow and encourage people to include the information that they think is important.

11.70 A number of submissions noted that in some circumstances instructional directives about matters other than medical treatment should be unenforceable. For example, an expressed preference for accommodation may not be available because of finances, or may be unsafe for the person.

11.71 The difficulties and impracticalities in implementing an instructional directive on matters other than medical treatment were noted. State Trustees Limited submitted that ‘if stand-alone statutory instructional directives are introduced they should not be binding on an attorney or an administrator in respect of financial matters’.

PERSONAL APPOINTMENTS AND INSTRUCTIONAL DIRECTIVES

11.72 In the consultation paper, the Commission suggested that combining a personal appointment with an instructional directive would encourage people to plan, discuss their wishes with loved ones, document those wishes and ensure that people who need to know are aware of those wishes. This practice appears to provide a more holistic approach to advance planning and avoids the difficulties associated with instructional directives made without a full appreciation of all the circumstances that might be relevant when making an important decision. The Commission asked whether the wishes expressed in a personal appointment should be binding but displacable in certain circumstances or whether decision makers should only be required to provide reasons for departing from stated wishes.

11.73 A number of submissions supported the approach of requiring personally appointed decision makers to consider any wishes expressed in a document making a personal appointment but not making these wishes binding.

11.74 Many responses favoured a requirement that a personally appointed decision maker be required to record their reasons for departing from wishes. The Law Institute of Victoria supported this approach, suggesting that personally appointed decision makers ‘should be required to record their reasons and retain them in case of a future

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90 For eg, Submissions CP 22 (Alzheimer’s Australia Vic) and CP 33 (Eastern Health).
91 Submission CP 47 (Dr Michael Murray).
92 Submissions CP 24 (Autism Victoria) and CP 35 (Ursula Smith).
93 For eg, Submissions CP 19 (Office of the Public Advocate).
94 For eg, Submissions CP 66 (Victorian Equal Opportunity and Human Rights Commission) and CP 78 (Mental Health Legal Centre).
95 Submission CP 78 (Mental Health Legal Centre).
96 For eg, Submissions CP 22 (Alzheimer’s Australia Vic) and CP 35 (Ursula Smith).
97 Submission CP 70 (State Trustees Limited).
98 For eg, Submissions CP 19 (Office of the Public Advocate), CP 33 (Eastern Health), CP 59 (Carers Victoria), CP 65 (Council on the Ageing Victoria) and CP 77 (Law Institute of Victoria).
99 For eg, Submissions CP 19 (Office of the Public Advocate), CP 22 (Alzheimer’s Australia Vic), CP 24 (Autism Victoria) and CP 35 (Ursula Smith).
VCAT application seeking to revoke their appointment’. State Trustees Limited supported a similar approach specifically in relation to enduring appointments of financial decision makers.

Other submissions considered that instructional directives made as part of an enduring appointment should be binding on personally appointed substitute decision makers and should only be overridden with authorisation from VCAT.

A similar view was put forward in response to the Commission’s online forum, which asked questions about the enforceability of instructional directives that are included with personal appointments:

> I do believe that the law should be much clearer about advanced statements, but it should be able to be reviewed by VCAT or something along those lines. I think there are times when we can make decisions that [are] not necessarily what will be best for us … Advanced statements are important, and they should as far as possible be binding, but there [need] to be times when they are able to be overturned, and at an absolute minimum the person should have to justify the reasons for what they are doing and have that approved by either VCAT or the [Public Advocate].

An alternative option suggested in submissions was to allow the person making an enduring appointment combined with an instructional directive to specify whether the instructional directive is intended to be binding on the personally appointed decision maker or merely act as a guide for decision making.

The majority of responses that considered whether the same rules should apply to enduring guardians and enduring attorneys (financial) thought that the same rules should apply to both types of appointment.

Victoria Legal Aid proposed that there might be a case for slightly different rules for enduring guardians and enduring attorneys (financial). It proposed a general requirement that a substitute decision maker seek a VCAT order to overturn the person’s wishes. However, where an attorney (financial) cannot implement a decision because they do not have the funds to do so, they should be able to depart from the person’s wishes if they provide a statement outlining the basis of their decision to VCAT and the person. VCAT should be permitted to order compliance with the person’s wishes if it concludes that they can be implemented.

**SANCTIONS**

Some submissions considered what should happen in circumstances where a binding instructional directive is overridden without proper lawful authority.

One suggestion was that the override be investigated and referred to VCAT or the police as appropriate.

