INTRODUCTION

13.1 In this chapter, the Commission makes recommendations for reform of the law concerning authorisation of medical treatment for people with impaired decision-making capacity.

13.2 The current law is complex, largely because it is sometimes necessary to consider a number of overlapping statutes as well as the common law in order to determine the legal rules that apply when a person is unable to make their own decisions about medical treatment.

13.3 This chapter deals with the substitute decision-making arrangements for medical treatment in the Guardianship and Administration Act 1986 (Vic) (G&A Act) and the Medical Treatment Act 1988 (Vic) that apply to all adults who are unable to make their own decisions about medical treatment. In Chapters 23 and 24, we consider the Disability Act 2006 (Vic) and the Mental Health Act 1986 (Vic), which also deal with substituted consent for medical treatment for people with impaired capacity due to particular disabilities. The law governing substitute consent for participation in medical research procedures is considered in Chapter 14.

13.4 There appears to be a widespread lack of understanding about how the law regulates medical treatment for people who lack capacity to make their own decisions, perhaps because of its complexity. The Commission’s recommendations aim to simplify the law and to improve community understanding of its operation.

13.5 This chapter contains recommendations that seek to achieve the following outcomes:

- streamlining the law regulating personal appointments of substitute decision makers for medical treatment by replacing the two existing mechanisms with one new process
- improving the procedure of automatically appointing a person to become the substitute decision maker for medical treatment when there is no personal guardian with the power to make these decisions
- providing appropriate external authorisation of important medical treatment decisions by making the Public Advocate the substitute decision maker of last resort in some instances.

CURRENT LAW

13.6 The common law supports the right of all adults with capacity to make decisions about what happens to their bodies. This means that it is unlawful for any medical practitioner to treat an adult without their consent, ‘except in cases of emergency or necessity’.1 The common law does not otherwise cater for people who are unable to make their own medical treatment decisions, because it does not allow an adult to authorise treatment for another adult in any circumstances.2

13.7 In Victoria, the common law rules concerning medical treatment have been supplemented by two pieces of legislation that allow people to make arrangements for medical treatment decisions when they are unable to make their own decisions. This legislation was first passed in the 1980s and subsequently broadened by amendment in the 1990s.

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1 Rodgers v Whitaker (1992) 175 CLR 479, 489.
2 See Bernadette Richards, ‘General Principles of Consent to Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), Health Law in Australia (Lawbook Co, 2010) 93–111.
13.8 Since 1986, the G&A Act has permitted a tribunal to appoint a guardian to make medical treatment decisions for a person with impaired decision-making capacity. Since 1988, the Medical Treatment Act, which sought to clarify the common law right of people to refuse medical treatment, has allowed a person with capacity to give a written direction about refusal of treatment that, in some circumstances, continues to operate when the person no longer has the capacity to make their own treatment decisions.

13.9 The Medical Treatment Act was amended in 1990 to allow a person with capacity to appoint an agent to make medical treatment decisions for them—including refusal of treatment—should they lose capacity in the future.³

13.10 In 1999, the G&A Act was amended to allow:

- a person with capacity to appoint an enduring guardian to make decisions for them if they lose capacity, including decisions about medical treatment, and
- a person to be automatically appointed by operation of the legislation, without the need for any tribunal appointment, with authority to consent to medical treatment on behalf of a person who is unable to consent themselves. The substitute decision maker is referred to in the legislation as the ‘person responsible’ and the process is referred to in this chapter as an ‘automatic appointment’ or a ‘statutory appointment’.

13.11 Both pieces of legislation responded to the needs of medical practitioners and the community for clearer allocation of legal responsibility for medical treatment decisions. The Medical Treatment Act sought to provide greater clarity and security about potentially life-ending withdrawal of treatment, while the ‘automatic appointment’ amendments to the G&A Act sought to establish an efficient means of obtaining consent to treat patients who lacked capacity to make their own decisions.⁴

13.12 The way in which these two Acts operate together is not clear because Medical Treatment Act agents and enduring guardians appointed under the G&A Act have very similar roles. While the Medical Treatment Act was initially concerned with end of life refusal of treatment, the 1990 amendment appears to permit a person with capacity to appoint an agent to make decisions about any medical treatment. An enduring guardian can also be given authority to make any medical treatment decisions for a person who is unable to do so, other than decisions about ‘special procedures’, which must be made by the Victorian Civil and Administrative Tribunal (VCAT).⁵

THE GUARDIANSHIP AND ADMINISTRATION ACT 1986 (VIC)

Substitute decision makers

13.13 The G&A Act authorises six different substitute decision makers to make some decisions, in some circumstances, for an adult who is ‘incapable of giving consent’⁶ to ‘medical or dental treatment’.⁷ They are:

- a guardian appointed by VCAT with power to make medical treatment decisions
- an enduring guardian appointed by the person concerned with power to make medical treatment decisions

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3 These are the provisions for appointment of an enduring power of attorney (medical treatment); see Medical Treatment Act 1988 (Vic) s 5A.
4 There had been a large number of applications to VCAT for relatively minor procedures. See Victoria, Parliamentary Debates, Legislative Assembly, 22 April 1999, 594–5 (Maree Teahan).
6 This term is defined in s 36 of the Guardianship and Administration Act 1986 (1986).
7 This term is defined in s 3 of the Guardianship and Administration Act 1986 (Vic). For ease of discussion, the term ‘medical treatment’ is used throughout this chapter to include what is described in part 4A of the Act as ‘medical or dental treatment’.
Medical treatment

- a person who is automatically appointed by operation of the legislation as a person responsible with power to consent to some forms of medical treatment
- VCAT, which can make decisions about any medical treatment, including a special procedure
- a ‘registered practitioner’, who can make decisions about any medical treatment, including a special procedure, when the practitioner has reasonable grounds for believing that the treatment is ‘necessary, as a matter of urgency’
- a ‘registered practitioner’, who can make decisions about any medical treatment other than a special procedure, when the practitioner has been unable to obtain consent from a person responsible for the proposed medical treatment which the practitioner believes to be in the best interests of the person concerned and appropriate notice has been given to the Public Advocate.

Powers of guardians

13.14 The extent of a guardian’s authority to make decisions concerning medical treatment depends on the powers given to the guardian by VCAT, or the powers given to an enduring guardian by a donor. A guardian can be given the power to make any medical treatment decisions that the represented person could make other than consenting to a special procedure. A guardian appointed to make health care decisions usually has the power to consent to any medical treatment offered by a registered practitioner, as well as the power to refuse or decline any treatment.

VCAT’s powers

13.15 VCAT has the power to make decisions about all forms of medical treatment, including special procedures, for an adult who is unable to make their own decisions. Special procedures are defined as permanent sterilisations, abortions, and removal of non-regenerative tissue for donation, as well as any other procedures named in regulations. Only VCAT can provide substitute consent for a special procedure.

13.16 VCAT has the power to consent to any medical treatment (or special procedure) offered by a registered practitioner, as well as the power to refuse or decline any treatment (or special procedure).

Powers of the person responsible

13.17 Section 37 of the G&A Act contains a hierarchy of people who are permitted by section 39 of the Act to consent to ‘medical (or dental) treatment’ for an adult who is incapable of doing so when there is no guardian with the power to make these decisions. These automatic appointment provisions overlap with those parts of the Act that permit a guardian to be given the power to make medical treatment decisions, because guardians are included in the list of people who are eligible to be a person responsible.

