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20 September 2017

Ms Emily Booth
Acting Committee Secretary
Legal Affairs and Community Safety Committee

Via email: lacsc@parliament.qld.gov.au

Dear Ms Booth

Guardianship and Administration and Other Legislation Amendment Bill 2017

MIGA appreciates the opportunity to make a submission to the Committee's inquiry into the Guardianship and Administration and Other Legislation Amendment Bill 2017.

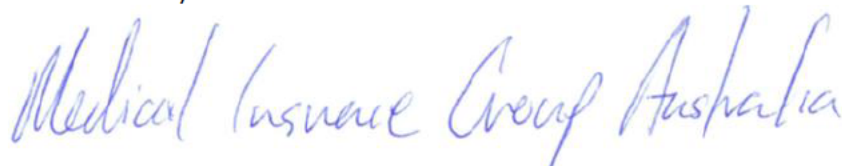
A copy of its submissions are enclosed.

MIGA is a medical defence organisation and medical indemnity insurer advising, assisting and educating medical practitioners, medical students, health care organisations and privately practising midwives throughout Australia. With over 30,000 members and a national footprint, MIGA has represented the medical profession for over 115 years.

More generally, MIGA welcomes the opportunity to contribute to the Committee's work relating to Queensland health care. It contributed to the Committee's inquiry into the Health and Other Legislation Amendment Bill 2016, and also to a number of inquiries conducted by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee relating to health care, including the recently completed inquiry into health practitioner regulation reforms.

Please contact Timothy Bowen by telephone 1800 839 280 or email [redacted]
if you have any questions about MIGA's submission.

Yours sincerely



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MIGA submission

Queensland Parliament
Legal Affairs and Community Safety Committee

Guardianship and Administration and Other Legislation Amendment Bill 2017 inquiry

September 2017

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Queensland Parliament
Legal Affairs and Community Safety Committee

Guardianship and Administration and Other Legislation Amendment Bill 2017 inquiry

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Executive Summary – MIGA's position

1. MIGA's position is:

   (a) to support clarity around the presumption of an adult having capacity to make decisions about their health care

   (b) whilst supporting the proposed principles for health care decision-making under the *Guardianship and Administration Act 2000* (Qld) (**GAA**) and the *Powers of Attorney Act 1988* (Qld) (**PAA**), certain issues for statutory health attorneys and other 'substitute' decision-makers to take into account require clarification, and the primacy of an advance health directive (**AHD**) needs to be made clear

   (c) the contemplated capacity assessment guidelines should directly address the health care context, be available in a variety of platforms (including web and app-based) and contain decision-making tools and case studies

   (d) it is necessary to clarify how to deal with disputes over who should act as a statutory health attorney when there is more than one potential candidate, most likely through further guidance on this issue, developed in consultation with key stakeholders, including MIGA

   (e) protections for medical and other health practitioners involving AHDs are too narrow, and should be wider in order to avoid placing unrealistic demands on practitioners through the spectre of liability for actions taken in good faith

   (f) where aspects of some AHDs made under the current regime will no longer be valid under the proposed changes, practitioners and the community need to be made aware of this before the new regime commences

   (g) AHDs which are valid at common law should be valid in Queensland, particularly to ensure there is not an inappropriate emphasis on form over substance, and so that practitioners do not face unreasonable obligations in interpreting them, particularly those made in other states and territories where different regimes apply.

MIGA's interest

2. MIGA is a medical defence organisation and medical indemnity insurer with a national footprint. It has represented the interests of the medical profession for over 115 years. Its more than 30,000 members and policy holders include significant numbers of medical practitioners practising in Queensland, both in community and hospital settings.

3. MIGA's lawyers regularly provide advice and assistance to its members and policy holders on health care decision-making, including capacity, AHDs (and their equivalents elsewhere),

guardianship and working with statutory health attorneys. Its lawyers are experienced in dealing with the varying regimes involving these issues across Australia.

4. Through its Risk Management Program, MIGA educates medical practitioners on a range of medico-legal issues which impact on issues of consent, guardianship, AHDs and other decision-making issues relating to health care.

