

TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into end-of-life choices

Melbourne — 18 November 2015

Members

Mr Edward O’Donohue — Chair

Ms Nina Springle — Deputy Chair

Ms Margaret Fitzherbert

Mr Cesar Melhem

Mr Daniel Mulino

Ms Fiona Patten

Mrs Inga Peulich

Ms Jaclyn Symes

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Mr Gordon Rich-Phillips

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Secretary: Ms Lilian Topic

Witnesses

Mr Bill O’Shea, member, health law and elder law committees, and

Ms Michelle Whyte, senior lawyer, legal policy, Law Institute of Victoria.

The CHAIR — I declare open the Legislative Council’s Standing Committee on Legal and Social Issues public hearing in relation to the inquiry into end-of-life choices. I welcome Mr Bill O’Shea from the Law Institute of Victoria, specifically from the health law and elder law committees, and Ms Michelle Whyte, senior lawyer, legal policy, also from the law institute. Thank you both for your attendance today. We have received your submission as well, which we thank you for.

Before I invite you to make some opening remarks, I caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders; therefore you are protected against any action for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today’s evidence is being recorded. You will be provided with proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee’s website. We have allowed 45 minutes for our session today. I again thank you both for being here with us this morning. I invite you to make an opening statement or opening presentation, and thereafter the committee will have questions.

Mr O’SHEA — Thank you very much, members, and thank you for the opportunity to appear before the committee. This is a very important topic and very close to the heart of the law institute, because we have been concerned about this topic for a number of years.

Firstly, there is an overarching principle for the law institute in relation to this topic, end-of-life choices — that is, the autonomy of the patient and the autonomy of the person involved. Personal autonomy is at the root of all this. It is a basic human right enshrined in our charter of rights that a person has autonomy to make decisions about their health care. Certainly when they are competent there is not much of a problem with that, but the issue for us and for this inquiry is what happens when the person has made those choices but loses capacity, and how do we ensure that to the maximum extent possible their choices are respected when they lose capacity? That really is fundamental and the background to all of our deliberations on this topic.

The second point I want to make is that the Law Institute of Victoria has no view on the subject of euthanasia. We are a membership organisation which has a diverse range of views, and we do not have an institutional, if you like, or a law institute position on that topic. We think there are a lot of issues in this area that require urgent change which can be done as a matter of good government and which we would hope would have bipartisan support around the existing legislation affecting end-of-life decision-making, and indeed the lack of legislation around end-of-life decision-making, so we will not be making or expressing any view on the topic of euthanasia. That might make you feel a bit more relaxed for the next 45 minutes.

If we could just talk about the current legislative framework, I have just spent 12 years as a general counsel at the Alfred, and this topic came across my desk quite often. On the legislative structure, which you are probably well aware, I guess the best place to start is the Medical Treatment Act, which was a far-sighted piece of legislation put in place, I think, in Victoria as the first state in Australia at the time. I think David White was the health minister at the time. It enables a person to refuse medical treatment for a current condition. That decision has to be respected by a medical practitioner, not by an ambulance officer, not by a nurse or an allied health worker; it just has to be respected by a medical practitioner. So it has those two limitations of medical practitioner and a current condition.

The problem illustrated in our submission is that a person who has an illness now, a long-term illness — for example, it might be Parkinson’s or it could be HIV — and says, ‘Well, if I develop pneumonia in the future, I do not want invasive antibiotic therapy or treatment’, they cannot refuse treatment. The law is very unclear on this subject, but there is a general view — I think the majority view — that they cannot refuse treatment for an infection which they do not currently have because it is not a current condition. Victoria is the only state that is saddled with the current condition rider in its Medical Treatment Act. That is the first problem, but nevertheless it is an opportunity for people to give an advance care directive on their medical treatment, applicable albeit only to medical practitioners.