13.18 The first person on the list who is available, willing and able to act is the person responsible, who has the authority to consent to or withhold consent to the proposed medical treatment. The section 37 list is:

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8 VCAT can also appoint another person to make these decisions: Guardianship and Administration Act 1986 (Vic) s 42N(6).
9 This term is defined in s 3 of the Guardianship and Administration Act 1986 (Vic) and includes registered medical and dental practitioners.
10 This concept is explained further in s 42A(1) of the Guardianship and Administration Act 1986 (Vic).
11 Guardianship and Administration Act 1986 (Vic) ss 42K and 42L.
12 Ibid s 3. There are currently no additional special procedures set out in regulations.
14 Ibid ss 39, 42N.
• an agent with an enduring power of attorney (medical treatment) appointed by the patient under the Medical Treatment Act\textsuperscript{15}
• a person specifically appointed by VCAT to make decisions about the proposed treatment
• a person appointed by VCAT under a guardianship order that includes authority to make decisions about the proposed treatment
• a guardian with enduring power of guardianship appointed by the patient and whose appointment includes authority to make decisions about the proposed treatment
• a person appointed in writing by the patient with authority to make decisions about the proposed treatment
• the patient’s spouse or domestic partner
• the patient’s primary carer
• the patient’s ‘nearest relative’.\textsuperscript{16}

13.19 If there is no person responsible available, or the medical practitioner cannot find out who the person responsible is, then the practitioner can make the decision to carry out the treatment without consent, providing they follow certain procedures, which are explained below.\textsuperscript{17}

The types of treatment covered
13.20 ‘Medical treatment’ is defined broadly by the G&A Act to include any medical treatment ‘normally carried out by, or under, the supervision of a registered practitioner’.\textsuperscript{18} ‘Dental treatment’ is similarly defined.\textsuperscript{19} The definition also expressly excludes a number of matters including:
• a ‘special procedure’
• a ‘medical research procedure’
• non-intrusive examinations made for diagnostic purposes
• first-aid treatment
• administration of pharmaceutical drugs according to prescription or, if it is a drug for which a prescription is not required, according to the manufacturer’s instructions
• anything else set out in regulations.\textsuperscript{20}

Consenting to a medical procedure
13.21 The person responsible must act in a person’s \textbf{best interests} when deciding whether to consent to medical treatment. The G&A Act requires the person responsible to consider a range of matters when making this ‘best interests’ determination. Those matters are:
• the wishes of the patient, as far as they can be ascertained

\textsuperscript{15} The authority of an agent appointed under the Medical Treatment Act 1988 (Vic) is discussed below.
\textsuperscript{16} Nearest relative is defined in s 3 of the Guardianship and Administration Act 1986 (Vic) as the spouse or domestic partner of the person, or if the person does not have a spouse or domestic partner, the first listed in the following hierarchy who is over the age of 18 years (with the eldest member of each category given priority): son or daughter; father or mother; brother or sister; grandfather or grandmother; grandson or granddaughter; uncle or aunt; nephew or niece.
\textsuperscript{17} Guardianship and Administration Act 1986 (Vic) s 42K.
\textsuperscript{18} Ibid s 3.
\textsuperscript{19} Ibid s 3.
\textsuperscript{20} There are currently no additional exclusions in regulations.
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- the wishes of any nearest relative or any other family members of the patient
- the consequences to the patient if the treatment is not carried out
- any alternative treatment available
- the nature and degree of any significant risks associated with the treatment or any alternative treatment
- whether the treatment is to be carried out only for the purposes of promoting and maintaining the health and wellbeing of the patient
- any other matters prescribed by the regulations.21

13.22 Additional matters can be relevant if the patient is likely to be able to make their own decision within a reasonable time. If the patient objects to a nearest relative being involved in the decision, the person responsible is not required to take that relative’s wishes into account.22 In addition, the person responsible cannot give consent at all unless:

- the medical practitioner states in writing that they believe a further delay in carrying out the treatment would result in a significant deterioration of the patient’s condition, and
- there is no reason to believe that treatment would be against the person’s wishes.23

13.23 If the person responsible consents to medical treatment, that consent has the same legal effect as if the patient had consented to the treatment with the capacity to do so.24

Withholding consent and refusing treatment

13.24 The powers of a person responsible differ from those of a medical agent under the Medical Treatment Act or a guardian with broad medical treatment powers, because a medical agent and a guardian may make a final and binding decision to refuse treatment for the represented person. A person responsible can only consent or withhold consent to the proposed treatment.

13.25 Part 4A of the G&A Act does not deal expressly with substitute refusal of treatment for a person with impaired decision-making capacity. While the Act gives the person responsible the power to consent to medical or dental treatment, it also recognises that consent may be withheld, because it permits a medical practitioner to proceed with treatment in some circumstances where the person responsible does not consent.25 This means that if person responsible withholds consent, it will not always amount to a refusal of treatment. This has led to considerable confusion about the difference between withholding consent under the G&A Act and refusing treatment under the Medical Treatment Act.

Carrying out medical treatment without consent

Emergencies

13.26 The G&A Act authorises a registered practitioner to perform medical treatment without consent in an emergency. An emergency exists when the procedure is necessary:

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21 Guardianship and Administration Act 1986 (Vic) s 38(1). There are currently no additional matters prescribed by regulation.
22 Guardianship and Administration Act 1986 (Vic) s 38(2).
23 Ibid s 42HA(2).
24 Ibid s 40.
25 Ibid s 42L.
• to save the patient’s life
• to prevent serious damage to the patient’s health, or
• to prevent the patient from suffering or continuing to suffer significant pain or distress.26

13.27 While there is also a common law power to perform medical treatment without consent in an emergency,27 this statutory power is probably more extensive than the authority given to medical practitioners by the common law.28

When the person responsible is unavailable or withholds consent

13.28 If a medical practitioner is unable to identify or contact the person responsible, they may still carry out a medical treatment procedure if they believe that the treatment is in the best interests of the patient and they give notice to the Public Advocate.29

13.29 If the person responsible is contacted but withholds consent to the medical treatment, the medical practitioner can still proceed with the treatment, if they believe it is in the patient’s best interests to do so and they advise both the person responsible and the Public Advocate of their intention to proceed with the treatment.30 The medical practitioner cannot proceed with the treatment until the person responsible has been given at least seven days to apply to VCAT to challenge that decision.31 VCAT has broad powers to make orders it believes are in the best interests of the patient.32

THE MEDICAL TREATMENT ACT 1988 (VIC)

13.30 The Medical Treatment Act originally sought to clarify the common law right of people to refuse medical treatment. The 1990 amendment33 that permits a person to appoint an agent as a substitute decision maker appears to allow the person to authorise the agent to make any decisions that the person could make about any medical treatment when the person is incapable of making their own decisions.34

Who can consent to or refuse treatment

13.31 Three groups of people can make decisions about medical treatment under the Medical Treatment Act. They are:
• patients themselves, if they have the capacity to so35
• agents appointed by an enduring power of attorney (medical treatment)36
• guardians appointed by VCAT, where VCAT has included the power to make decisions about medical treatment in the guardianship order.37

13.32 A person with capacity to make their own treatment decisions may appoint an agent ‘to make decisions about medical treatment’38 for them if they become ‘incompetent’.39 The appointment is made by using an enduring power of attorney

26 Ibid s 42A(1).
29 Guardianship and Administration Act 1986 (Vic) s 42K.
30 Ibid s 42L.
31 Ibid s 42L(2)(a).
32 Ibid s 42N(6).
33 Medical Treatment (Enduring Powers of Attorney) Act 1990 (Vic).
34 See section 5A and Schedule 2 to the Medical Treatment Act 1988 (Vic). While ‘medical treatment’ when used in section 5A and Schedule 2 must mean ‘medical treatment’ as defined in section 3 of that Act, that statutory definition appears to be much broader than the definition of ‘medical treatment’ in section 3 of the Guardianship and Administration Act 1986 (Vic).
35 Medical Treatment Act 1988 (Vic) s 5.
36 Ibid ss 5A(1)(aa).
37 Ibid s 5A(1)(b). The Medical Treatment Act does not refer to personally appointed enduring guardians.
38 Medical Treatment Act 1988 (Vic) ss 5A(2)(a), sch 2(2).
39 Ibid s 5A(2)(b).
13.33 The Medical Treatment Act contains a very broad definition of ‘medical treatment’, describing it as the carrying out of an operation, the administration of a drug or other like substance, or any other medical procedure. It expressly excludes palliative care.  

13.34 The distinction between medical treatment and palliative care has been a matter of some controversy, despite the fact that the Medical Treatment Act contains definitions of both terms. In 2003, Justice Morris of the Victorian Supreme Court found that artificial nutrition and hydration via percutaneous endoscopic gastrostomy (PEG) was medical treatment rather than palliative care. This finding permitted a guardian with powers to make decisions about a person’s medical treatment to refuse PEG for a represented person by relying upon the refusal of treatment provisions of the Medical Treatment Act.