100 Submission CP 77 (Law Institute of Victoria).
101 Submission CP 70 (State Trustees Limited).
102 For eg. Submissions CP 66 (Victorian Equal Opportunity and Human Rights Commission), CP 73 (Victoria Legal Aid), CP 75 (Federation of Community Legal Centres (Victoria)) and CP 78 (Mental Health Legal Centre).
104 Submissions CP 13 (Dying with Dignity Victoria), CP 63 (Shih-Ning Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)). This proposal was made specifically in relation to appointments combined with instructional directives that are intended to provide for medical treatment decisions.
105 For eg. Submissions CP 22 (Alzheimer’s Australia Vic), CP 24 (Autism Victoria), CP 35 (Ursula Smith), CP 47 (Dr Michael Murray), CP 59 (Careers Victoria), CP 77 (Law Institute of Victoria) and CP 78 (Mental Health Legal Centre).
106 Submission CP 73 (Victoria Legal Aid).

107 For eg. Submissions CP 24 (Autism Victoria) and CP 35 (Ursula Smith).
11.82 The Catholic Archdiocese of Melbourne did not support the creation of new offences. It submitted that:

The Church would not support creating new offences for people failing to comply with instructional directives. The issue is one of trust. The purpose of giving a power of attorney is to entrust matters to that person. If there were offences associated with holding a power of attorney, then it would be foolish to be prepared to accept the role and their function would be undermined and be likely to fall into disuse.108

11.83 State Trustees Limited expressed a similar view that the introduction of further sanctions for overriding an instructional directive might discourage people from accepting an enduring appointment. The submission noted that sanctions already exist under general law, such as an action for a breach of fiduciary duty, and that the legislation provides the power to revoke an enduring power of attorney.109

11.84 Other submissions supported sanctions for unlawfully overriding a valid directive.110 The Public Advocate considered that penalties should be consistent with the penalties that exist for breaches of other duties by substitute decision makers.111

11.85 The Mental Health Legal Centre submitted that:

We strongly support sanctions for unlawfully overriding an advance directive. Such sanctions must also be enforceable through a robust body which reports directly to parliament. It would be appropriate for sanctions to be severe in cases of gross violations of the law. In our view it is also imperative that data is collected on the frequency and circumstances of overrides of advance directives and that the responsible body have the power and resources to investigate individual cases and systemic issues.112

THE COMMISSION’S VIEWS AND CONCLUSIONS

11.86 The Commission recognises the desirability of allowing people to make statutory advance care directives to guide future decision making about them if they lose capacity. Advance directives promote autonomy and dignity and they reduce the burden on state-supported substitute decision makers.

11.87 It is important to recognise that members of the community have a range of views on how they wish to guide future decision making. These views may be influenced by their cultural background, religion or personal life experience. In order to provide the maximum respect for each person’s dignity and to allow them to guide decision making in a way that reflects their values and preferences, it is desirable to provide a range of mechanisms that enable people to guide decision making about them beyond the loss of capacity.

11.88 In some instances, it will be impossible for people to predict the type of decisions that may need to be made for them in the future. For this reason it will often be preferable to provide for future decision making by combining an appointment of a trusted person as a substitute decision maker with instructions that guide, rather than bind, decisions. It is also important that people are encouraged to discuss their goals, values and preferred outcomes with the person they are appointing, as well as with friends and family. This means that recorded instructions are more likely to be understood and followed.

108 Submission CP 27 (Catholic Archdiocese of Melbourne).
109 Submission CP 70 (State Trustees Limited).
110 For eg, Submissions CP 19 (Office of the Public Advocate), CP 71 (Seniors Rights Victoria), CP 73 (Victoria Legal Aid) and CP 78 (Mental Health Legal Centre).
111 Submission CP 19 (Office of the Public Advocate).
112 Submission CP 78 (Mental Health Legal Centre).
However, consultations also highlighted that some people may want to provide directions or instructions and not appoint a substitute decision maker. Some people are very reluctant to give decision-making responsibility to someone else. Other people may not have anyone who they want to appoint to make decisions for them but may still wish to provide instructions about future decisions. Some people may consider decision making that involves refusal of medical treatment too stressful for a family member or friend, and might choose instead to make those decisions themselves when they are still able to do so.

A RANGE OF MECHANISMS TO ACCOMMODATE FUTURE WISHES

The Commission believes new guardianship legislation should permit people to plan for future decision making in three ways:

- appointing an enduring personal guardian or enduring financial administrator\(^\text{113}\) without providing any instructions or conditions
- appointing an enduring personal guardian or enduring financial administrator and combining this with an instructional directive that provides limitations, conditions, or instructions about the exercise of their powers
- making a ‘stand-alone’ instructional directive without the appointment of a substitute decision maker that provides binding or guiding instructions about health care or guiding instructions about other future decision making.

