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BY:

Submission No. 69

AMA
VICTORIA



**Submission to Victorian Law Reform Commission Review of Victoria's
Guardianship and Administration laws**

AMA Victoria

Question 1: Do you have any general comments about matters influencing the need for change in the law? Are there any important matters that should affect the content of future guardianship laws?

Legislative reform must help to make Victoria's guardianship laws clearer, and must encourage people to plan ahead wherever possible.

There is general confusion and uncertainty among doctors as to the scope and applicability of Victoria's current guardianship laws to both clinical practice and patient care. As a consequence, doctors are unsure of how best to advise their patients when they wish to appoint a substitute decision maker, and which legislative instrument(s) are appropriate in the circumstances. Doctors are aware that several pieces of legislation exist to govern processes for appointing a substitute decision maker, and doctors are often unsure as to the relevant Act to apply in particular circumstances.

There is need for greater clarity of the law. The law should clearly set out the options available to a patient when appointing a substitute decision maker, and the requisite procedures involved.

Doctors have indicated that they are unsure of the difference between the various options for substitute decision-making, including enduring powers of attorney (medical treatment), enduring powers of guardianship, and others.

While simplification of guardianship laws would greatly aid doctors, any legislative reform on these issues would need to be widely promulgated among doctors, other health professionals and the public.

Greater emphasis should be given to the issue of Advance Care Planning (ACP). ACP could be included in legislative reform governing substitute decision-making. Legislative reform must encourage people to plan ahead prior to becoming incapacitated. Doctors' perceptions are that many patients would not have gone ahead with various forms of treatment if they had known, or had considered the consequences, of the treatment which was given.

Patients should also be more informed of the benefits of ACP and how their wishes may be recorded. Doctors should play an active role in this process.

AMA Victoria recognises that doctors need more education about substitute decision-making laws and their implementation.

Question 3: Do you agree with the Commission's draft general principles for new guardianship laws?

We agree with the principles outlined.

Question 4: Are there principles you think should be added or removed from these general principles?

In accordance with the belief that guardianship laws should aim to promote human dignity by enabling individuals to participate in decisions that affect them, we submit that patients be made aware of their right to refuse medical treatment and to express their wishes as to future treatment.

Question 5: Do you agree with the Commission's proposal that Victoria's various substitute decision-making laws be consolidated into one single Act?

We support the proposed consolidation. Reducing the number of Acts would clarify the law and simplify the rules for those dealing with them on a daily basis. The various Acts among which Victoria's substitute decision-making laws are spread, mean that it can be difficult for doctors to adequately comprehend how such laws interact with one another. It is submitted that Option C would provide this clarity and simplicity. A consolidated Act would mean that health professionals' obligations would be clarified, and one clear, central reference point for doctors dealing with relevant legislation would be the case.

It is imperative that the language used in any new legislation is clear and accessible. The law must work for health professionals in practice.

It is submitted that ACDs be included in a Power of Attorney section and that people should be able to record their wishes as to organ donation in ACDs, as in Queensland's *Powers of Attorney Act 1998*.

Question 10: Do you have any specific ideas about how to better target education about guardianship laws?

There should be more information on ACP and substitute decision-making made available to the medical profession and patients. Educational materials need to be widely distributed to the public at large and in particular to those members of the public who are more likely to make substitute decision-making appointments.

Informative materials also need to be targeted specifically towards doctors in order to assist them to become more aware of their obligations and the circumstances in which a substitute decision maker might be appointed. In their experience, many doctors don't know the existence of the *Medical Treatment Act* or the *Guardianship & Administration Act* let alone how those statutes relate to medical practice and patient care.

More material should be produced specifically for use in doctors' surgeries and waiting rooms. Information should also be readily accessible to seniors' groups.

Consideration could be given to including a Medicare item number for ACP and associated substitute decision-making instruments. This could ensure that conversations around ACP happen with greater frequency as a dedicated item number would provide doctors with the incentive to set aside time for ACP with their patients. Patients might well find it useful if their doctor were to explain to them, from a medical point of view, the legislative instruments that are available.

Question 12: Would an educational and awareness campaign assist the community to better understand and make use of guardianship laws?

An educational campaign would be beneficial in raising awareness of guardianship laws and how they may be used. Such a campaign might form the foundation for an ongoing program.

It is important that education is provided to people when they need it – when patients reach an age where they may soon lose the capacity to make decisions for themselves. One way in which this could be done is by disseminating materials to patients within aged care facilities and their families.

Further, a campaign could be targeted to volunteers who may be dealing with patients likely to require substitute decision-making in the near future. Informational material could be provided to volunteer groups in order to reach those for whom the education would be relevant and useful. The campaign should also target health professionals.

While it is imperative that doctors have the requisite knowledge to be able to engage with the legislation, and to help facilitate a decision for a patient, it should not be the doctor's role to have to inform patients about the law. Patients themselves and their relatives need to be aware of relevant legislative provisions.

General Practitioners (GPs) in particular have found that while some members of the public seem to be familiar with the relevant provisions, others are not. Any educational campaign must reach all members of the community – all patients should be able to make an informed decision as to how to appoint a substitute decision maker and how they might record their wishes regarding future treatment.

Question 14: Do you agree with the Commission's proposal to introduce new supported decision-making arrangements?

Question 15: Do you agree with any or all of the proposed roles of supporters and co-decision makers?

Question 16: What steps would need to be taken in order to ensure that these appointments operated fairly and efficiently?