13.35 The Commission sees no need to revisit the meaning of these terms in the Medical Treatment Act. The matter is best left to the courts for decision on a case-by-case basis. The Commission also notes that the terms of reference provide that ‘issues associated with end of life decisions, beyond those currently dealt with by the Medical Treatment Act 1988, are not within the scope of the review’.

13.36 An agent or guardian must be informed about a patient’s current condition before they can refuse medical treatment on the patient’s behalf. There must be sufficient information as would allow the patient to make their own decision about whether to refuse the treatment. The agent or guardian can refuse treatment if it would cause unreasonable distress to the patient or if there are reasonable grounds for believing that the patient would consider the treatment unwarranted if they were able to make the decision themselves.

13.37 When an agent or guardian decides to refuse treatment on behalf of a patient, it is necessary to complete a ‘refusal of treatment certificate’. This certificate requires the agent or guardian to declare that:

- they are authorised to make medical treatment decisions for the patient
- the patient is at least 18 years old
- they have been informed about the patient’s condition
- they understand this information
- they believe that the patient would not want the treatment to be administered.

13.38 Two witnesses must certify that they are satisfied that the agent or guardian has been informed about, and understands, the patient’s condition to the extent that would be sufficient if the patient were able to make their own decision. One of these two people must be a registered medical practitioner.
Consenting to medical treatment


Carrying out medical treatment when there is a refusal of treatment certificate

13.40 If an agent or guardian has completed a refusal of treatment certificate, the Medical Treatment Act only allows medical treatment to be undertaken if the power of the agent or guardian is suspended or revoked by VCAT.49 Any person who has a special interest in the affairs of the patient can apply to VCAT for this to happen.50 VCAT may suspend or revoke the power, or revoke the certificate itself, if it is satisfied that it would not be in the patient’s best interests for the refusal of treatment to continue, or for the agent to continue to hold the power.51

OTHER JURISDICTIONS

13.41 All other Australian jurisdictions, except the Northern Territory, have legislation similar to the G&A Act that provides for automatic appointees to make medical treatment decisions for adults with impaired decision-making capacity. It is instructive to consider some of the important points of difference.

DISTINCTION BETWEEN MINOR AND MAJOR TREATMENT FOR THE PURPOSES OF CONSENT

13.42 In New South Wales, as in Victoria, a doctor may carry out a medical treatment procedure without the consent of the person responsible if they are unable to identify or contact the person responsible. In New South Wales, this can happen only if the procedure fits the Act’s definition of minor treatment.52 Major treatment would require a guardian to be appointed, or an application to the tribunal for its consent. Minor treatment is any treatment, other than special treatment or clinical trials, not defined by regulation as being major treatment.53

13.43 The New South Wales regulations describe major treatment as:

- injection of long-acting hormones for contraception or regulating menstruation
- administering a drug of addiction
- administering a general anaesthetic or, in some cases, a sedative
- any treatment to eliminate menstruation
- certain treatments that affect the central nervous system
- treatments that have a high level of risk in relation to death, brain damage, paralysis, scarring, distress, prolonged recovery, etc.
- any test for HIV.54

13.44 In Queensland, minor and uncontroversial treatment may be carried out without consent, as long as the health practitioner believes it will promote the patient’s health and wellbeing and that there are no objections to it. The Act does not actually define ‘minor and uncontroversial’ treatment, leaving this matter to be determined on a case-by-case basis.55

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49 Ibid s 5D. Otherwise the medical practitioner may commit the offence of medical trespass: at s 6.
50 The Public Advocate and the agent or an alternate agent may also apply: Medical Treatment Act 1988 (Vic) 5C(2).
51 Medical Treatment Act 1988 (Vic) ss 5C(3).
52 Guardianship Act 1987 (NSW) s 37.
53 Ibid s 33.
54 Guardianship Regulation 2005 (NSW) reg 10.
55 Guardianship and Administration Act 2000 (Qld) s 64.
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PRINCIPLES TO GUIDE DECISION MAKERS

13.45 The Australian Capital Territory legislation includes principles that guide the decisions made by any substitute decision maker—any decision about medical treatment must be made according to those principles.\(^{56}\) The Queensland Act complements its broad decision-making principles with specific health care principles.\(^ {57}\)

PROVISION OF INFORMATION

13.46 The Australian Capital Territory legislation also includes a provision requiring health professionals to give certain information to a ‘health attorney’, who is the Australian Capital Territory equivalent of a person responsible.\(^ {58}\) The Act also requires a health professional to inform the Public Advocate if a health attorney is consenting to a particular medical treatment procedure for a period longer than six months.\(^ {59}\)

AUTOMATIC APPOINTMENTS OF SUBSTITUTE DECISION MAKERS

13.47 New South Wales was the first Australian jurisdiction to respond to the problems associated with substituted consent for medical treatment by establishing a scheme for automatic statutory appointments of substitute decision makers.\(^ {60}\) Other jurisdictions quickly followed, and now Victoria, the Australian Capital Territory,\(^ {61}\) South Australia,\(^ {62}\) Queensland\(^ {63}\) and Tasmania\(^ {64}\) all deal with automatic appointment of substitute decision makers for medical treatment in legislation broadly similar to that operating in New South Wales.

13.48 In Queensland, a person known as the ‘statutory health attorney’ is automatically appointed to make decisions about health care matters if no one has been appointed under the Guardianship and Administration Act 2000 (Qld) to make health care decisions. Health care matters must first be dealt with according to any health directive made by the person concerned, then by any guardian appointed by the tribunal, and then by any enduring appointment made by the person. If none of these appointments has been made, the ‘statutory health attorney’ appointed under the Powers of Attorney Act 1998 (Qld) becomes the decision maker.

13.49 The legislation sets out a hierarchy of people who can be the ‘statutory health attorney’, being first the spouse of the person, then their unpaid carer, then their close friend or relative and then, finally, if none of those people are available, the Queensland Adult Guardian.\(^ {65}\)

13.50 In all of these jurisdictions, other than Queensland, automatic appointees can only make decisions about medical treatment. In Queensland, admission to some nursing facilities is included in the list of health care decisions to which a statutory health attorney can consent.\(^ {66}\)

Alberta, Canada

13.51 While all of the Australian jurisdictions have some kind of ‘standing list’ of automatic appointees, the Canadian province of Alberta takes a different approach, permitting a medical practitioner to choose who the appropriate decision maker should be.

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56 Guardianship and Management of Property Act 1991 (ACT) s 32E.
57 Guardianship and Administration Act 2000 (Qld) sch 1.
58 Guardianship and Management of Property Act 1991 (ACT) s 32G.
59 ibid s 32.
60 See Guardianship Act 1987 (NSW) s 33A.
61 See Guardianship and Management of Property Act 1991 (ACT) pt 2A.
62 See Guardianship and Administration Act 1993 (SA) s 59.
63 See Guardianship and Administration Act 2000 (Qld) s 66 and Powers of Attorney Act 1998 (Qld) s 63.
64 See Guardianship and Administration Act 1995 (Tas) s 39.
65 Powers of Attorney Act 1998 (Qld) s 63.
66 Guardianship and Administration Act 2000 (Qld) sch 2 s 5.
In Alberta, a ‘specific decision maker’ is authorised to make various health care decisions. This person is a relative chosen by the health care provider applying criteria set out in the legislation.67

Tribunal reviews

13.52 Each Australian jurisdiction with an automatic appointments system provides for some limited tribunal review of the way in which the powers are exercised in a particular case. In Queensland, the actual appointment can be reviewed,68 while in New South Wales, as in Victoria,69 a tribunal can be asked to consent to treatment that the person responsible has refused to authorise.70

COMMUNITY RESPONSES

13.53 In the consultation paper, the Commission identified a number of reform proposals that sought to simplify the law governing substitute decision making for medical treatment for people with impaired capacity.

HARMONISATION OF THE G&A ACT AND THE MEDICAL TREATMENT ACT

13.54 An important option was the proposal to harmonise the G&A Act and the Medical Treatment Act to overcome the confusion caused by having two Acts that allow a person to make two different appointments of a substitute decision maker with medical treatment powers. The Commission suggested that Medical Treatment Act agents and enduring guardians with medical treatment powers should merge within a new, single personal appointment of a person to make substitute medical treatment decisions.