This approach, which seeks to promote autonomy, reflects the principle in the National Framework for Advance Care Directives that a person’s culture, background, history or spiritual and religious beliefs may mean that a person exercises their autonomy in a variety of ways. Some people prefer to exercise their autonomy by making the decision on their own behalf, while others prefer delegating decisions to others or making collaborative decisions with close family members or friends.\(^\text{114}\)

RECOMMENDATIONS

Ways of documenting wishes, instructions or directions

New guardianship legislation should enable a person with capacity to document instructions about future decision making by:

- appointing an enduring personal guardian or enduring financial administrator with no instructions about how to exercise or how not to exercise their decision-making powers, or
- appointing an enduring personal guardian or enduring financial administrator with instructions about how to exercise or how not to exercise their decision-making powers, or
- making a stand-alone ‘instructional directive’.

Instructional directives

An instructional directive should be able to provide:

- binding instructions or advisory instructions about health matters
- advisory instructions about personal and lifestyle matters, other than health matters and financial matters, that should be taken into account and followed where reasonably possible but should not be legally binding.

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113 In Chapters 5 and 10, the Commission recommends replacing the term ‘enduring guardian’ with ‘enduring personal guardian’ and ‘enduring attorney (financial)’ with ‘enduring financial administrator’.

114 A National Framework for Advance Care Directives - September 2011, above n 58, 25.
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‘STAND-ALONE’ INSTRUCTIONAL HEALTH CARE DIRECTIVES

11.92 The Commission believes that the statutory right to make binding instructional directives about health care should be broader than the circumstances currently provided for by refusal of treatment certificates under the Medical Treatment Act. A statutory scheme should provide for binding instructional directives about medical treatment in a broader range of circumstances. To reflect these changes, the name ‘refusal of treatment certificate’ should be replaced with ‘instructional health care directive’.

RECOMMENDATIONS

Replace ‘refusal of treatment certificate’ with ‘instructional health care directive’

135. The ability to make refusal of treatment certificates under the Medical Treatment Act 1988 (Vic) should be replaced with a statutory scheme that provides for binding instructional directives about health care to be made in a broader range of circumstances. To reflect these changes, the name ‘refusal of treatment certificate’ should be replaced with ‘instructional health care directive’.

Existing refusal of treatment certificates—transitional arrangements

136. Refusal of treatment certificates made under the Medical Treatment Act 1988 (Vic) prior to the introduction of new provisions for instructional directives should retain their force as a legally valid way of refusing treatment to the extent that this was authorised by the Medical Treatment Act.

Preservation of common law

11.93 A key policy aim in providing for statutory instructional health care directives is to provide certainty for the person providing the directions and for health professionals. There is no intention to reduce or alter any existing rights. For this reason, the Commission considers that any existing common law rights to make advance statements about consent to or refusal of treatment should be retained to deal with any situations not contemplated by the proposed statutory scheme and to protect people who have already prepared common law statements.

RECOMMENDATION

Preservation of common law

137. New guardianship legislation should provide that the existence of statutory provisions to make an instructional health care directive does not affect any existing common law right to make an advance directive about medical treatment.

Scope of instructional health care directives

Future as well as current conditions

11.94 The Commission believes that people should be able to make instructional health care directives about future as well as current conditions. The existing requirement under the Medical Treatment Act that a refusal of treatment certificate may only be made about a current condition is inconsistent with the law in the other five Australian jurisdictions that have enacted legislation of this nature. The Commission also notes
that this approach is consistent with the principle in the National Framework for Advance Care Directives that ‘[d]irections can be written to apply to any period of impaired decision-making capacity, and are not limited to the end of life’.115

11.95 People are unlikely to take the step of making an instructional health care directive refusing or consenting to treatment unless they have strongly held views about the matter. For many people, this would only arise if they have a condition that requires them to consider treatment options and have received advice about it. However, the Commission considers that people with capacity should have the right to refuse a particular type of treatment or to refuse all medical treatment for reasons that might be deeply personal. Some people have strongly held ethical or religious views about medical treatment and for these reasons may not wish to receive treatment regardless of the outcome. Such people may wish to provide a binding instruction to this effect about treatment of future conditions and not rely on a substitute decision maker to enforce their beliefs.