The second piece of legislation is the Powers of Attorney Act, which commenced on 1 September. Under personal matters, people can appoint an attorney — a principal can appoint an attorney — to deal with their personal matters. It replaced the old enduring guardianship concept, where the personal matters attorney can make decisions on lifestyle matters for the principal. We would say that the Powers of Attorney Act does not allow a principal who is given a power on personal matters to refuse medical treatment, so there are some issues around what are the powers given to a person holding powers of attorney for personal matters.

If I could just go back to the Medical Treatment Act for a second, what the Medical Treatment Act also allows is the person to appoint an enduring medical power of attorney which only applies when they lose capacity, and that attorney can refuse medical treatment subject to certain requirements in the act. So the medical power of attorney can refuse medical treatment. An attorney under the Powers of Attorney Act probably cannot refuse medical treatment. Our view would be they cannot; you would need to have a medical power of attorney before that could happen.

The third legislation is the Guardianship and Administration Act. Now that allows decision-making about an incompetent patient to be made by what is called the 'person responsible', and section 38 sets out a hierarchy of who is the person responsible. I will tell you that this is the greatest challenge for medical and nursing staff. We had a preprinted, laminated sheet of section 38 on every desk at the Alfred so that staff could work out who the person responsible was when they had an incompetent patient, and they had to work out who they should go to for consent.

The first person on the hierarchy is the medical power of attorney, and it works its way down. You end up with relatives and nieces and nephews right at the bottom, and the spouse is somewhere in the middle — the domestic partner is somewhere in the middle. The person responsible, unless they are the medical power of attorney at the top of the list, cannot refuse medical treatment. The guardianship act does not allow them to refuse, as the Medical Treatment Act does. So a person appointed as a medical guardian can refuse under the Medical Treatment Act, but a person responsible who is consenting for an incompetent patient under the guardianship act cannot refuse medical treatment.

What they can do — and excuse me for splitting hairs here — is they can not consent to medical treatment. So a doctor will offer them treatment. They will say, 'Look, your mother's got pneumonia. We are offering you certain treatment' — the treatment might be antibiotic therapy — 'She is unconscious. We would like you to consent'. Now the person responsible can consent to that treatment, but they cannot refuse it because they are not holding a medical power of attorney. But they can simply say, 'I'm not going to consent to that'. Now is that a refusal of treatment? Are they really refusing treatment? They can say, 'I'm walking out of the room. I'm not consenting to that'. So what do the doctors do? I can tell you that they ring up the general counsel, that is what they do. What do they do? They have a person responsible who is basically abrogating her responsibilities — his or her responsibilities — by not consenting. The answer is that they have serve a section 42M notice on the family saying, 'We're going to treat. We think it's in your mother's best interest to treat and we're going to do it', and you go to section 42M of the guardianship act and you go through the process.

Now this is a bit shambolic, I have got to say, to have these three acts running in parallel. It is okay for me, I have been doing it for 12 years, but for a nurse on the ward or someone in the emergency department or a doctor or an ambulance officer, it is a legislative morass, really, for them. So we need a clearer legislative framework for how you deal with medical treatment for incompetent patients.

We have a number of recommendations, but before I come to that I will just go to one other step. Organically in Victoria the advance care plan has developed — it really starting at Austin Health with Bill Silvester's work and has been picked up by most other health services now in Victoria — where a person can write an advance care plan setting out their intentions. Now, if you like, that is a medical directive, but it is not enforceable because the common law in Victoria does not seem to support an advance care directive or plan, which are sort of synonymous now, with enforceability. We do not believe that it is enforceable. A doctor who ignored an advance care plan — left it in the drawer and never read it — might have a problem in the sense that the family can say, 'You haven't acted in my mother's best interest because you never bothered to read her plan'. But it is really not — that would be the extreme end. But if a doctor read it and thought, 'Oh yes, okay, I take that on board', there is no real obligation to do it.