13.55 We discuss community responses to that idea in Chapter 10 and the Commission’s recommendation to combine those appointments. We consider that recommendation in more detail later in this chapter. In Chapter 17, the Commission recommends new principles to guide substitute decision makers. Later in this chapter, we also consider additional principles that should guide medical treatment decisions.

AUTOMATIC APPOINTMENTS—THE PERSON RESPONSIBLE

13.56 The Commission also proposed reform of the automatic appointments scheme in the G&A Act. In the consultation paper, the Commission noted the apparent widespread lack of awareness of the automatic appointment process and the role of the person responsible.

13.57 The Commission proposed retaining the ‘person responsible’ hierarchy but suggested changes to clarify the role and responsibilities of the position.

The person responsible hierarchy

13.58 Community responses and submissions were generally supportive of the current ‘person responsible’ hierarchy and the current Act’s provisions,71 although some people voiced concerns about lack of awareness of the system by members of the community and by medical practitioners.72 Other responses pointed to the limited oversight of the framework and a lack of understanding by the person responsible about their role.73

67 Adult Guardianship and Trusteeship Act, SA 2008, c A-4.2, s 89(1).
68 Powers of Attorney Act 1998 (Qld) s 113.
69 Guardianship and Administration Act 1986 (Vic) s 42NW.
70 Guardianship and Administration Act 1987 (NSW) s 44.
71 Submissions CP 19 (Office of the Public Advocate), CP 17 (Catholic Archdiocese of Melbourne), CP 44 (Leadership Plus), CP 59 (Carers Victoria), CP 71 (Senior Rights Victoria).
72 Submission CP 68 (Australian Nursing Federation), CP 73 (Victoria Legal Aid).
73 Submission CP 19 (Office of the Public Advocate), CP 65 (Council on the Ageing Victoria).
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13.59 The Victorian Equal Opportunity and Human Rights Commission advocated changes to the current hierarchy, arguing that all personal appointments should precede VCAT appointments.74

13.60 There were concerns expressed about the hierarchy’s lack of cultural variability and the fact that it automatically favours the oldest person in any category when determining the identity of the nearest relative. The Catholic Archdiocese of Melbourne noted that the person responsible might not always be the most appropriate individual in the circumstances to make a decision.75 The submission conceded, however, that a legislative scheme for automatic decision makers cannot capture the range of personal and cultural factors that make one person, rather than another, a more suitable substitute decision maker.76

Scrutiny of automatic appointees

13.61 In its consultation paper, the Commission asked whether new guardianship legislation should provide for enhanced scrutiny of decisions of automatic appointees by use of practices such as random auditing by the Public Advocate of decisions by ‘persons responsible’.

13.62 There were mixed responses to the proposal. Various submissions thought that the current provision, which permits an application to VCAT concerning a person’s best interests in the context of proposed treatment, was adequate.77

13.63 The Public Advocate pointed out that the ability to apply to VCAT to remove the ‘person responsible’ is rarely exercised despite serious doubts about the way that someone is making decisions.78

DEFINITION OF MEDICAL TREATMENT

13.64 In the consultation paper, the Commission proposed expanding the definition of ‘medical treatment’ in the G&A Act because of concerns that it excluded procedures for which prior consent would be required when dealing with a person with capacity. The Commission noted that broadening the definition would mean that people connected to the person with impaired capacity rather than health professionals would be responsible for more substitute health care decisions than is currently the case.

13.65 There was broad support for widening the definition to encompass a broader range of treatments that fall within ordinary perceptions of medical treatment. One submission commented that a broader definition would be consistent ‘with the increasing trend for health professionals other than doctors to provide health care’.79 The range of available health care services is much broader than that currently covered by the definition of ‘medical treatment’ in the G&A Act, and includes alternative medicines and paramedical services.

13.66 The Public Advocate suggested broadening the definition to include the administration of pharmaceutical drugs as well as paramedical and complementary medical procedures, while also making it consistent with the definition of ‘medical treatment’ in both the Medical Treatment Act and the Mental Health Act.80 The most significant of these differences, as noted above, is the Medical Treatment Act’s exclusion of

75 Submission CP 27 (Catholic Archdiocese of Melbourne).
76 Ibid.
77 Submission CP 22 (Alzheimer’s Australia Victoria), CP 27 (Catholic Archdiocese of Melbourne), CP 59 (Carers Victoria), CP 73 (Victoria Legal Aid).
78 Submission CP 19 (Office of the Public Advocate).
79 Submission CP 63 (Shin-Ning Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)).
80 Submission CP 19 (Office of the Public Advocate).
palliative care from its definition of medical treatment. The Public Advocate also suggested that legislation should list examples of treatments that fall within the new definition.

The inclusion of the administration of ‘medication’ within the definition, as is the case in New South Wales, was strongly supported by most submissions that commented on this issue, including the Public Advocate, Epworth Health Care and the Catholic Archdiocese.

The Public Advocate pointed out that current practice makes it easy to provide standard medications where practitioners cannot obtain consent from the person responsible. However, the Public Advocate also pointed out that administering certain drugs is not always a simple and uncontroversial procedure. It can amount to treatment that has more significant consequences than some treatments currently regulated by the Act, such as when there are adverse effects from the administration of a drug.

Several submissions expressed concern about the use of behaviour modifying drugs. The AMA noted that the Act’s current exclusion of pharmaceutical drugs from its definition of medical treatment has allowed the excessive use of behaviour modifying drugs in aged care facilities, because consent for their administration is not required. A submission by Dr Michael Murray argued that ‘this is an area subject to significant abuse with regular failure to consult’.

Respecting Patients’ Choices did not support expanding the definition of medical treatment to include the provision of ‘medication’. They believe that expanding the definition to encompass pharmaceuticals would make the treatment of patients unable to consent to oral medication ‘very difficult’.

Broadening the definition of medical treatment to include complementary and paramedical procedures was widely supported.

MINOR MEDICAL PROCEDURES

In the consultation paper the Commission also asked whether a medical practitioner should be required to obtain formal consent from the patient or the person responsible for minor and uncontroversial medical treatment.

The reform option presented in the consultation paper would allow medical practitioners to perform minor procedures without consent, subject to satisfying certain procedural conditions that might include: notifying VCAT; seeking a second medical opinion; or recording in the patient’s file the decision to perform the procedure without consent and the reasons for doing this.

Two approaches for distinguishing between ‘minor’ and ‘major’ treatment were discussed in the consultation paper:

- the New South Wales approach, which defines major treatment and provides that minor treatment is that which is not major treatment.

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81 Medical Treatment Act 1988 (Vic) s 3.
82 Submission CP 19 (Office of the Public Advocate).
83 Ibid, CP 20 (Epworth HealthCare), CP 27 (Catholic Archdiocese of Melbourne) and CP 69 (Australian Medical Association (Victoria)).
84 Submission CP 19 (Office of the Public Advocate).
85 Ibid.
86 Consultation with the Australian Medical Association Victoria Limited (18 May 2011).
87 Submission CP 47 (Dr Michael Murray).
88 Submission CP 47 (Respecting Patient Choices Program—Austin Health).
89 For e.g., submission CP 19 (Office of the Public Advocate), CP 20 (Epworth HealthCare), CP 24 (Autism Victoria), CP 33 (Eastern Health), CP 59 (Carers Victoria), CP 68 (Australian Nursing Federation) and CP 75 (Federation of Community Legal Centres).
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- the Queensland approach, which refers to, but does not define, ‘minor and uncontroversial’ treatment and provides examples of procedures that may fall into this category. Two examples are given: the administration of an antibiotic requiring a prescription and the administration of a tetanus injection. A health care practitioner must also be satisfied that the treatment will promote the health and wellbeing of the patient and that there are no objections to it.91

13.75 While some submissions advocated adopting the New South Wales or Queensland approaches,92 others highlighted definitional problems and the potential for abuse in removing the safeguard of consent for minor procedures.93 Seniors Rights Victoria supported the Queensland approach.94

13.76 The submission by members of the Health Law Research Program at the QUT Faculty of Law suggested that ‘minor and uncontroversial’ should be ‘narrowly defined’.95 They doubted whether procedural safeguards suggested in the consultation paper would be effective because there is no oversight of these decisions.96

