Health Legislation Amendment Bill (No. 3) 2025

Submission No:	16
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Publication:	
Attachments:	
Submitter Comments:	

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Feedback to Consultation Bill amending the *Transplantation and Anatomy Act 1979* ('TAA'): November 2025

Thank you for the opportunity to provide feedback to the proposed changes to the TAA to introduce specific ante-mortem interventions provisions.

General

I previously provided feedback to Qld Health on earlier proposed changes to the TAA. I was glad to see that issues that I were taken on board with aspects of the current proposed amendments much improved. As highlighted in my prior submission, it is good that Queensland has recognised and is taking steps to clarify the situation in relation to when ante-mortem interventions can lawfully be provided in Queensland. We have recognised that legal frameworks have hampered consistent clinical care across Australia in this area.[1]

As already acknowledged by the Committee, the Australian Law Reform Commission (ALRC)[2] is actively reviewing the human tissue legislation across Australia and have indicated that ante-mortem interventions is an area of interest.[3] With Queensland, like New South Wales and Victoria, developing its own model of how to regulate ante-mortem interventions there is a danger of patchwork and inconsistent regulation across the country. However, I would hope that any reforms at the current time would not preclude consideration of a national consistent approach that might be found after the ALRC finishes its review (in 2026). Ideally, States and Territories would adopt legislation that was largely consistent, including in relation to ante-mortem interventions, to allow for consistency of practice across Australia.

Specific Issues

Provision for authorisation for adult lacking decision-making capacity – s 25C

- The proposed Queensland provision has adopted a similar approach to NSW by electing that the senior available next of kin of the person ought to be the decision-maker (rather than the approach of Victoria where the medical treatment decision maker – i.e. substitute decision-maker during a person's life – is the person able to consent to ante-mortem interventions). Either approach has its merits, but the approach chosen by Qld does raise the increased possibility of having two substitute decision-makers actively involved in making decisions at the end of a person's life, with each having authority in a different area (i.e. end of life treatment decisions vs ante-mortem intervention and removal of blood for tissue donation viability decisions).
- At the time of a removal of blood for tissue donation viability decision (or even once a decision has been made to withhold or withdraw life-sustaining measures and ante-mortem interventions are considered), substitute decision-makers (regulated under the *Guardianship and Administration Act* (GAA) and the *Power of Attorney Act* (POAA)) could presumably be called upon to indicate preferences or make decisions regarding end of life care. Substitute

[1] Then, S.-N., Martin, D.E. and Opdam, H.I. (2025), Ante-mortem interventions for deceased donation: legal barriers and uncertainty in Australia's decision-making frameworks. Med J Aust, 223: 236-240. https://doi.org/10.5694/mja2.70020

[2] NB: I am a member of the ALRC Advisory Committee for the Review of Human Tissue Laws. The views expressed here are my own and do not represent that Advisory Committee's or ALRC's views.

[3] Review of Human Tissue Laws: Issues Paper (2025) | ALRC

decision-makers for end of life care will often, but *not always,* be the same people who make deceased donation decisions (i.e. senior available next of kin). [4]

- Substitute decision-making for adults lacking decision-making capacity is generally regulated under the *GAA* and the *POAA*. As the proposed provisions introduce a form of substitute decision-making for health interventions while a person is alive, consideration ought to be given to how these provisions will intersect with substitute decision-making under the GAA and POAA. I note that in NSW, this is expressly provided for under s 27F of the *Human Tissue Act 1983* (NSW). Anticipating that there may be circumstances of overlap between end of life treatment/care decision-making and blood removal/ante-mortem intervention decision-making (and noting the point above that the decision-makers will often, but *not always* be the same) the legislation should similarly clarify how conflicts can be resolved between the two legislative frameworks.
- Absent from the proposed legislation and from the provisions in NSW and Vic is guidance for substitute decision-makers regarding *how* they should make the decision to consent or refuse consent to blood removal/ante-mortem interventions. Consideration should be given to providing these decision-makers with guidance (i.e. decision-making principles). Priority should be given to what the patient would have wanted[5] and/or aligning it with the decision-making principles (General Principles and Health Care Principle) in the GAA and POAA.

Provision for authorisation for a child – s 25C

- While I appreciate that the amendments are proposed to address the issue of ante-mortem intervention authorisation, the changes do raise some implications for how children are treated under the TAA. The proposed new sections simply refer to 'a child' and makes no distinction between a mature child who has decision-making capacity (often called a 'Gillick-competent child') and those who lack decision-making capacity. Under the new provisions, authority to consent for ante-mortem interventions in a child is given to the senior available next of kin, regardless of the capacity of the child.
- While the TAA is not consistent throughout in terms of whether a Gillick-competent child has decision-making rights separate from parents, at relevant sections it does require a child to 'agree' (see sections 12C, 18, 21C[6]). I raise the issue of whether, in line with contemporary understandings and recognition of the emerging autonomy of adolescents, the amendments should account for children that are assessed as being Gillick-competent to provide consent directly rather than always defaulting to the senior available next of kin. I appreciate that this may be a matter that is considered further once the ALRC has made its final recommendations as it is, once again, a matter where a nationally consistent approach is desirable.

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[4] This issue was identified and discussed in Then S, Martin DE, Transitions in decision-making authority at the end of life: a problem of law, ethics and practice in deceased donation. *Journal of Medical Ethics* 2022;**48:**112-117. https://doi.org/10.1136/medethics-2020-106572

[5] See discussion in Then SN, Martin DE, McGee A, Gardiner D & N El Moslemani, Decision-making About Premortem Interventions for Donation: Navigating Legal and Ethical Complexities, *Transplantation* 107(8):p 1655-1663, August 2023. *DOI:* 10.1097/TP.0000000000004591

[6] I note that s 21C TAA refers to consent as required by the National Statement. The National Statement recognises that some mature children can consent to research participation independently: Chapter 4.3, The National Statement on Ethical Conduct in Human Research, 2025, National Statement on Ethical Conduct in Human Research 2025 | NHMRC

Please feel free to contact me if you wish to discuss any of the issues I have raised.

Kind regards

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