It is submitted that although these proposed roles are based on principles of protecting patient autonomy and respecting patient choices, there are more effective ways of achieving these aims.

The proposals seem to suggest that the individuals to be appointed to these roles must be a person trusted by the patient. A supporter or co-decision maker to be appointed by a patient is likely then to be a family member or close friend. It is unclear what benefit would be derived from formally appointing such persons to one or other of these roles particularly when the same decision could have been reached without the need for a formal appointment process.

Question 38: Do you think that the law concerning instructional medical directives should be set out in legislation?

We could support the inclusion of instructional medical directives in legislation. As the population ages, more people will want the ability to record in advance their wishes as to their future health care. ACDs would provide patients with a means to participate in future health care decision-making and may help to reduce the stress to families that participation in health care decisions can cause. Information contained in an ACD would provide clear guidance for those making difficult decisions at a difficult time.

ACDs could also encourage conversations regarding end of life treatment options to occur, and at an earlier stage. ACDs should result from a process of reflection, discussion and communication of health care preferences that respects the patient's right to take an active role in their health care, in an environment of shared decision-making between the patient and doctor. The role of the doctor is key to this process in providing guidance, advice and in discussing treatment options with patients. ACDs should be reviewed as the patient's condition, and possibly preferences, change.

If ACDs were to be established in legislation, the law should also provide statutory protection for doctors who comply with an ACD, or who do not comply if they have reasonable grounds to believe it is inconsistent with good medical practice. This is important so as to preserve doctors' professional clinical judgment.

We do not support that ACDs should be legally enforceable. If ACDs were to become legally enforceable, they may lead the doctor into a situation that he or she believes does not reflect good clinical care. Doctors should be under no absolute legal obligation to follow an ACD that is not consistent with good medical practice. It is important that the law achieves a balance between protecting a person's right to request or refuse treatment, and preserving the right of doctors to do what is clinically appropriate in the circumstances.

Further, doctors should be under no obligation to follow an ACD to which they hold a conscientious objection. It is submitted that adequate protection is also available for health professionals who do not comply with an ACD where the existence of the ACD or the revocation of the ACD was unknown.

Question 39: Do you think it should be possible to make statutory instructional directives about things other than medical treatment?

We support the making of statutory instructional directives about matters other than medical treatment; for use for example by mentally ill patients who are institutionalised for a period of time.

Question 46: Should there be an electronic registration system for advance directives?

There is a need for ACDs to be clear and easily accessible. However an electronic register may not be practical. There are issues as to who has the authority to make changes to the register, how easy is it to change, and whether the register is being consistently reviewed and updated. Patients potentially requiring substitute decision-making such as elderly patients may not be familiar with how to use computers let alone electronic registers.

An alternative would be for ACDs to be included in hospital admission papers, in GP patient records, or on the e-health record. It is important that the creation and recording of ACDs must be done in consultation with a doctor.

Question 51: Do you agree with the Commission's suggestions for capacity principles (Option A) and a legislative definition of incapacity (Option B) in order to provide legislative guidance on how to determine when a person is unable to make their own decisions? Are there additional or other ways to provide this guidance?

Currently there is little guidance given to doctors in hospitals as to how to assess capacity. This is inadequate given that doctors must frequently assess a patient's capacity when they are filling out consent forms. It is important to note that a patient's capacity can fluctuate and the level of capacity required for different decisions can vary.

It is submitted that the principles outlined in Option A would be useful in assisting doctors to assess a patient's capacity to make decisions. Upon the inclusion of these principles into legislation there should be a coordinated education program to aid doctors to address them. Option A importantly allows for flexibility for doctors in assessing capacity while at the same time giving good practical guidance.

Question 74: Do you think there should be specific laws about people being admitted to and remaining in residential care facilities in situations where they do not have capacity to consent to those living arrangements but are not objecting to them?

We support the introduction of specific laws about people being admitted to residential care facilities where they do not have the capacity to consent to those living arrangements but are not objecting to them.

Laws of this kind would protect the rights of the patient, and importantly such laws could protect the rights of doctors when admitting patients to residential care facilities. In a situation where it is clear that a patient is not going to recover, doctors should be protected in their decision if they decide to move the patient to another facility. Doctors should not have it imposed upon them by a patient or their family members that a patient is kept in the hospital where they perceive that it is no longer of any benefit to them. Legislative provisions confirming this would be useful and facilitate better treatment for the patient being admitted and free up hospital resources for other patients in need.

We support the introduction of safeguards which seek to ensure that individuals who are or who may be deprived of their liberty in a hospital or care home are identified and the decision is externally reviewed and authorised, even if the person is not actively seeking liberty.

Question 80: Should a broader definition include the prescription and administration of pharmaceutical drugs?

We support Option B. A broader definition of medical treatment should include the prescription and administration of medication.

Question 82: Do you think a distinction should be made between minor and other medical procedures when a person is unable to consent? If yes, how should the distinction be made between minor and other procedures?

We do not support that a distinction be made between minor and other medical procedures when a person is unable to consent. It is submitted that clear and adequate definitions of minor and other medical procedures are not adequate to date. Notwithstanding the above, a legal definition of these terms may also not correlate with a medical definition.

More information is needed as to how the distinction between minor and other procedures would be made.

Question 85: Do you believe the process for obtaining substituted consent to participation in medical research procedures should be the same as the process for obtaining substituted consent for medical treatment?

We would support Option B. All medical research should need to be approved by the person responsible, or that the Office of the Public Advocate should be notified.