The problem gets into real focus when an elderly patient, for example, is in a nursing home, has an adverse event in the middle of the night, has an advance care plan which says, 'I want to be left in my bed and I want to be made comfortable', and the family arrive, and say to the nurse in charge — because there is often not a doctor around — 'You've got to resuscitate my mother'. And the nurse says, 'Well, there's an advance care plan here. She didn't want to be resuscitated' or 'She didn't want to have major intervention. She just wanted to be made comfortable'. The family says, 'You are to take her to the Alfred emergency department by ambulance straightaway, and if you don't I'll regard you as being negligent. You're not really doing your job. You are

failing in your duty of care to my mother'. So what do they do? What does the doctor do when you have got a family that is basically trying to override the advance care plan? Furthermore, what if the family member is the person responsible? Or indeed, what if the family member is the medical power of attorney? That further confuses matters. Does the plan apply instead of the medical power of attorney's view? What if the attorney says, 'Well, my mother wants full treatment on her plan. I'm the attorney. I say, "No treatment"'.

So it is really a mess. We think the best way to protect health workers, be they doctors, nurses, whoever, when they are faced with an advance care plan, is to make the advance care plan enforceable; in other words, force them to follow the plan subject to a number of possible exclusions. That gives them protection, it gives them immunity, as does the current refusal of treatment certificate. The doctor gets immunity against suit, and it is an argument they can put to the family and say, 'Look, my hands are tied. Your mother's made a plan, and the new legislation passed in Victoria' — which we hope one day will be — 'says we have to follow it'. We would see that as a protection for health workers. I know from meetings with the AMA that that is certainly their view as well, that at the moment the law is very uncertain for doctors and others in this space when they are faced with these decisions.

In terms of — and Michelle is going to jump in at any minute; I can see it and I am welcoming — —

Ms WHYTE — I may, but you are doing a fantastic job.

Mr O'SHEA — I will keep going while I am on a roll. The other issue that I think I would like to draw to your attention is we think there is a blueprint for the area of advance care directives being made enforceable through the Rees report into guardianship of 2012. Neil Rees produced what we think is the blueprint for the law on guardianship. It is regarded extremely highly by all legal practitioners. Chapter 11 of that 2012 report sets out in fact draft legislation that assists in making directives enforceable, and includes exclusions. For example, a directive might be in place, but the technology — the science — in 2015 might have changed since 1963, whereby a person could be put on ECMO if they had heart failure waiting for a transplant; ECMO might have been developed after that plan was made. If that is the case, the doctors can go against the plan; it is a way of avoiding the plan. They might say that the plan is too vague for them to understand it, it was badly drafted so they can ignore it or make the best of it, but not be held to it. If it is an emergency, they might not be required to follow the plan if they have not got time because they are trying to resuscitate someone who has come out of a car accident and they do not want to spend an hour and a half looking for the plan.

All of these are covered in Neil Rees's report and I would commend it to the committee. It was prepared, I think, for the Brumby government in the Brumby government era. It has a large number of recommendations that caused a lot of confusion for the Baillieu and Napthine governments because how do you implement 400-odd recommendations? But I think chapter 11, for your work, is highly relevant; I would commend that chapter to you. Michelle, did you want to add anything?

Ms WHYTE — No, I do not think I have anything.

Mr O'SHEA — Our recommendations would be — just very quickly — we believe the Medical Treatment Act should be heavily amended, if not repealed. We would like to see the medical power of attorney removed from the Medical Treatment Act and put into the Powers of Attorney Act under personal effect matters so that you can make a medical power of attorney in that act. We would like to see the Medical Treatment Act, if you like, renamed the medical planning act, where all issues around end-of-life decision-making, including advance care plans and their enforceability, could be included, as could the requirements about medical refusal of treatment.

Refusal of treatment immunities are in the Medical Treatment Act. The same immunities could be applied to someone giving effect to an advance care plan. In fact we drafted some legislation based on that previously; the law institute has already done that. It is a very simple process to include advance care plans in the Medical Treatment Act and change its name to the medical planning act. I think that is a really good solution and we commend it to the committee.