Instructional directive cannot be used to request an unlawful intervention

11.96 The Commission acknowledges the concern expressed in some submissions that instructional health directives might be seen as a means of authorising interventions that unlawfully hasten death. To avoid doubt, new guardianship legislation should state that an instructional health care directive cannot be used to request an unlawful act and a health provider is not required to follow a direction that is unlawful. This approach is consistent with the policy recommended in the National Framework for Advance Care Directives.116

Conscientious objection

11.97 The Commission accepts that a lawful direction may be inconsistent with a health professional’s conscience. New guardianship legislation should permit a health professional to refer a patient to another health professional if their personal views or beliefs prevent them from complying with lawful directions in a valid instructional health care directive. The National Framework for Advance Care Directives supports this approach.117

Advance consent and advance refusal

11.98 The Commission believes that a principal118 should be able to provide advance consent as well as advance refusal to treatment. The South Australian, Western Australian and Queensland statutory schemes provide for this step and the Commission considers this would be a useful addition to Victorian law.

11.99 There are two situations where an ability to provide advance consent may be particularly important. The first is where an individual is concerned that family members or close friends may not consent to treatment that they wish to have and prefer to provide this direction on their own behalf. An individual may wish to provide a binding direction to consent to a particular treatment without discussing this with family or friends. This may occur when the family and friends have a strong religious or ethical belief that a particular treatment should be refused, but the individual does not adhere to this belief and wishes to consent to this treatment.

11.100 The second situation is where the individual has personal experience of an illness and particular treatments and wishes to consent to a particular treatment because it is effective; this may be combined with the refusal of another type of treatment.

115 Ibid 14.
116 Ibid 32.
117 Ibid 41.
118 In Chapter 10, the Commission recommends replacing the term ‘donor’ (a person who makes an enduring appointment) with ‘principal’.
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Not to be used to demand treatment

11.101 The Commission notes the concern that an instructional health care directive not be used to demand particular medical interventions or treatment. The Commission agrees with the principle expressed in the National Framework for Advance Care Directives that ‘health care professionals are not required to offer treatment that they consider neither medically beneficial nor clinically appropriate’. New guardianship legislation should include this limitation on the use of an instructional health care directive.

RECOMMENDATIONS

Scope of instructional health care directives

138. An instructional health care directive should allow the principal to:
   (a) give directions about health care and medical treatment for their future health care
   (b) give information about their directions
   (c) provide information about exercising the power.

139. The principal should be able to make instructional health care directives about future as well as current conditions.

140. The principal should be able to provide advance consent to treatment as well as advance refusal. However, a principal cannot demand treatment that is not offered.

141. To avoid doubt, new guardianship legislation should specifically provide that an instructional health care directive allows the principal to give directions about requiring a life-sustaining measure to be withheld or withdrawn in particular circumstances.

Instructional health care directives cannot authorise euthanasia or assisted suicide

142. New guardianship legislation should include a statement that an instructional health care directive cannot authorise, justify or excuse taking positive steps to assist someone to end their life unlawfully.

Conscientious objection

143. A health professional should be required to refer the patient or enduring personal guardian to another health professional if their personal views or beliefs prevent them from complying with lawful directions in a valid instructional health care directive.

Psychiatric treatment

11.102 The Commission is not proposing that instructional health care directives made in relation to psychiatric treatment should be binding when the person becomes an involuntary patient under the Mental Health Act 1986 (Vic). The Commission has made this decision for two reasons:
   • These matters are currently being considered by the Victorian Government’s review of the Mental Health Act and lie within the domain of that review.

119 A National Framework for Advance Care Directives - September 2011, above n 58, 15.
The complexity of issues in relation to instructional directives for psychiatric treatment is such that, in the Commission’s view, it is preferable for the person to appoint an enduring personal guardian and to provide that person with instructions about their treatment wishes. This matter is discussed in detail in Chapter 24.

**RECOMMENDATION**

**Psychiatric treatment**

144. Any directions in an instructional health care directive about psychiatric treatment are not binding if a person becomes an involuntary patient under the *Mental Health Act 1986*(Vic).

**Requirement for advice and informed decision making**

11.103 The Commission recognises that it is desirable that a person making an instructional health care directive receive information about the consequences of refusing or consenting to a particular medical treatment. The forms created for instructional health care directives should encourage this step.

11.104 The Commission considers that while people should be encouraged to seek information about medical treatment referred to in an instructional directive, this step should not be mandatory. A requirement that the person making the directive receive information would be inconsistent with the National Framework for Advance Care Directives, which states that ‘[l]aw and policy must not require that a competent adult … be medically informed or seek or follow medical advice’.

Requirement for advice and informed decision making does not exist at common law and nor is it required by the statutory schemes in Queensland, South Australia, the Australian Capital Territory and the Northern Territory.

