Queensland Nurses' Union

Submission to

Health and Disabilities Committee

Queensland Law Reform Commission Recommendations

on Guardianship Laws Inquiry

December, 2011

Nurses.
For you. For life.

because we care
Quality care for older Australians

Introduction

The Queensland Nurses' Union (QNU) thanks the Health and Disabilities Committee for providing the opportunity to comment on the Queensland Law Reform Commission's (QLRC) recommendations on guardianship laws. In this submission we provide comments on specific items raised in the issues paper (2011)

About the QNU

Nurses and midwives are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU - the union for nurses and midwives - is the principal health union in Queensland. The QNU covers all categories of workers that make up the nursing and midwifery workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 45,000 financial members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Guardianship Laws

The QNU recognises that many people who are concerned about the potential to lose capacity to make decisions about their health care wish to make their decisions clear through an advance health directive (AHD) or appointing an attorney to make decisions on their behalf under guardianship legislation. They may also wish to make arrangements with family members.

These types of decisions can raise sensitive and complex ethical, legal and clinical issues.

The *Guardianship and Administration Act 2001* (GAA Act) and the *Power of Attorney Act 1998* (POA Act) provide the legislative framework for decision making for adults whose capacity is impaired. Our comments relate to some of the QLRC recommendations for amendments to these acts.

Item 1.6 - Amendment to the Glossary

'good medical practice'

Health care has changed significantly since the definition of 'good medical practice' was inserted into the GAA (by amendment) in 2001 to the extent that so-called 'medical' decisions are now not made solely by medical practitioners in isolation to other health professionals.

Modern contemporaneous health care is now provided after consideration of all aspects of care by a multidisciplinary team using a holistic model. This multidisciplinary team may include practitioners from various regulated professions including (but not limited to) medicine, nursing and midwifery, psychology, etc. From 1 July 2012 it will include Aboriginal and Torres Strait Islander health practitioners and others.

All such practitioners will have relevant and important input into the decision-making process regarding those health matters regulated by the GAA. Significantly, the *Health Practitioner Regulation National Law Act 2009 (Qld)* (the National Law), which came into operation on 1 July 2010, requires that all regulated health practitioners exercise the knowledge, skill, judgment and care that would be reasonably expected by their peers.

To this end, we submit that the GAA should be amended to remove any reference to 'good medical practice' and substitute this phrase with 'good *professional* practice'. This term should have the associated definition that reflects the objectives and professional practice requirements of the National Law for all regulated health practitioners, any of whom may be involved in the decision-making process on matters relevant to the GAA.

Item 2.3

The QNU believes that there should be an obligation on health services to enquire if the care recipient has an Advance Health Directive (AHD) in place because the existence of the AHD will have an impact on the development of the care plan and the alerts on the patient file. There would be minimal extra work for admitting health professionals if the AHD existence (and brief summary of) was incorporated into the assessment process upon admission and alerted on the file.

Item 2.4

The QNU does not support omission of the current protection for a health provider who ignores a valid direction because of their belief that it is inconsistent with good medical practice. Section 144 of the National Law enables the public or a practitioner to report a health practitioner for professional conduct that is of a lesser standard than that expected by the public or their peers.

If the AHD is inconsistent with professional practice then there is a legal obligation on the health practitioner not to follow the AHD, otherwise the health practitioner exposes themselves to disciplinary action by the relevant professional regulatory board.

We refer to our previous comments about substituting 'good medical practice' for 'good professional practice' in the Glossary.

Item 4.3

The QNU believes that the reference to commencement or continuation of a life-sustaining measure should remain in the definition of 'health care'. We have justified this previously through our comments regarding good professional practice (above) and the following rationale contained in item 4.6 below.

Item 4.6

In our view, the limitations on when a direction in an AHD to withhold or withdraw a life-sustaining measure can operate should not be omitted from guardianship legislation. Similarly, the limitation on when a direction in an AHD to withhold or withdraw artificial nutrition or hydration can operate should not be omitted nor treated differently from other life-sustaining measures. The QLRC appears to be contemplating artificial nutrition or hydration (AN&H) in the same paradigm as other life-supporting measures such as respiratory support. However, this is a narrow view of the need for AN&H, supported by referring to case law that addressed only a terminal illness matter [*Re BWV; Ex parte Gardner* (2002) 7 VR 506].

The QNU is mindful that there are a number of mental illness conditions that might warrant AN&H as a life-sustaining measure, such as psychosis, anorexia nervosa, bulimia nervosa or severe depression where the person has lost mental capacity and/or wants to die, but requires AN&H to enable treatment to recover that capacity and potentially save their life. Persons with such illnesses often refuse treatment and have the ability to make AHD's to that effect when still having mental capacity. If such a person made an AHD to withdraw life-sustaining measures, or AN&H, and there were no limitations on when that directive could operate, then acting on the AHD could end the person's life despite them having a treatable condition.

Conclusion

The QLRC's recommendations appear to take a narrow perspective in their consideration of as GAA as relevant to end of life matters only. There are a number of other organic and functional conditions where use of the GAA is appropriate and where decisions can be life-saving. The autonomy of the individual is well worth protecting, but not at the expense of their unnecessary demise. It must be borne in mind that the object of the GAA is to protect the public as well as enable it.