The CHAIR — Mr O'Shea, thank you very much for that presentation and the recommendations you have advanced this morning. I would like to ask two questions, if I may. First of all, as the former general counsel at the Alfred, that situation you described where the medical power of attorney is contradictory to an advance care plan, how do you navigate that? That is the first question.

The second question is in relation to the enforceability of advance care plans and your recommendation that they be legally enforceable. I note the government has foreshadowed changes to that effect. We have heard varying evidence supporting that proposition. We have also heard evidence saying that that would create uncertainty because you cannot foreshadow all future medical scenarios. I would be interested in your thoughts on that proposition as well.

Mr O'SHEA — I will just take the last point first. The Rees report deals with foreshadowing medical scenarios. It basically says if a medical power of attorney is superseded by, for example, changes in medical science, then it does not have to be any longer enforceable. If the doctor's view is that the patient, if competent, and knowing what the current situation was with medical science would not want that particular directive to remain, that is, if you like, an exclusion for the doctors. So there is no reason why the legislation cannot have carve-outs for various scenarios. Those scenarios are covered in the Rees report. For example, the directive might have been overborne like a will — stood over by relatives. If there was evidence that the person had been overborne when making the directive, the same would apply; the doctor would have a get-out clause. Sorry, your first question was?

The CHAIR — How you as a former general counsel at the Alfred — —

Mr O'SHEA — What do we do with it? Because there is legal uncertainty around the advance care directive, the doctor's view is that you read it and you put it into the melting pot in your head when you are trying to work out what is in the best interests of the patient, and you take that on board. You have to consider it; you have to turn your mind to it and think about and be able to tell a coroner or a court later on, 'Yes, I thought about it, but I didn't follow it' or 'I did follow it for these reasons'.

If you have a medical power of attorney in front of you which says, 'I've been appointed and under the act I've gone down the act and I've looked at all the criteria for me refusing treatment. I believe they're fulfilled; the patient wouldn't want this if she was competent and I am telling you now that I am refusing on her behalf', then that is binding on a medical practitioner because the Medical Treatment Act says so, and that is fair enough. If the doctors thought that the medical power of attorney was acting capriciously, then they can go and challenge it at VCAT or wherever; they can challenge it. But generally speaking, if an attorney had gone through and satisfied the act, then that is a binding decision on doctors under current law.

Ms SPRINGLE — You just mentioned situations where there may be evidence that a patient was overborne by relatives or others. What would be considered evidence in that regard?

Mr O'SHEA — It could be nurses' evidence. It could be that the patient came into hospital and the family said, 'Look, Mum, you've got to sign this because you don't want treatment, do you?', and there was evidence from nurses or other staff at the hospital.

Ms SPRINGLE — It would be within the medical environment as opposed to previously?

Mr O'SHEA — It could be the family coming along and saying, 'My brother just wants to get his hands on the property. He doesn't want Mum to be in hospital, to linger on, and he really forced her to sign this'. If there is evidence of that and he is prepared to go on an affidavit to that effect, then that would be something that the treating team would take on board.

Ms PATTEN — This might be for both of you. We have heard about medical power of attorney. You talked about moving medical power of attorney into the other act. There have been some conversations that the medical power of attorney should be a separate person to the power of attorney who might deal with the finances of that person. We have particularly been talking about elder abuse, like the last example you gave. I am just wondering about your thoughts on whether they could be the same person or do you think they should be separate?

Ms WHYTE — I think the language at the moment is quite confusing, having a medical power of attorney, and we have just had the brand-new Powers of Attorney Act where, if someone is appointing their enduring power of attorney, they are now for financial and personal matters — all decisions that I would otherwise make. People will be making the assumption that their enduring power of attorney will be making those medical decisions. Because the medical power of attorney sits in a separate act and with a separate government department, the administration of it is really confusing. It is confusing for lawyers to advise clients as well as for

medical practitioners, especially when family members who do have an enduring power of attorney assume that they can make those decisions. We would recommend that there be clarity over those decisions.