**Prescribed forms**

11.105 It is important that the forms for instructional directives are as easy to use as possible. The forms should be developed in consultation with a wide range of stakeholders. The Commission considers that it would be desirable to develop these forms at the same time as forms for personal appointments and supporters. This would encourage consistency in format and avoid unnecessary repetition of work.

11.106 The Commission believes it should be mandatory to use the approved form. This will help ensure that information provided to a person making an instructional health care directive is consistent and increases the chances that formal requirements, such as witnessing, are followed.

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120 Ibid 32.
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RECOMMENDATIONS

Prescribed forms

145. New guardianship legislation should provide that an instructional health care directive must be in the prescribed form.

146. The forms should be developed by a multidisciplinary team in consultation with a wide range of community members as well as representatives from professional organisations and interest groups.

147. The forms should be user-friendly, simple, written in plain English and provide appropriate information about how to complete them. The forms should have a consistent design.

148. The forms and any associated information and educational material should be available in a range of community languages. Translated forms should be in a bilingual format that includes both English and the community language.

Witnessing requirements

11.107 Two of the most important functions of witnesses to documents of this nature are to check understanding and to provide safeguards against abuse. Witnesses should confirm:

- the age and identity of the person making the instructional health care directive
- that the person understands the contents of the instructional health care directive and the implications of completing it
- that the person is signing the directive voluntarily without inducement or coercion.

11.108 The Commission considers that the witnessing requirements for an instructional health care directive should correspond with those for enduring personal appointments which are considered in detail in Chapter 10. This step is desirable in the interests of simplicity and consistency and because the range of powers that an enduring personal guardian may be given include powers to consent to or refuse medical treatment.

11.109 Consistent with the recommendations for personal appointments in Chapter 10 there should be two witnesses to an instructional health care directive:

- One witness should either be authorised to witness an affidavit or be a registered medical practitioner (authorised witness).
- The other witness need not have any special qualification (non-authorised witness).

11.110 The Commission notes that these witnessing requirements are more stringent than those suggested by the National Framework on Advance Care Directives. The Framework suggests that one independent witness should be required and that witnesses should not be limited to a defined set of professional groups. The Commission considers that a balance between adequate safeguards and not making witnessing unnecessarily cumbersome is provided by requiring two witnesses, one of whom is an authorised witness who is either eligible to witness affidavits or is a registered medical practitioner.

121 Ibid 31.
11.111 The Commission considered whether the authorised witness should be a medical practitioner. However, given the conclusion that a person need not seek medical advice in order for the instructional health care directive to be followed, the Commission believes that there should not be a formal requirement that one of the witnesses is a registered medical practitioner. This view is consistent with the National Framework on Advance Care Directives.122

11.112 As discussed in Chapter 10, the Commission considers that further thought should be given to who should be automatically excluded from witnessing documents. In that chapter, the Commission suggested allowing relatives to witness an enduring appointment if they are a non-authorised witness, but excluding relatives from acting as the authorised witness. The same approach could be taken in relation to witnessing of instructional health care directives.

**RECOMMENDATION**

**Witnessing requirements**

149. An instructional health care directive should be signed and dated by two witnesses who are present at the time the instructional health care directive is made. One of the witnesses must be a person who is authorised to witness an affidavit or a registered medical practitioner. The witnesses must be satisfied that:

(a) the principal is at least 18 years old

(b) the authorised witness has seen appropriate identification documents, which confirm the principal’s identity. The Act or regulations should detail what combination of documents is eligible as effective proof of identification

(c) the principal’s decision is made voluntarily and without inducement or compulsion

(d) the principal understands the nature and likely effects of each direction in the instructional health care directive

(e) the principal understands that a direction in an instructional health care directive operates only while the principal lacks capacity to make decisions about the matter covered by the direction

(f) the principal understands that they may revoke a direction in the instructional health care directive at any time they have capacity

(g) the principal understands that, at any time they are incapable of revoking a direction, they are unable to effectively oversee the implementation of the direction.

**Enforceability of an instructional health care directive**

11.113 New guardianship legislation should specify that an instructional health care directive is binding if it is valid and the direction governs circumstances that have arisen.

11.114 If a health care professional or substitute decision maker considers the directive may be invalid or the maker would not have intended the direction to apply in the circumstances that have arisen, they should be required to apply to the tribunal for a determination concerning its effect.

122 Ibid.
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11.115 The legislation should contain a non-exhaustive list of the circumstances in which the directive is not binding because the principal would not have intended that it be followed. These should include situations where:

- Circumstances, including advances in medical science, have changed since the completion of the instructional directive to the extent that the principal, if they had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

- The instructional health care directive is uncertain or there is persuasive evidence to suggest that the instructional health care directive is based on incorrect information or assumptions.