5. Recently MIGA has been involved in:

   - the ongoing NSW Law Reform Commission's Review of the NSW *Guardianship Act*

   - the recently completed Australian Law Reform Commission Elder Abuse inquiry

   - the Victorian Department of Health & Human Services *Simplifying Medical Treatment Decision Making and Advance Care Planning* consultation, which led to the development of the Victorian *Medical Treatment Planning and Decisions Act 2016*, due to commence early next year

   - the NSW Health Review of Advance Care Directives project.

   Each of these projects have addressed similar issues to those raised in MIGA's submissions.

Presumption of capacity (Bill cls 7 and 56, new ss 11 GAA and 6C PAA)

6. MIGA supports the proposed clearer reiteration of the presumption of capacity in determining whether an adult is able to make decisions about their own health care.

7. It is also appropriate that those involved in an adult's health care are entitled to rely on a court or tribunal decision or appointment to indicate that an adult lacks capacity.

General and health care principles for decision-making (Bill cls 8 and 56, new ss 11B and 11C GAA, and ss 6C and 6D PAA)

8. In general, MIGA supports the proposed principles for health care decision-making.

9. However, it has some concerns about how a number of the principles may apply in practice.

10. The breadth of certain terms used in health care principle 3 could cause confusion.

11. The requirement for a health care decision-maker to take into account "***any alternative*** *health care that is available*" or "*whether proposed health care can be postponed because a* ***better health care option*** *may become available*" could cause issues for medical and other health practitioners in advising decision-makers and caring for their patients.

12. The concepts of "*any alternative*" and "*better health care option*" are too broad. For instance, they could require decision-makers to consider care options which the treating team consider

inappropriate and / or unable to give meaningful advice about. This could cause significant practical problems in providing health care.

13. The better approach would be to confine these principles to "*any* ***appropriate*** *alternative health care*" and "***more appropriate*** *health care option"*. The use of the term 'appropriate' would also make the principles more consistent with the language used elsewhere in the Bill.

14. Health care principle 4, as presently drafted, could cause confusion about the primacy of an AHD.

15. It is conceivable that this principle could be read as only requiring an AHD to be considered, not necessarily followed where valid, as would be expected under s 35 of the PAA.

16. The principle requires clarification to reflect the primacy of a valid AHD.

17. In addition, given the changes to the existing principles, it is important that practitioners and the community have concise and easily available resources summarising the changes before they come into effect.

Capacity assessment guidelines (Bill cl 41, s 250 GAA)

18. MIGA supports the development of guidelines to assist in making assessments about capacity to make health care decisions.

19. It is important that these guidelines incorporate specific guidance for medical and other health practitioners in assessing a patient's capacity.

20. It is imperative that the wide-ranging elements relevant to an assessment of health care capacity in a health care context are addressed in a meaningful way. Depending on the situation in question, these can include:

    - nature of condition
    - gravity of decision involved
    - potential consequences
    - differences between consent to and refusal of treatment
    - potential considerations of irrationality and reasonableness
    - influences of others.

    MIGA is concerned to ensure that these elements be given their due weight in each health care context. Their comparative importance should not be reduced or minimised in the interests of seeking uniform assessments across a range of situations. This poses risks of compromising or confusing capacity assessments in health care, and of other unintended consequences.

21. The contemplated guidance should be available in a variety of formats and platforms, including web and app-based, and include things such as decision-making tools and case studies specific to common health care capacity scenarios. In MIGA's experience, these things can be very helpful to practitioners.

Statutory health attorneys (Bill cl 67, s 63 PAA)

22. MIGA supports the proposed clarifications about who cannot act as a statutory health attorney.

23. However, it is concerned that this does not assist the situation of where there is more than one person who falls within one category of a statutory health attorney, and there are differences over who should act as the attorney. For instance, there could be multiple people who care for them, or who are considered close friends or relations.

24. MIGA's members regularly encounter situations of where more than one person can act as an attorney, creating potential for conflict.

25. Clarification of who should be the principal or prevailing attorney, or alternatively how to resolve disputes between potential attorneys if there is no primacy, would be helpful for practitioners.

26. It may be difficult to determine an appropriate set of criteria to determine primacy in decision-making in a way which could be set out in legislation.

27. However, it would helpful for further guidance to be developed for practitioners and the community around this issue, including the use of case studies. This should be developed in consultation with key stakeholders such as MIGA.