Mr O'SHEA — The Powers of Attorney Act allows for the appointment of different people for different roles. You could appoint one person to be your enduring financial attorney. You could appoint another person to be your attorney for, let us say, your banking. You could appoint another person to be your attorney for lifestyle issues — who visits and where I am going to live when I am no longer competent. There is no reason why you could not appoint another person who would have medical power and who could do the medical treatment decisions for you. The act already allows for that, and we would not see any problem in legislating and amending it for that.

Ms PATTEN — I guess what I am trying to work out is whether that medical power of attorney should be a separate person from someone who might be dealing with the financial matters of that person.

Mr O'SHEA — The act could provide for that. It could say that under the Powers of Attorney Act a person has the right to appoint a medical power of attorney. So you have got an attorney for financial matters, an attorney for personal matters and an attorney for medical matters, and it would be clear that the person appointed would be a person for medical matters with the power to refuse medical treatment. Instead of having two categories as we have now in the act, you could have three. Arguably medical is personal, but because of the power to refuse treatment — because it is such a significant power — it is probably better, as you suggest, to have that separate from personal matters. A person might want to choose a particular person who can refuse treatment who might have different skills and knowledge to the person who runs their bank account or who decides where they are to live.

Ms PATTEN — Do you think it should be mandated that that medical power of attorney should be a separate person to the person who — —

Mr O'SHEA — I do not see any problem with that at all in the legislation.

Ms WHYTE — It could fit in the current Powers of Attorney Act because you can already nominate different powers to different people.

Mr O'SHEA — The only caveat I have got with all this — and I think this is the problem with the guardianship review — is that there are two ministers involved here. There is the Attorney-General involved on powers of attorney and guardianship and the health minister in relation to the Medical Treatment Act. I think we have always had an issue that the reason we had a guardianship report that did not deal with medical treatment is that the law reform commission was commissioned by the Attorney-General to do the review and not the health minister. If there had been a commission from both ministers, we might have had medical treatment dealt with by Neil Rees at the same time. I think that is an issue. We need both ministers to cooperate on this to achieve proper legislative reform.

Mr MELHEM — Going back to the question about the power of attorney, you are not suggesting that a person who has the power of attorney to deal with financial affairs — for example, a sibling — cannot be at the same time a power of attorney for medical? You are not suggesting that you cannot have one or the other?

Mr O'SHEA — No, we are not saying that anyone who was an attorney for financial affairs would also be able to deal with medical treatment. I think Ms Patten's suggestion, which we agree with, is that it is such an important power that it should be clearly separated in the act so that anyone appointed with that power is clearly known, and there might even be a separate pro forma available where you actually appoint under that act a person as your medical power of attorney, just as there is now under the Medical Treatment Act. But it seems more logical to put all the powers of attorney in one act rather than having them spread across legislation.

Mr MELHEM — On another point — and I think you have touched on it — is the enforceability of the advance care plan. I think you did talk about some opt-out for doctors. Apart from that example, basically, would you recommend it should have the same power as a will, so there is no ambiguity about the wishes of the patient when that patient put the plan together. You then follow that clear instruction to the letter unless there is some confusion.

Mr O'SHEA — We would, but you would wish lots of incompetent patients had the same rights as deceased patients under a will. In Victoria incompetent patients are much more badly done by than deceased patients, particularly in organ donation, which I will not go into here. Deceased patients get a really raw deal on organ donation when families overbear the medical team. If it was under a will, they would be in the Supreme Court arguing about it, not in the medical treatment room. We have the same view here in relation to advance care plans. The autonomy of an incompetent patient who made their choices known when they were competent should be respected, just as the wishes of a will-maker should be respected after they die.

Of course, not all wills are enforceable. If a will-maker is overborne, yes, you can challenge the will, or if you leave out someone who is dependent on you at the time, you can challenge the will. There are always get-out clauses, but at the moment there is no protection for the incompetent patient at all. There is no way that the incompetent patient can legally have their wishes enforced.