RECOMMENDATIONS

Enforceability of an instructional health care directive

150. An instructional health care directive should be binding on health providers and substitute decision makers if it is valid and the direction operates in the circumstances that have arisen.

151. A direction in an instructional health care directive does not operate if the maker would not have intended it to apply in the circumstances that have arisen. This occurs if one of the following applies:

(a) Circumstances, including advances in medical science, have changed since the completion of the instructional health care directive to the extent that the principal, if they had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.

(b) The instructional health care directive is uncertain.

(c) There is persuasive evidence to suggest that the instructional health care directive is based on incorrect information or assumptions.

Offence of medical trespass

11.116 The offence of medical trespass in section 6 of the Medical Treatment Act should be extended to apply to a health provider who knowingly provides medical treatment to a person that is contrary to the person’s wishes as expressed in an instructional health care directive and that is not otherwise authorised by law. The requirement that the offence be limited to those circumstances where a health provider knowingly provides treatment despite the views expressed in a directive protects those health professionals who act in good faith when assisting people who appear to be need of treatment.

11.117 A medical practitioner who knowingly provides medical treatment to a person that is contrary to the person’s wishes as expressed in an instructional health care directive would also be liable to professional sanctions for misconduct and would be at risk of civil or criminal proceedings for assault.
RECOMMENDATION

Offence of medical trespass

152. The offence of medical trespass in section 6 of the Medical Treatment Act 1988 (Vic) should be extended to apply to a health provider who knowingly provides medical treatment to a person that is contrary to that person’s wishes as expressed in an instructional health care directive and that is not otherwise authorised by law.

Registration

11.118 The Commission considers that certainty is best provided by requiring that instructional health care directives are registered. However, because of privacy concerns about medical matters, some people might be discouraged from making an instructional health care directive if registration is compulsory. In time, these privacy concerns might evaporate if the register is seen to operate successfully in relation to personal and tribunal appointments of supporters and substitute decision makers.

11.119 The Commission recommends voluntary registration in the first instance. However, health providers should be required to check the online register to determine if an instructional health care directive is in place before providing treatment. The Commission does not believe that this requirement will be overly burdensome if the online register discussed in detail in Chapter 16 is introduced.

RECOMMENDATION

Registration

153. It should not be compulsory to register an instructional health care directive.

Protection for health providers for non-compliance with instructional health care directives

11.120 A health provider should be protected from liability when they are acting in good faith without actual knowledge either that an instructional health care directive exists or when they comply with a directive that is invalid. This protection should only apply if the health provider has checked the online register before proceeding.

Emergency treatment

11.121 The legislation should also permit a health provider to act in emergencies where time is of the essence without any reference to an instructional health care directive. This protection should extend to circumstances where emergency treatment is required and the health provider knows there is an instructional health care directive in place but has reasonable grounds for believing that it is inoperative. The protection should be limited to circumstances where the health provider believes on reasonable grounds that one of the following applies:

- Circumstances, including advances in medical science, have changed since the completion of the instructional directive to the extent that the principal, if they had known of the change in circumstances, would have considered the terms of the direction inappropriate.

- The instructional health care directive is uncertain or there is persuasive evidence to suggest that the instructional health care directive is based on incorrect information or assumptions.
RECOMMENDATIONS

Protection for health providers for non-compliance with instructional health care directives

154. New guardianship legislation should provide the following protection for health providers:

(a) A health provider is not affected by an instructional health care directive to the extent that the health provider, acting in good faith, does not have actual knowledge that the person has an instructional health care directive.

(b) A health provider who—acting in good faith and without actual knowledge that an instructional health care directive is invalid—acts in reliance on the directive, does not incur any liability to the principal or anyone else because of the invalidity.

(c) A health provider has a duty to determine whether an instructional health care directive is in place by checking the register before providing treatment. A health provider who fails to check the register and provides treatment that is inconsistent with the directive will not be protected from liability by the provisions providing protection for a lack of actual knowledge. A health provider is not required to check the register if emergency treatment is required.

Emergency treatment

155. If emergency treatment is required and the health provider is aware of an instructional health care directive but does not have time to apply to the tribunal to determine if it is valid or if a direction in the directive is operative, and they believe on reasonable grounds that one of the following applies:

(a) circumstances, including advances in medical science, have changed since the completion of the instructional health care directive to the extent that the principal, if they had known of the change in circumstances, would have considered the terms of the direction inappropriate

(b) the instructional health care directive is uncertain

(c) there is persuasive evidence to suggest that the instructional health care directive is based on incorrect information or assumptions

then the health provider does not incur any liability, either to the principal or anyone else, if the health provider does not act according to the directive.