13.77 The Public Advocate supported permitting ‘minor and uncontroversial’ treatment to proceed without consent.97 The Public Advocate favoured the New South Wales definitional approach, which defines ‘major treatment’.98 As a safeguard, the Public Advocate recommended that practitioners obtain a second opinion, noted on the patient’s medical record and verified by that practitioner’s signature.99

13.78 Epworth HealthCare agreed that ‘minor’ procedures should not require consent if the procedural conditions outlined in the consultation paper are satisfied.100

13.79 Other health bodies were generally supportive but uncertain about how to differentiate between ‘minor’ and other forms of treatment. The Royal District Nursing Service favoured it in principle, but said that they needed to consider how the two concepts could be distinguished in practice.101

13.80 Victoria Legal Aid and the Victorian Equal Opportunity and Human Rights Commission (the commission) did not support this proposal. Victoria Legal Aid argued that a lesser standard should not apply to individuals with diminished capacity.102 The commission highlighted the practical problem of drawing a distinction between ‘minor’ and other forms of treatment. However, the commission’s main objection was that the proposal had the potential to lead to human rights abuses.103 The commission argued that ‘the current situation allowing substitute consent to medical treatment is already fraught with human rights implications that require strict safeguards to prevent abuse’.104 Accordingly, the commission contended that where a person receiving treatment is unable to consent, lifting the requirement for consent by a substitute decision maker unacceptably infringes a core human right enshrined in the Charter of Human Rights and Responsibilities Act 2006 (Vic) (the Charter).105

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90 Guardianship and Administration Act 2000 (Qld) s 64(1).
91 Ibid.
92 For eg, Submissions CP 19 (Office of the Public Advocate), and CP 63 (Shin-Ning Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)).
93 Submission CP 35 (Ursula Smith), CP 56 (Disability Discrimination Legal Service), CP 73 (Victoria Legal Aid) and CP 75 (Federation of Community Legal Centres (Victoria)).
94 Submission CP 71 (Seniors Rights Victoria).
95 Submission CP 63 (Shin-Ning Then, Prof Lindy Willmott & Assoc Prof Ben White (QUT)).
96 Ibid.
97 Submission CP 19 (Office of the Public Advocate).
98 Ibid.
99 Ibid.
100 Submission CP 20 (Epworth HealthCare).
101 Consultation with Royal District Nursing Service (9 March 2011).
102 Submission CP 73 (Victoria Legal Aid).
104 Ibid.
105 Ibid.
13.81 Some submissions highlighted the fact that individuals understand and experience medical treatment differently. Alzheimer’s Australia (Victoria) said that treatments are never insignificant for individuals who are weak and lack capacity. Autism Victoria said that a person living with the condition may become distressed because they do not comprehend ‘the difference or consequence of a procedure whether minor or not’.107

**SPECIFIC PRINCIPLES FOR MEDICAL DECISION MAKERS**

13.82 In the consultation paper, the Commission proposed that automatic appointees should adopt a substituted judgment approach to medical decision making by seeking to make decisions that the person would make themselves, if they had capacity to do so. The Commission noted that this approach differs from the existing ‘best interests’ standard because it focuses on the likely wishes of the represented person. We discuss this approach to decision making more generally in Chapter 17. In that chapter, the Commission recommends that decision makers should make decisions that promote the personal and social wellbeing of the person they are representing. This approach involves a consideration of substituted judgment principles.

13.83 Most responses to the consultation paper supported a substituted judgment approach to decision making although the submission from Alzheimer’s Australia (Victoria) pointed out the difficulty in determining what should happen when the substitute decision maker faces a medical treatment decision that the represented person had not considered when they had capacity.108

13.84 The Public Advocate suggested that the patient’s personal and social wellbeing should be the key guide. It was noted that the principle of substituted judgment is important but should not be the only factor that the person responsible relies upon to make a decision. The Public Advocate supported a general set of principles to assist decision makers in all types of decisions, and the inclusion of additional principles to guide decision makers in relation to medical treatment.110

13.85 The Ad Hoc Interfaith Committee and the Catholic Archdiocese of Melbourne argued that best interests should be retained as the guiding principle for health decisions. They argued that this approach best serves people with disabilities, and that there are significant risks associated with the proposal to make substituted judgment the paramount consideration.112

**SPECIAL MEDICAL PROCEDURES FOR MINORS**

13.86 The Public Advocate believes that guardianship provisions concerning medical treatment should apply to all people with disabilities, not just those over the age of 18. Currently, the Family Court makes medical treatment decisions for children that are beyond parental capacity. The Public Advocate noted these decisions are often ‘ethically complex’. It questioned the appropriateness of these decisions being

106 Submission CP 22 (Alzheimer’s Australia Vic).
107 Submission CP 24 (Autism Victoria).
108 Submission CP 22 (Alzheimer’s Australia Vic).
109 Submission CP 19 (Office of the Public Advocate).
110 Ibid.
111 Submissions CP 27 (Catholic Archdiocese of Melbourne) and CP 52 (Ad Hoc Interfaith Committee).
112 Ibid.
113 Guardianship and Administration Act 1986 (Vic) pt 4A.
114 Submission CP 19 (Office of the Public Advocate).
115 Department of Health & Community Services v JMB and SMB (Marion’s Case) (1992) 175 CLR 218 ruled that consent to certain medical procedures falls outside parental authority. Marion’s Case involved the proposed sterilisation, for reasons not based on medical necessity, of a young woman with an intellectual disability. As Fehlberg and Behrens note, the judgment had ‘three key features’: the sterilisation procedure was significant and irreversible; the likelihood that parents misjudge their child’s present and future ability to consent and ‘best interests’; and the ‘consequences of a wrong decision are particularly grave’. Belinda Fehlberg and Juliet Behrens, Australian Family Law: The Contemporary Context (Oxford University Press, 2008) 261, quoting (‘Marion’s Case’) 175 CLR 218, 250.
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determined in the Family Court because of the adversarial nature of that Court and the prohibitive costs of Family Court applications.116

13.87 The Public Advocate argued that, in some circumstances, VCAT would be a more appropriate body to make these decisions for children with a disability than the Family Court.117 It was argued that VCAT is better suited to make such decisions because it is ‘an accessible and inquisitorial forum’ with experience in hearing cases concerning medical treatment of adults.118 The Public Advocate suggested that VCAT should be able to make medical decisions concerning children.119 This would result in VCAT having shared jurisdiction with the Family Court to consent to special procedures for children with disabilities.

13.88 The Commission does not believe that it is constitutionally possible to implement the Public Advocate’s suggestion, because the Victorian Parliament referred its relevant legislative powers to the Commonwealth in 1986.120 Even if it were possible for the Victorian Parliament to legislate about this matter, it would be unnecessarily confusing for a Commonwealth court and a Victorian tribunal to have concurrent jurisdiction in relation to complex medical treatment issues that often require quick and final decisions.

THE COMMISSION’S VIEWS AND CONCLUSIONS

A NEW PERSONAL APPOINTMENT FOR MEDICAL DECISION MAKING

13.89 The Commission believes that it is important to streamline the law regulating personal appointments of substitute decision makers for medical treatment by replacing the two existing mechanisms with a new, simple process. It is unhelpful to have two mechanisms—an agent appointed under the Medical Treatment Act and an enduring guardian with medical treatment powers appointed under the G&A Act—for personally appointing a person to make medical treatment decisions for the principal when they are unable to make their own decisions.

13.90 The Commission recommends that new guardianship legislation should contain only one mechanism for personally appointing a substitute decision maker for medical treatment. This proposal would effectively merge the two current personal appointments of substitute decision makers for medical treatment.

13.91 The proposed new enduring personal guardian, discussed in Chapter 10, would become the sole new mechanism for personally appointing a medical substitute decision maker. The person who makes the appointment would determine the extent of the powers given to their enduring personal guardian, which could include the end of life decision-making powers that may be given to an agent appointed under the Medical Treatment Act. This step would be a matter of choice for the person who makes the appointment.

