

TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into end-of-life choices

Melbourne — 18 November 2015

Members

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Witnesses

Ms Colleen Pearce, public advocate,

Mr Phil Grano, principal legal officer and

Dr John Chesterman, director of strategy, Office of the Public Advocate.

The CHAIR — Good afternoon. I would now like to welcome the Office of the Public Advocate and welcome Ms Colleen Pearce, the public advocate; Mr Phil Grano, the principal legal officer; and Dr John Chesterman, the director of strategy. Thank you to the three of you for joining us this afternoon.

Before I invite you to make an opening statement, 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 a proof version of the transcript in the next week or so, and ultimately transcripts will be made public and posted on the committee's website.

We have allowed approximately 1 hour for our time today. I would like to again thank the three of you for being with us and invite you to make an opening submission or opening remarks, and we will have questions thereafter. Thank you.

Ms PEARCE — Thank you very much. I will begin by just saying a little bit about of the work of the Office of the Public Advocate and then hand over to my colleagues John and Phil for the detail. Just for the record, the Office of the Public Advocate has a range of functions, but probably the most important in relation to this committee is guardian of last resort for adults with a decision-making disability. The majority of the clients under statutory guardianship are over the age of 65, so about 60 per cent of our clients would be over the age of 65, and a significant proportion of those are over the age of 80. Many of those decisions that we are required to make involve either an accommodation decision or a healthcare decision.

We also have a number of other functions, but importantly we have a community visitors program. Our community visitors visit supported residential services, acute mental health facilities and disability services, and we would come in contact there with a range of people who are experiencing end of life. The majority of our discussion today really will concern those two particular groups, and I will hand over to John now for the detail.

Dr CHESTERMAN — Thanks, Colleen. As you know, we are an independent statutory office with a broad range of functions under the Guardianship and Administration Act and other pieces of legislation, and we work to protect and promote the rights, interests and dignity of people with disabilities. As Colleen has said, we provide a number of services to work towards these goals, including the provision of advocacy, investigation and guardianship services. Last financial year we were guardian in relation to 1511 matters — I say matters rather than people because sometimes it is the same person for more than one occasion — and we conducted 438 investigations and 381 cases of advocacy.

The public advocate's functions can include acting as a guardian for an adult when appointed by VCAT with the power to refuse life-sustaining treatment. This is particularly relevant to today's inquiry. We were the plaintiff in the landmark BWV case, where the artificial provision of food and water was ruled to amount to medical treatment, which the guardian could refuse. That is a significant legal case to which we were a party.

OPA has a number of other relevant roles in relation to medical treatment decisions and legislative requirements, all of which are addressed in our submission. For instance, we receive what are called section 42K notices, where non-emergency medical treatment is proposed for an adult who cannot consent to it and where there is no person responsible able to provide consent. We took 470 of these in the last financial year. We also provide an advice service, which offers information and advice on a diverse range of topics affecting people with disability. Last year we fielded over 14 000 calls. Calls relating to medical consent and healthcare treatment were one significant minority category of calls; about 12 per cent of calls dealt with that particular topic.

We have a range of publications that are relevant to medical consent, guardianship and powers of attorney, including our *Take Control* guide, which I will hand up. I have multiple copies here. I also have a number of brochures on powers of attorney, guardianship, administration and medical decision-making. They may be of interest to members of the committee. I am able to hand them around now or later leave them with the secretary.

The CHAIR — Thank you.

Dr CHESTERMAN — Colleen chairs and I am a member of the Advance Care Planning Strategy Implementation Advisory Group, and we played an advisory role in relation to the development of the then

Despite all our endeavours, OPA is routinely confronted with members of the public and the health services system who do not know the law in this area, and the gist of our submission can be summarised in this way. When it comes to the making of decisions about end-of-life medical care our laws are complex, sometimes unclear and we would say in need of reform. The complexity and lack of clarity of these laws inhibit the ability of Victorians to make decisions about their own medical treatment. For instance, as members know, the legal status of advance directives is somewhat limited and unclear. The complexity of our laws is particularly evident when individuals are not able to make their own decisions and when the laws concerning substitute medical consent are engaged. In such situations members of the general public and indeed medical professionals are often uncertain about the answers to basic questions, such as who can consent to treatment and who can refuse it.