Copies of instructional health care directives

11.122 The Commission believes that hospitals and nursing homes should be required to take measures to ensure that any instructional health care directive is placed with the patient’s clinical records so that all relevant staff are alerted to it. There is a similar provision in the Medical Treatment Act for refusal of treatment certificates.123

123 Medical Treatment Act 1988 (Vic) s 5E.
RECOMMENDATION

Copies of instructional health care directives
156. The chief executive officer of a hospital or a nursing home must take reasonable steps to ensure that a copy of any instructional health care directive applying to a patient in the hospital or home, and of any notification of the cancellation of such directive, is placed with the patient’s record kept by the hospital or home.

Tribunal declaration about an instructional health care directive
11.123 The Commission believes that a health care provider, substitute decision maker or any person with a special interest in the affairs of the principal who considers that an instructional health care directive is invalid or should not be followed should be able to apply to VCAT for a determination about its effect.

11.124 VCAT should have the power to determine the validity of the directive and to declare whether any of the provisions of a valid directive are no longer operative because the maker would not have intended it to apply in the circumstances that have arisen. In cases of this nature, the tribunal should also have the power on its own motion to appoint a personal guardian to make the health care decision in question.

RECOMMENDATION

Tribunal declaration about an instructional health care directive
157. If a health provider, substitute decision maker or any person with a special interest in the affairs of the principal considers that an instructional health care directive is not or may not be valid, or that a direction in an instructional health care directive does not operate because the principal would not have intended it to apply in the circumstances that have arisen, they can apply to VCAT to make a determination about the effect of the directive.

Recognition of instructional health care documents made in other Australian jurisdictions
11.125 It is desirable to recognise instructional health care directions made in other Australian jurisdictions whenever reasonably possible.

11.126 At present, Western Australia and Queensland are the only Australian jurisdictions that recognise interstate instructional health care directives. Queensland recognises a directive made in another jurisdiction if it complies with the laws of that other jurisdiction. The Commission supports adopting this approach in Victoria.

124 Guardianship and Administration Act 1990 (WA) s 110ZA; Powers of Attorney Act 1998 (Qld) s 40.
125 Powers of Attorney Act 1988 (Qld) s 40.
Chapter 11

Documenting wishes about the future

RECOMMENDATION

Recognition of instructional health care documents made in other Australian jurisdictions

158. Instructional health care documents made in other states should be recognised in Victoria to the following extent:

(a) If a document prescribed by regulation is made in another state and complies with that state’s document requirements, then, to the extent the document’s provisions could have been validly included in an instructional health care directive made under the Victorian Act, the document must be treated as if it were an instructional health care directive made under, and in compliance with, this Act.

INSTRUCTIONAL DIRECTIVES—PERSONAL AND FINANCIAL MATTERS

11.127 The Commission agrees with the widely expressed view that people should be able to provide instructional directives about the things that are most important to them. These matters should not be limited to medical treatment decisions but may encompass broader matters such as preferences for support, accommodation and residential care, or preferences that financial assets are used to provide a certain level of care.

11.128 Instructions or preferences are likely to function best when the appointment of a substitute decision maker is combined with an instructional directive and discussed with friends, family and the appointed substitute decision maker. Educational programs about advance care directives should encourage this approach. The forms created for documenting instructional directives should encourage people to think broadly about their views and wishes and discuss these with significant people in their lives.

11.129 The Commission also recognises that some people may not be able, or may not wish, to appoint a substitute decision maker. These people should still have a right to express their preferences and have them followed wherever possible. This maximises their autonomy and provides people with more confidence that their wishes, values and preferences will be taken into account when important decisions are made. It is the Commission’s view that a right to make instructional directives on lifestyle or financial matters should be recognised by statute.

11.130 New guardianship legislation should permit people to make instructional directives about personal or financial matters. In many circumstances, however, instructional directives about matters other than medical treatment will be unenforceable. For example, an expressed preference for a particular accommodation type may be impossible because it no longer provides an appropriate level of care or because finances may be unavailable.

11.131 For this reason, the Commission believes that statutory instructional directions about matters other than about health care decisions should be taken into account and followed where reasonably possible, but should not be legally binding. The Commission believes that if instructions are not followed, the reasons for doing so should be recorded to help ensure that the instructions are properly considered and to assist if any future challenge to the decision arises.
Instructional directives—personal and financial matters

159. A principal may create an instructional directive that provides advisory instructions about personal and lifestyle matters and financial matters. These matters should be taken into account and followed where reasonably possible but should not be legally binding.