Mr MELHEM — In relation to safeguards, what recommendation would you give the committee? Do doctors, for example, actually have to sign off on a case involving the stopping of treatment or, I suppose, let the person die? You could have something in a will or an advance care plan. What sort of safeguard would you recommend to make sure there is no abuse by beneficiaries or other interested parties saying, 'Time for my mum to go' or 'Time for my uncle to go, because I cannot wait; it has become a burden'? What sorts of safeguards would you put in place to protect the vulnerable?

Mr O'SHEA — You can only make an advance care plan when you are competent. You have made it when you are competent, and then you become incompetent. The problem now with the current law is that you have an argument for the medical staff between the person trying to uphold the plan when the medical power of attorney might have a different view. That is an impossible situation at the moment, and we just discussed that earlier. We do not see any issue of abuse, given that the person has made the plan when they are competent. It is simply a matter of the medical staff looking at the exclusions that are possible and giving due consideration to them. We do not see this as a way to prematurely end the life of a relative. Only the patient can sign it; it cannot be signed by a third party. If the patient cannot write, they could direct a third party, but they would be competent, so it is made when they are competent and respected when they are incompetent. We do not see any danger from that point of view, any more than a medical refusal of treatment at the moment. A person makes a refusal of treatment when they are competent, and they expect when they are incompetent for that medical treatment to be followed, and if the doctor does not follow it, then they can be sued for medical trespass.

The problem with that, as I alerted you to before, is that it is not binding on ambulance officers. It is not binding on healthcare workers other than doctors. The act says it is only binding on medical practitioners and only for a current condition, so it is severely limited. There are good reasons for why the current condition was put in, but I think nowadays, given long-term diseases and the fact that you have not contracted something that might be terminal, you should be able to give a directive on that just the same as any other condition.

The CHAIR — Mr O'Shea, just following up on the point you made just then and on the point you made earlier about the limitation in the Medical Treatment Act being exclusive to medical practitioners, what is the breadth of health professionals that should be covered in the view of the LIV? Ambos — —

Mr O'SHEA — Our view is that health professionals should be covered, but I think we would also want ambulance officers covered, because they have a real problem when they turn up in the middle of the night at a nursing home. If you call the ambulance, you have got to expect them to resuscitate somebody. Why would you have called the ambulance? So it is a real problem for ambulance officers. They would not be health professionals under the AHPRA legislation, for example, so you need to extend it for them.

The CHAIR — So the AHPRA legislation would cover basically the list of — —

Mr O'SHEA — The 9 or 10, or whatever it is, categories of health practitioners. That is a simple way to cover the field at the moment. It excludes social workers, and there are a few professions that are not covered by AHPRA, but it is 9 or 10 categories, and it would certainly be a huge improvement, provided ambulance officers were included as well.

The CHAIR — Just one follow-up question to the challenges of enforceability of advance care directives or plans, noting the vagaries of what might happen into the future and the notion of informed consent. Legally can you have informed consent for a condition that you currently do not know you may contract?

Mr O'SHEA — The whole point of this legislation is to overcome any doubts about whether you can have informed consent. A doctor could say to you, for example, 'You've got Parkinson's disease, and it is likely to progress to the point where you could get dementia and you could contract pneumonia. If that was to happen, we can treat the pneumonia or not treat the pneumonia. What would you want to happen?'. You have not got a current condition under the current law, so you cannot make any binding call on that, but if you legislated to allow that person to say, 'If that's the case and there is no other better treatment for the pneumonia or there is no way I could be brought back to where I was beforehand and have a good quality of life, I don't want that treatment'. If that is enforceable, then you overcome any issues around informed consent.

Ms SPRINGLE — In your recommendation around emergency treatment it talks about health professionals not being liable if the terms of the advance care directive are uncertain.

Mr O'SHEA — Correct.