13.92 No useful purpose is served by retaining two statutory mechanisms for personally appointing a substitute decision maker to make decisions about medical treatment. Given the need for certainty about the extent of a substitute decision maker’s powers when making end of life decisions, new guardianship legislation should contain provisions that mirror the existing sections of the Medical Treatment Act that permit agents and guardians to make refusal of treatment certificates.121

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116 Submission CP 19 (Office of the Public Advocate).
117 Submissions IP 8 (Office of the Public Advocate) and CP 19 (Office of the Public Advocate).
118 Submission CP 19 (Office of the Public Advocate).
120 Commonwealth Powers (Family Law – Children) Act 1986 (Vic).
121 Medical Treatment Act 1988 (Vic) ss SA–SF.
13.93 While this recommendation would cause those sections in the Medical Treatment Act that concern substitute decision makers to be removed and folded into new guardianship legislation, the remaining sections should be retained because they establish a useful process by which a person can give directions about unwanted medical treatment.

13.94 To avoid doubt, it would also be helpful for new legislation to provide that VCAT can appoint a personal guardian with the power to make decisions about any health care matters that the represented person could make a decision about, other than special procedures.

13.95 New guardianship legislation should also make it possible for a person who completes a refusal of treatment certificate—whether as a principal or as an enduring personal guardian with the power to do so—to file that certificate with the Registrar of Births, Deaths and Marriages for inclusion in the online register that is described in Chapter 16.

**RECOMMENDATIONS**

A new personal appointment for medical decision making

199. New guardianship legislation should permit a person to appoint an enduring personal guardian to make decisions about health care matters for them when they do not have the capacity to make their own health care decisions, including the power to complete a refusal of treatment certificate in the manner in which this step can be taken by an agent appointed under the *Medical Treatment Act 1988* (Vic).

200. New guardianship legislation should integrate the provisions in the *Medical Treatment Act 1988* (Vic) concerning the appointment of an agent to make medical treatment decisions for a person who lacks capacity with the provisions in the new legislation concerning health decision-making powers that can be given to an enduring personal guardian.

201. If the provisions in the *Medical Treatment Act 1988* (Vic) concerning the appointment and powers of an agent are fully integrated with provisions in new guardianship legislation concerning the appointment and powers of an enduring personal guardian, the provisions of the Medical Treatment Act concerning the appointment of an agent should be repealed in so far as they apply to appointments made from the date of the commencement of new guardianship legislation.

202. It should be possible for the tribunal to appoint a personal guardian with the power to make decisions about health care matters for a person who does not have the capacity to make their own health care decisions.

203. It should be possible for a person who makes a refusal of treatment certificate for themselves in accordance with the provisions of the *Medical Treatment Act 1988* (Vic), or an enduring personal guardian with the power to make a refusal of treatment certificate for the principal, to file that certificate with the Registrar of Births, Deaths and Marriages for inclusion in the online register.
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AUTOMATIC APPOINTMENTS

13.96 While the Commission recommends retention of the statutory scheme of automatically appointing a person to make medical treatment decisions for a person who is unable to make their own decisions, it proposes a number of improvements.

Health decision makers

13.97 The name of the person who is automatically appointed to make treatment decisions by virtue of their relationship to the person who lacks capacity to make their own decisions should be changed because the current term—‘person responsible’—is not widely known or understood. The Commission recommends that this person should be referred to as the ‘health decision maker’ because this term clearly describes the nature of the role.

Guardians distinguished from health decision makers

13.98 The automatic appointment scheme for medical treatment decisions should be clearly distinguished from personal guardians with the power to make medical treatment decisions.

13.99 The G&A Act does not effectively differentiate a guardian with medical treatment powers from a person who is automatically appointed as a person responsible, because it includes guardians within the hierarchy of people who can be the ‘person responsible’. This unnecessary step appears to limit the powers of a guardian who acts as a person responsible, because a person responsible is only permitted to consent to treatment or withhold consent. In contrast, a guardian with medical treatment powers can consent to treatment or refuse treatment for the represented person when acting as a guardian. It is unlikely that this was the intended outcome when guardians and Medical Treatment Act agents were included in the list of people who could be a person responsible.

13.100 The Commission believes that if someone has appointed a personal guardian with the power to make medical treatment decisions, or if VCAT has made such an appointment, the personal guardian should be the first person who is asked to make decisions for a person who is unable to make their own decisions. This person should act as a personal guardian when they make these decisions and not as a statutory ‘health decision maker’.

13.101 The automatic appointment scheme should only operate when there is no personal guardian with the appropriate powers or when that person is not available to make the necessary treatment decisions. The automatic appointment scheme should not include a personal guardian among the hierarchy of substitute decision makers, because a personal guardian with the appropriate powers is already authorised to make medical treatment decisions. The automatic appointment scheme is a default mechanism for appointing a substitute decision maker when there is no one with the authority to make the decision in question.

RECOMMENDATION

Automatic appointment of a health decision maker

204. New guardianship legislation should provide for the automatic (statutory) appointment of a substitute decision maker—to be known as a health decision maker—to make medical treatment decisions for a person who lacks the capacity to make their own decisions and who does not have an enduring personal guardian or a personal guardian with the power to make those decisions for them.
The powers of guardians and health decision makers

13.102 The difference between the medical treatment powers of a personal guardian and those of a health decision maker should be clearly explained in new legislation. Under current law, the extent of a guardian’s powers differs from those of a person responsible when making medical treatment decisions for a person who is unable to make their own decisions. While the drafting of the G&A Act generates some confusion, a guardian with health care powers has the power to make any medical treatment decision that the represented person can make, other than consenting to a special procedure. As an adult has a common law right to refuse any medical treatment, a guardian with appropriate powers must also have the authority to refuse treatment on behalf of the represented person.

13.103 The Commission recommends that new guardianship legislation should clearly indicate that a personal guardian with the power to make health care or medical treatment decisions has the authority to consent to any treatment or to refuse that treatment. Any person who sought to challenge a refusal of treatment would do so by asking VCAT to consider whether the personal guardian should retain authority to make some or all medical treatment decisions for the represented person.

13.104 Under the G&A Act, a ‘person responsible’ has the power to consent to any medical treatment for the represented person, other than a special procedure. The person responsible also has the power to withhold consent to any medical treatment. Withholding consent does not constitute refusal of treatment, because the registered practitioner is permitted to proceed with the treatment if the person responsible and the Public Advocate have been given an opportunity to apply to VCAT for a determination about what should happen in the circumstances and they decline to take this step within a designated period.

13.105 There are good policy reasons for distinguishing between the powers of an enduring guardian and a health decision maker to act in a way that causes a represented person not to receive treatment recommended by a registered practitioner. Personal guardians are people who have been chosen by the person concerned or VCAT to make important decisions for that person. It is appropriate that they have the power to make any decisions that the represented person could make in the circumstances. Health decision makers are automatic or default appointees—they are chosen because of their relationship to the person concerned rather than following an individual determination of their suitability to make medical treatment decisions. It is appropriate that these people have more limited powers than personal guardians.

13.106 The Commission recommends that a health decision maker should have similar powers to those of a person responsible—the power to consent to or withhold consent to any medical treatment other than a special procedure. New guardianship legislation should also contain a process similar to that in the G&A Act that permits a registered practitioner to proceed when consent has been withheld after the health decision maker and the Public Advocate have been given a reasonable opportunity to seek a ruling from VCAT about the proposed treatment.

122 The form set out in sch 4 of the G&A Act for use when appointing an enduring guardian refers to a power ‘to consent to any health care that is in my best interests’ and subsequently refers in a note to the power of an enduring guardian ‘to consent or withhold consent to medical or dental treatment’. This wording is unfortunate because a decision about medical treatment could be a positive decision to refuse that treatment rather than an equivocal decision to withhold consent.
124 Guardianship and Administration Act 1986 (Vic) s 39(1)(b).
125 Ibid s 42L.
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RECOMMENDATIONS

The powers of guardians and health decision makers

205. New guardianship legislation should clearly indicate that a personal guardian with the power to make health care or medical treatment decisions has the power to consent to or refuse any ‘medical treatment’, other than a ‘special procedure’, for the represented person when that person lacks the capacity to make their own decision about the matter.

206. A health decision maker should be permitted to consent or withhold consent to any ‘medical treatment’, other than a ‘special procedure’, for the represented person when that person lacks the capacity to make their own decision about the matter.