160. A substitute decision maker who is aware of any instructional directive should be required to follow the wishes expressed in an instructional directive where reasonably possible.

Enduring appointments combined with instructional directives

161. A person should be able to appoint an enduring personal guardian or enduring financial administrator and combine the appointment with a personal instructional directive.

ENDURING APPOINTMENTS COMBINED WITH INSTRUCTIONAL HEALTH CARE DIRECTIVES

11.132 If a principal wishes to appoint an enduring personal guardian with health care powers and combine the appointment with an instructional health care directive, the principal should be able to specify if the instructional health care directive is binding for the matters it covers, or intended as a guide only. In situations where the principal specifies that the instructional directive is binding for the matters it covers, the enduring personal guardian should act as an advocate to ensure that health professionals comply with the directive. It should only be possible to override a binding instructional health care directive by tribunal order.

11.133 If the principal specifies that the instructional health care directive is for guidance only, the enduring personal guardian should be required to take the direction into account when making a decision that is in the person’s personal and social well-being as part of the substituted judgment consideration. We discuss this further in Chapter 17.

RECOMMENDATION

Enduring appointments combined with instructional health care directives

162. A principal who combines the appointment of an enduring personal guardian with an instructional health care directive should be able to specify if the instructional health care directive is binding for the matters it covers, or intended as a guide only.

163. If the principal specifies that the instructional health care directive is binding, the enduring personal guardian should act as an advocate to ensure that the medical treatment complies with the directive.

164. It should only be possible to override a binding instructional health care directive as set out in recommendation 151 above.

165. If the principal specifies that the instructional health care directive is to provide guidance only, the enduring personal guardian should consider the direction but is not bound to follow it.
Enduring appointments combined with instructional directives about personal or financial matters

11.134 A principal who combines the appointment of an enduring personal guardian or enduring financial administrator with an instructional directive, other than an instructional health care directive, should be able to specify express conditions or limitations on the exercise of power. If the conditions or limitations are sufficiently specific and clear they should be binding on the enduring personal guardian or enduring financial administrator. An example of a limitation or condition might be a direction not to invest the principal’s funds in particular companies or industries or not to sell a particular item of property. It should only be possible to override express conditions or limitations of this nature by order of the tribunal.

11.135 A principal should be able to provide general guidance about their values, wishes or preferences in an instructional directive by use of non-binding instructions. For example, they may state that they wish to remain in their home as long as possible, or nominate people they wish to see. They also might wish to express ethical values and indicate a preference that investment decisions support these values.

11.136 The Commission accepts the point made in consultations that these types of instructions will not always be able to be enforced. Requiring the tribunal approval for each departure would make it very difficult for a substitute decision maker to do their job, would place a strain on the tribunal and could discourage people from accepting an enduring appointment. For these reasons, the Commission believes that instructions other than express and specific limitations or conditions should guide decision making as part of a substituted judgment consideration, but should not be legally binding on enduring personal guardians or enduring financial administrators.

RECOMMENDATION

Enduring appointments combined with instructional directives about personal or financial matters

166. A principal who combines the appointment of an enduring personal guardian or enduring financial administrator with an instructional directive, other than an instructional health care directive, should be able to specify binding conditions or limitations on the exercise of power and non-binding instructions to guide decision making.

OUTCOMES-BASED INSTRUCTIONAL DIRECTIVES

11.137 The Commission believes it is important that people are encouraged to create instructional directives using outcomes-based terms. The Commission agrees with Respecting Patient Choices’ observation that outcomes or goals are more likely to remain stable over time and provide the greatest assistance to those people who strive to implement directives long after they were recorded.

11.138 People should be encouraged to discuss their instructions, wishes and values with family, medical professionals and anyone they are appointing as an enduring personal guardian or enduring financial administrator. Some of the steps suggested by
Respecting Patient Choices for advance planning are applicable to planning for all types of decision making in the future:

- thinking about your future medical care/decisions that are important to you
- choosing someone to speak for you
- writing down your wishes
- informing others of your decisions.\(^{126}\)

**RECOMMENDATION**

Outcomes-based instructional directives

167. People should be encouraged to write an instructional directive using outcomes-based terms. It should be possible to record personal values, ethics, religious and cultural beliefs, wishes and life goals. Any forms created should encourage this.

168. People should be encouraged to discuss their instructions, wishes and values with family, medical professionals and anyone they are appointing as an enduring personal guardian or enduring financial administrator. Any forms created should encourage these discussions.