Ms SPRINGLE — So would you be advocating for a standard pro forma type of advance care directive across the state? We have heard a lot of varying views around what they should look like, what they should include and what they should be based on. Would you be advocating for a standardised document?

Mr O'SHEA — At the moment we have standardised documents for powers of attorney, which have blank spaces for people to put their particular directives in. We would see no problem in that. I would be wary about having, for example, standard clauses such as, 'I don't want treatment for pneumonia' or 'I don't want treatment for mouth ulcers' or 'I don't want radiotherapy'. The law institute's view would be I think that you leave that to the patient to decide.

It is possible that the public advocate, for example, could publish sample directives for people, a bit like the sample rules for incorporated associations. You would have an example of clauses that you could use, but they would not be binding. You would not have an invalid directive just because you did not follow the sample wording, but it might be a guide for people to help them to make that decision.

Our view is also that this plan should be made with your GP and not just made in isolation. It should be a consultative process, and it should be discussed with your family and with your doctor and with anyone else who is important in your life and not just done in isolation. Hopefully the wording would not be a problem, but if at the end of the day it was a problem for doctors, I think they deserve the right to continue to treat, particularly in an emergency if they cannot really work out what it is the patient wanted. I think to prescribe the wording could actually cause more problems than it solves.

Ms WHYTE — With the current powers of attorney you have the prescribed forms, so it can stretch from 2 pages to 26 pages depending on what is needed and what the donor wants to put in. So it would be something like that, with some sort of flexibility but also some consistency about what is required.

Mr O'SHEA — But not invalidity if they get it wrong. I think that would be a pity.

Mr MELHEM — One last question from me. There are sets of recommendations that you have put before the committee, which more or less address what we do currently. You are not looking necessarily at going beyond what the current situation is. Have you got any thoughts, for example, about voluntary euthanasia in all circumstances, like the Netherlands? Is that something you have given any consideration to?

Mr O'SHEA — We do not have a view on euthanasia. You were not here at the start, but I said at the start that the law institute does not have a view on euthanasia. We are a membership organisation that has a range of views on the subject. But we think the issues we have talked about this morning are much more relevant or as relevant as euthanasia as a topic to people and something which we think can be done with the stroke of a pen and which we would hope has bipartisan support, because it is really not particularly contentious. It is just tidying up a legislative situation that has grown like Topsy. You know, it has just gradually evolved to the point where advance care plans have come from the community; they have not come from government. They have come from medical practitioners like Bill Silvester and have been adopted by the community, and now governments are really faced with sort of catch-up in a way by saying, 'Let's see how we can give some legal effect to those plans that have come from the community'. We think this is relatively easy to implement, and as I said before, a lot of the hard work has been done by Professor Rees in his guardianship report.

Ms PATTEN — Thank you for that. With looking at the advance care directives and, I guess, merging them with the refusal-to-treat concept, at the moment you cannot refuse palliative care. You cannot refuse food and water, for example. Would the position of the LIV be to enable you to refuse that, because sometimes end of life is the only way you can take an action?

Mr O'SHEA — You do not have to drink the water or eat the food; you just cannot refuse it.

Ms PATTEN — When you are not competent or conscious, you — —

Ms WHYTE — Yes, when you have lost capacity.

Mr O'SHEA — We really have not got a definite view on it. We have not really looked at palliative care, have we, Michelle?

Ms WHYTE — No, not extensively, not outside the legislative framework that is here.

Mr O'SHEA — Under the Medical Treatment Act palliative care which involves invasive treatment, such as putting in a line, still requires consent from the person responsible. That is a bit of a pity because, if the person responsible disagreed with the decision to palliate a patient, they could make it very difficult to do the palliation by refusing to consent to the insertion of a line. So it does raise problems. To provide palliative care can sometimes require medical consent, and that can be a problem, but basic palliative care, such as making a person comfortable by the administration of medications, does not require consent.