207. New guardianship legislation should contain a process similar to that set out in sections 42L, 42M and 42N of the Guardianship and Administration Act 1986 (Vic), which permits a registered practitioner to proceed with treatment when consent has been withheld by the health decision maker after the health decision maker and the Public Advocate have been given a reasonable opportunity to seek a ruling from the tribunal about the proposed treatment.

Hierarchy of health decision makers

13.107 The Commission recommends retention of the person responsible hierarchy in the G&A Act subject to two changes. First, for the reasons just given, the hierarchy should not include an enduring personal guardian or a guardian appointed by VCAT with medical treatment powers because the automatic process should only come into effect when there is no personal guardian with authority to make medical treatment decisions.

13.108 Secondly, in Chapter 9, the Commission proposed the introduction of a new joint decision-making arrangement known as a ‘co-decision making order’. In some circumstances, a person with impaired decision-making ability who has a co-decision maker in relation to medical treatment may lose the ability to participate in those decisions. In this situation, the co-decision maker should become the health decision maker.

13.109 The Commission acknowledges that the process of choosing a medical substitute decision maker for a person by use of a statutory automatic appointment system is not without its flaws. A person who is automatically appointed to make decisions for another is not required to meet the suitability requirements in sections 23 and 47 of the G & A Act that VCAT must consider before it makes an appointment. Additionally, this person might not be the one who would have been chosen to act in this role by the person who is unable to make their own medical treatment decisions.

13.110 Different cultures have different concepts of the role of family, and sometimes their broader community, in decision making. Some cultures are more inclined to recognise multiple decision makers and extended family, while some have a role for community elders. In the consultation paper, the Commission acknowledged the challenge of designing a system that can adapt to different cultural circumstances and yet remain workable for third parties, such as medical practitioners, who often need to identify a substitute decision maker quickly.
The automatic appointment scheme gives statutory recognition to the longstanding practice of asking a person’s next of kin to make medical treatment decisions when they are unable to do so. While the entire process, and particularly the definition of ‘nearest relative’, is open to criticism, the scheme is a workable, yet imperfect, means of seeking authorisation to treat a person who is incapable of making their own decision about the matter when it is not practical to conduct a hearing to decide who the most appropriate person is to make the decisions in question.

**RECOMMENDATION**

**Hierarchy of health decision makers**

208. The hierarchy of statutorily appointed health decision makers in new guardianship legislation should be:

(a) the patient’s co-decision maker with authority in relation to medical treatment decisions

(b) the patient’s spouse or domestic partner

(c) the patient’s primary carer

(d) the patient’s nearest relative.

**The Public Advocate as decision maker of last resort**

13.112 The Commission recommends that the Public Advocate should become the decision maker of last resort when there is no personal guardian with medical treatment powers or a health decision maker who is available to make a decision about ‘significant treatment’ for a person who is unable to make their own decision. This proposal mirrors the position in Queensland, where the Adult Guardian is the health decision maker of last resort.127

13.113 The current system of permitting a registered practitioner to proceed in the absence of consent, if the practitioner has made reasonable efforts to locate a substitute decision maker and if the practitioner notifies the Public Advocate of an intention to proceed without consent, does not appear to operate successfully. It seems that the Public Advocate receives relatively few notices, perhaps because the process is time consuming and not widely known.

13.114 It is important that significant medical procedures are authorised by someone who is responsible for the wellbeing of the person concerned and who is not directly involved, either professionally or financially, in the administration of those procedures. It is also important that this process of external authorisation is restricted to significant medical procedures and that health professionals are able to administer routine treatment to a person who is unable to make their own decisions, without the need for external authorisation or unhelpful reporting requirements.

13.115 The Public Advocate’s role as the decision maker of last resort should be limited to those matters that constitute ‘significant procedures’, because of the need to ensure that the Public Advocate’s resources and the time of health professionals is expended wisely. The distinction between ‘significant procedures’ and ‘routine procedures’ is discussed below.

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126 Guardianship and Administration Act 1986 (Vic) s 3.
127 Powers of Attorney Act 1998 (Qld) s 63.
128 Guardianship and Administration Act 1986 (Vic) s 42K.
RECOMMENDATION

The Public Advocate as decision maker of last resort

209. The Public Advocate should be permitted to consent to or refuse any ‘medical treatment’, which is ‘significant treatment’, for a person who does not have the capacity to consent to that treatment and who does not have a personal guardian with the relevant powers, or a health decision maker, to act as the person’s substitute decision maker.

Definition of medical treatment

13.116 The Commission recommends changes to the statutory description of the range of medical treatment that requires the consent of a substitute decision maker if a person is unable to consent to their own medical treatment. The Commission believes that the statutory definition of medical treatment should be expanded to include some medical procedures that are currently excluded. It should also be divided into two categories—‘significant procedures’ and ‘routine procedures’—for the purposes of determining the processes to follow when there is no personal guardian or health decision maker to make decisions for a person who is unable to consent to their own medical treatment.

13.117 The Commission believes that the statutory definition of medical treatment should encompass the administration of prescription pharmaceutical drugs. All pharmaceutical drugs—prescription and non-prescription drugs—are expressly excluded from the current definition of medical treatment in the G&A Act. This means that, in practice, prescription drugs are often given to a person who is unable to consent to their own medical treatment without any authorisation by a guardian or a person responsible.

13.118 The current definition is also limited to ‘medical treatment’ or ‘dental treatment’. While these terms are not defined exhaustively, they are limited to treatment carried out ‘by or under the supervision of a registered practitioner’. This probably means that intrusive treatments carried out by allied health professionals, which might technically constitute an assault if performed without consent, do not fall within the authorisation powers of a person responsible.

13.119 The Commission believes that the statutory definition of medical treatment should also be expanded to include procedures performed by allied health professionals which are intrusive and which would constitute an assault in the absence of consent.

13.120 There was widespread support for including the administration of pharmaceutical drugs within the statutory definition of medical treatment. The administration of some prescription drugs may be as significant and intrusive for a person as other medical treatment procedures that fall within the statutory definition. Some people expressed concern about the liberal use of psychotropic medication in some aged care facilities without any authorisation by a guardian or person responsible. It is appropriate that substitute decision makers make these important health care decisions.

13.121 The administration of non-prescription medication seems less problematic. It appears sufficient to rely on normal care principles for ensuring that those medications are not misused or overused by people who are unable to make their own decisions. The Commission believes that the new definition of medical treatment should specifically exclude medication that can be obtained without a prescription and is normally self-administered, provided it is administered in accordance with the manufacturer’s instructions. This approach is taken in Queensland guardianship legislation.

129 Ibid s 3.
RECOMMENDATION

Definition of medical treatment

210. New guardianship legislation should contain a definition of ‘medical treatment’ that is in similar terms to the definition of ‘medical or dental treatment’ in section 3 of the Guardianship and Administration Act 1986 (Vic) except as follows:

(a) The administration of pharmaceutical drugs for which a prescription is required should fall within the definition.

(b) Paramedical and allied health procedures which involve a touching of the person’s body and which are intrusive should fall within the definition.

Significant and routine medical procedures

13.122 As noted earlier, the current system of permitting a registered practitioner to administer medical treatment in the absence of consent, if the practitioner has made reasonable efforts to locate a substitute decision maker and if the practitioner notifies the Public Advocate of an intention to proceed without consent, is unwieldy and should not be retained in new guardianship legislation.

13.123 The Commission proposes that the Public Advocate should become the decision maker of last resort when the treatment in question is ‘significant’. When the treatment in question is ‘routine’, the health professional concerned should be permitted to proceed in the absence of any authorisation, if appropriate notes are made of unsuccessful attempts to locate a personal guardian or health decision maker for substitute consent.

13.124 It is not easy to devise principled and practical definitions of ‘significant’ and ‘routine’ medical treatment. The Commission believes that a two-step process is required. New guardianship legislation should define the concepts in broad terms, with their practical meaning amplified by guidelines prepared by the Public Advocate in conjunction with relevant professional bodies and interest groups.

13.125 An important principle to bear in mind when seeking to define ‘significant treatment’ is that people who are unable to consent to their own treatment should be dealt with in the same way, whenever possible, as people who are able to consent to their own treatment. If a health professional would ordinarily seek specific consent to performing a particular procedure from a person with capacity to consent to their own treatment, this procedure should presumptively be ‘significant treatment’ that requires external authorisation when performed upon a person who is unable to consent.