28. MIGA supports the use of mediation in these contexts, subject to time constraints, and the roles of the Public Guardian and Queensland Civil and Administrative Tribunal in resolving disputes.

29. However, it believes practitioners and the community need further, appropriate clarification about how to deal disputes over who should act as attorney. This is to try and avoid initial disputes escalating to a point where more formal resolution mechanisms are required.

Protections for health providers (Bill cls 72-73, ss 100 and 102 PAA)

30. MIGA supports protections for medical and other health practitioners who rely on an AHD, or its absence, in good faith.

31. It endorses the comment made on page 16 of the Bill's Explanatory Notes, namely:

> "*…it is not realistic or practical in all circumstances for a person acting in reliance on an AHD, or a power for a health matter under an enduring document or a direction in an AHD to know the AHD or power for a health matter is invalid, or the direction in the AHD does not operate.* ***Nor should they be expected to be able to assess the legality of the direction or document***

> ***beyond its face value.*** *This is especially the case for a health professional who may be required to provide emergency treatment*."

32. MIGA is concerned that the amended protections for practitioners are too narrow.

33. Firstly, the protections apply only to 'liability', without defining what this includes.

34. Under the *Acts Interpretation Act 1954* (Qld), Sch 1, 'liability' defined as "*any liability or obligation (whether liquidated or unliquidated, certain or contingent, or accrued or accruing)*". This tends to imply a civil liability, i.e. for damages.

35. Accordingly, the term 'liability' could be read narrowly include civil liability only, and not 'liability' in the criminal or professional regulatory and disciplinary contexts. This is an insufficient protection for practitioners.

36. The liability protection should be extended to clarify that the protections from 'liability' under amended ss 100 and 102 of the PAA includes offences, civil liability, adverse disciplinary findings and / or determinations of a breach of professional standards or etiquette.

37. Secondly, the protections contemplate protection only for practitioners in relation to AHDs invalidly made in another state, which have been revoked or where there are issues about whether they could have been made at all. They do not extend to all issues around of validity of an AHD made in Queensland, such as scope or form.

38. This limitation on the protections is concerning given the Queensland regime imposes certain legal requirements around AHD scope and form. As illustrated by the extract from page 16 of the Bill's Explanatory Notes set out above, it can be challenging for a practitioner acting in good faith to determine all aspects of validity in all situations. It is unreasonable to expect them to do this.

39. Instead, MIGA proposes that the protections be extended for practitioners who, in good faith, are unaware of potential invalidity generally of an AHD made in Queensland.

Changes to who can be an eligible attorney under an AHD (Bill cl 79, s 169 PAA)

40. The proposed changes contemplate that some statutory health attorneys validly appointed under an AHD can no longer act in that role as they will be persons who will no longer be permitted to act as attorneys.

41. Given this, there needs to be a focus on ensuring medical and other health practitioners, and the community, are made aware of this change before the new regime commences.

Validity of common law advance health directives

42. MIGA also supports recognition being given to common law AHDs, advance care directives and their equivalents in Queensland.

43. It acknowledges the potential benefits of a statutory AHD regime, but is concerned that this can place an unnecessary emphasis on form over substance, and unduly impede the provision of health care.

44. Deficiencies in AHD form should not prevent it from being followed if it meets common law requirements, as set out clearly in *Hunter New England Area Health Service v A* [2009] NSWSC 761. This is a regime which has been in place for a long time, is both workable and practical.

45. This issue is particularly important for patients normally resident outside Queensland, or who made an AHD or its equivalent outside Queensland.

46. Although s 40 of the PAA contemplates validity of an AHD or its equivalent if it:

    - meets the requirements for validity where it is made, and

    - is not beyond the scope of an AHD which can be made in Queensland,

    the potential problem with this is that it could then require medical and other health practitioners to make an assessment of validity against a regime which is unfamiliar to them.

47. The comments made in the Bill's Explanatory Notes at page 16 about those dealing with AHDs, namely "*…Nor should they be expected to be able to assess the legality of the direction or document beyond its face value"* provide further reason why AHDs and their equivalents made at common law should be valid.

48. Consequently, AHDs and their equivalents which are valid at common law should be valid under the Queensland statutory regime.