In fact palliative care does not require consent, because doctors are not offering anything. A lot of families do not really understand, and in fact a lot of doctors do not understand that either. They think they need to get the consent of the family to offer palliative care, but in fact they are not offering any treatment, so they do not need any consent. But ideally the family should be on board — the family should agree with it. Theoretically the family could go to the Supreme Court and get an injunction to prevent palliative care being done, but they cannot do anything much else. It is always good for medical teams to have the family on side, but the tricky bit is where that palliative care does require what is called medical treatment along the way, and that can be held up. Maybe that could be an issue that could be addressed — that once palliative care is initiated, then consent is deemed to be given to whatever medical procedure is required to give effect to the palliative care.

Ms PATTEN — I think this is where we have had some witnesses come before us who have spoken about experiences where the only thing keeping that person alive is the water and possibly the handfeeding that they are receiving, and there is no ability to refuse that treatment because it is actually not a medical treatment.

Mr O'SHEA — There is if it is through a peg, but not orally in the normal way of eating that food. That is true.

Ms PATTEN — I was just interested with the 42M — was that common?

Mr O'SHEA — No, it is never used. It is so confusing. What is it? Five or seven days notice and then you have got to serve notice on them, and I think you have got a chance to go to VCAT afterwards. The whole thing is just shambolic. No-one uses it. We talked about it in our submission. When you have a refusal-of-treatment certificate you have got to give it to the CEO and the public advocate. Nobody does this. You would not want to audit that procedure in public hospitals in Melbourne. Half of them have never heard of it, and the ones that do are much more concerned about the treatment of the patient than to be doing administration, filling out these forms. There might be good reason for it, because it is a very important document — a refusal-of-treatment certificate — but it all needs to be tidied up and made — —

Ms WHYTE — Clearer. With the medical practice and legal framework there is a huge gap at the moment.

The CHAIR — That is a good way to put it.

Mr O'SHEA — There was a recent survey done by a group in Queensland that looked at doctors' knowledge of end-of-life procedures, and they gave them seven questions to answer. The average score was about three and a half out of seven, including doctors who specialise in end-of-life care, who just find the whole topic totally confusing — and you cannot blame them for that. It is just not clear enough.

Ms PATTEN — One of the other issues around making advance care directives or advance care plans enforceable was, as you mentioned also, the changing nature of medical technology and also that a patient's quality of life, or perceived quality of life, may change through a procedure. Would you see that we would be able to put a review of that advance care directive within the legislation, possibly reviewed every two years or once they are past 75, or reviewed every five years, to enable it to be a more specific plan? Because, as you say, a doctor will look at a plan and say, 'That was written 20 years ago, when this and this and this were not enabled'.

Mr O'SHEA — We always recommend that people review their wills every two or three years. They should review their powers of eternity every two or three years. All sorts of things can happen in families that can change the situation for the person you have appointed. That is not legislated; it is a recommendation we make. If we were to put it into advance care plans, that would be the only category where there is a legislative requirement to review. I would have thought that is maybe a step too far in terms of compliance. Does it mean that if you do not review it the plan is invalid? I would have thought that maybe the department of health in its campaign on encouraging people with these plans would be to say, 'You review it every two or three years, just as you do your power of attorney and your will'.

The legal profession has got a role here too. When a client comes in to make a will our view would be that the solicitor should say to them, 'Have you got an advance care plan? Have you got a power of attorney for personal affairs and for medical? If not, we can do it right here and now. Then when you come back and see me to review your will in three years, we will review these at the same time'.

The CHAIR — Ms Whyte and Mr O'Shea, are there any final comments you would like to make to us before we close?

Ms WHYTE — I was just going to make a point on that. With advance care planning something that we would also recommend is that the medical profession are resourced to be able to work with any advance care planning. I think that is important as well.

The CHAIR — Thank you both for your submission and your evidence today. It has been most informative for the committee.

Mr O'SHEA — Thank you very much.

Witnesses withdrew.