13.126 Another important principle to bear in mind is subjective assessment of the significance of some procedures. While some medical and dental procedures might be routine from a professional perspective, the degree of intrusion or momentary pain that people might experience could cause them to regard the procedure as significant.

13.127 The Commission suggests that the following matters should fall within the statutory definition of ‘significant treatment’:

- ‘significant degree of bodily intrusion’, which may include internal and intimate examinations
- ‘significant risk’ to the patient, including treatments that may result in some serious bodily damage

130 Ibid’s 42K.
• ‘significantly negative side effects’, including the administration of pharmaceutical drugs with serious adverse effects
• ‘significant distress’, including the distress a person may feel when they are about to receive an injection or a particular treatment that is known to cause them fear and anxiety.

13.128 The statutory definition of ‘significant treatment’ should be complemented by guidelines prepared by the Public Advocate in consultation with professional associations and groups that represent the interests of consumers of health services. The guidelines should indicate, with reasonable precision, the procedures that fall within the concept of ‘significant treatment’ or for which the Public Advocate is the decision maker of last resort.

13.129 The Commission proposes that a registered practitioner should be authorised to perform a ‘routine procedure’ on a person who is unable to consent and who does not have a personal guardian or health decision maker to provide substitute consent, if reasonable attempts have been made to locate such a person and notes are kept of the steps taken. This recommendation would overcome the current requirement that a registered practitioner notify the Public Advocate in writing of their intent to perform treatment upon a person who is unable to consent and who does not have a locatable substitute decision maker.

13.130 The Commission recommends that registered practitioners should be required to take reasonable steps to locate a personal guardian or health decision maker before they are authorised to perform a routine procedure on a person who is unable to consent to that procedure.

13.131 This requirement would not affect the ability of a registered practitioner to perform any necessary treatment in an emergency, because the Commission proposes that the existing emergency treatment powers in the G&A Act\(^{131}\) should be reproduced in new guardianship legislation.

**RECOMMENDATIONS**

**Significant and routine medical procedures**

211. New guardianship legislation should define ‘significant treatment’ as a medical or dental procedure, other than an emergency procedure or a special procedure that:

(a) involves a significant degree of bodily invasion, or

(b) involves a significant risk to the patient, or

(c) is likely to have significantly negative or unpleasant side effects for the patient, or

(d) is likely to result in significant distress for the patient, and

(e) would ordinarily cause a medical practitioner to seek specific consent from a person with capacity before proceeding.

**Guidelines to be developed by the Public Advocate**

212. The Public Advocate should develop and publish guidelines in consultation with relevant professional bodies and other interested organisations to assist registered practitioners when determining whether a particular procedure is ‘significant treatment’.

\(^{131}\) Ibid s 42A.
Definition of routine treatment
213. New guardianship legislation should define ‘routine treatment’ as a medical or dental procedure that is not an ‘emergency procedure’, a ‘significant procedure’ or a ‘special procedure’.

Consent to a significant medical treatment
214. New guardianship legislation should provide that if a person is unable to consent to ‘significant treatment’, the registered practitioner may undertake that procedure only with the consent of:
   (a) a personal guardian with the power to make decisions about the matter, or if there is no such person or that person cannot be reasonably located
   (b) a health decision maker, or if there is no such person or that person cannot be reasonably located
   (c) the Public Advocate.

Consent to a routine medical treatment
215. New guardianship legislation should provide that if a person is unable to consent to a ‘routine procedure’, the registered practitioner may undertake that procedure:
   (a) with the consent of a personal guardian with the power to make decisions about the matter, or if there is no such person or that person cannot be reasonably located
   (b) with the consent of a health decision maker, or if there is no such person or that person cannot be reasonably located
   (c) in the absence of consent if the registered practitioner has taken reasonable steps to locate a personal guardian or a health decision maker and the registered practitioner believes the treatment will promote the personal and social wellbeing of the person concerned.
216. New guardianship legislation should require a registered practitioner who performs a ‘routine procedure’ upon a person in the absence of consent to make notes in that person’s file of attempts made to locate any personal guardian or health decision maker.

ADDITIONAL CONSIDERATIONS TO GUIDE MEDICAL DECISION MAKING
13.132 In Chapter 6, the Commission recommends that all people who have discretionary powers under new guardianship legislation should be guided by statutory principles when exercising those powers.
13.133 The Commission believes that there is value in listing additional considerations to guide personal guardians and health decision makers when making medical treatment decisions for another person. Many of these considerations are drawn from the existing provisions of the G&A Act.
Additional considerations for personal guardians and health decision makers

217. New guardianship legislation should contain a list of matters for personal guardians and health decision makers to consider when making medical treatment decisions for a represented person. Those considerations are:

(a) any instructional directive prepared by the represented person
(b) whether the represented person is likely to be able to make a decision about the treatment themselves within a reasonable time, and the effect on the person’s condition of waiting for the person to make the decision themselves
(c) the extent to which the proposed treatment is likely to be of benefit to the person
(d) the extent to which the proposed treatment is likely to cause distress to the person
(e) alternative treatments available, and the extent to which these are likely to benefit the patient or to cause distress to the person
(f) other likely risks associated with the proposed treatment, or any alternative treatments available, for the person.

Emergency Procedures

13.134 The G&A Act authorises a registered practitioner to undertake any form of medical treatment without consent where it is ‘necessary, as a matter of urgency’ to ‘save the patient’s life’, ‘prevent serious damage to the patient’s health’, or ‘prevent the patient from suffering or continuing to suffer significant pain or distress’. 132 This authority appears to be broader than the common law power to provide treatment without consent ‘in cases of emergency or necessity’. 133 It is unclear whether the common law power extends to treatment given without consent to ‘prevent serious damage to the patient’s health’ or ‘prevent significant pain or distress’. 134 A registered practitioner who relies upon this authority in good faith is not liable for any criminal, civil or professional consequences that might otherwise result from treating a patient without consent. 135

13.135 The Commission did not receive any suggestions to change the emergency treatment powers in the G&A Act and it is unaware of any circumstances in which the extent of this power has been contentious. The Commission believes that section 42A of the G&A Act contains a fair and reasonable description of those circumstances in which a registered practitioner should have the authority to treat any person without consent. This section should be retained in new legislation.

132 Ibid s 42A(1).
133 Rogers v Whitaker (1992) 175 CLR 479, 489.
134 See Skene, Law and Medical Practice, above n 123, 113–14 for a discussion of the relevant case law.
135 Guardianship and Administration Act 1986 (Vic) s 42A(2).
RECOMMENDATION

Emergency procedures

218. New guardianship legislation should continue to authorise a ‘registered practitioner’ to perform ‘medical treatment’ upon a person who does not have the capacity to consent to that treatment in emergencies. Section 42A of the Guardianship and Administration Act 1986 (Vic) should be reproduced in new legislation.

SPECIAL PROCEDURES

13.136 Only VCAT can authorise a ‘special procedure’ for a person who is unable to make their own decisions about medical treatment.136 A person cannot authorise an enduring guardian or an agent appointed under the Medical Treatment Act to consent to a special procedure for them. VCAT cannot appoint a guardian to make a decision about a special procedure and it is beyond the power of a person responsible to consent to a special procedure.

13.137 Special procedures are medical procedures with permanent consequences. At present three procedures are included within the statutory definition of a special procedure. They are:

- permanent sterilisations
- abortions
- removal of tissue for the purpose of donation to another person.137

13.138 It is sound policy to require an independent, expert tribunal to decide whether a person who is unable to make their own medical treatment decisions should have a medical procedure that has significant, irreversible consequences. The Commission believes that the ‘special procedure’ process should be retained in new guardianship legislation. The Commission sees no need to recommend that any procedures be added to or removed from the existing list of special procedures.

RECOMMENDATION

Special procedures

219. New guardianship legislation should continue to require VCAT authorisation before a ‘special procedure’ can be performed upon a person who lacks the capacity to consent to that procedure.

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136 Ibid s 39(1)(a).
137 Ibid s 3. There are currently no additional special procedures set out in regulations.