The confusion about our substitute medical consent laws is caused in part simply because of the range of substitute decision-making laws that exist and the interrelated elements of the relevant legislation in this field. We have the Guardianship and Administration Act, the Medical Treatment Act, the Mental Health Act and now the Powers of Attorney Act. These pieces of legislation provide a variety of ways by which decisions can be made for individuals upon them losing the ability to make their own decisions.

Just to give you a very clear example of this confusion, so to speak, we have a statutory health decision-making hierarchy in our guardianship legislation and another piece of legislation, the Medical Treatment Act, that overlays this and enables the refusal of treatment in certain circumstances. This means our laws create a confusing distinction between withholding consent to medical treatment, which a person responsible can do under the guardianship legislation, and the refusal of medical treatment as per the Medical Treatment Act. We can elaborate on that in questions if you would like us to do so.

Our submission to this inquiry, as you know, makes eight recommendations and in doing so we adopt a number of the recommendations made by the Victorian Law Reform Commission in its 2012 review of our guardianship laws. In making these recommendations our objectives are to promote the ability of individuals to plan for their future and to better protect and promote the rights of persons who require a substitute decision-maker to make important medical treatment decisions on their behalf when they do not have the ability to make their own decisions.

In summary, we seek two things: improved education of medical professionals around substitute medical consent and clearer laws concerning substitute medical consent and the recognition of advance instructional directives. I am happy to leave those comments there, and we are looking forward to engaging with the committee members.

The CHAIR — Thank you for that. I ask, by way of the first question: much of what you say is consistent with the view of the law institute. I am not sure if you have read the law institute's submission, but would that be accurate that much of your — —

Dr CHESTERMAN — Phil is a member of that group.

Mr GRANO — Yes, I was involved to some extent in the law institute and I am aware of their submission.

The CHAIR — Their fundamental proposition to us today was that the law is disjointed and, in part, incoherent to a lay bystander. To a point, you have said today that is your position as well.

Dr CHESTERMAN — Yes, we agree.

Ms PATTEN — With that difference with the medical power of attorney, the nearest relative and such like, some of the conversations we have had about the medical power of attorney and probably shifting it into the Guardianship Act so it is standardised, and I think that is the LIV's position, do you have an opinion on whether the person who can make those medical decisions and specifically refuse treatment decisions should be separate from the person who might have the financial power of attorney for that person? As you can imagine, there are people who are saying that there could be a conflict in those two powers.

Dr CHESTERMAN — By and large, yes, we would want the person to be separately appointed. An individual may choose to appoint the same person to make those decisions, but that then is the individual's choice, assuming they have the capacity to make that decision. But, yes, you certainly would not want some automatic decision-making process to merge those two roles.

Ms PEARCE — No, I agree with that.

Mr GRANO — I think there is a provision in the Medical Treatment Act — I will just try to drag it up — where there is something about if you have improperly obtained or you have improperly signed a refusal of medical treatment certificate, you can be prosecuted for doing so: 'A person ... who is a beneficiary under the will ... or ... has an interest ... and who, by deception, fraud, misstatement or undue influence, procures or obtains ... the execution of a certificate' — that is, a refusal of treatment certificate — 'forfeits any interest under the will, instrument or intestacy, as the case requires'. So there has been some recognition that there can be a conflict of interest, and the law to some extent has tried to address that in that provision.

Mr MELHEM — To follow up from that, if a person appointed a daughter to be their power of attorney as far as financial and everything else, and power of attorney as well in relation to medical, and they are two separate forms, it would have to be difficult to prove. For example, the daughter would have made a decision, 'Do not resuscitate if my mother collapses'. How do you go about investigating, because the person on whose behalf the decision has been made has got dementia and is not capable of making her own decision? How can you then prove that the daughter was not making that decision to benefit, because 'You're sitting there wasting my money or spending my money, my inheritance'?

Mr GRANO — If the daughter were to act under her power of attorney and sign a refusal of treatment certificate, she has to have a doctor and another person say as well that she has been properly informed about the circumstances of her mother's or father's illness, the consequences of what is going on, so she has to be properly informed.

If the doctor had real concern about what this person was doing and thought this was so contrary to the best interests of the patient, then they can go to VCAT immediately and seek to have the power of attorney set aside on the basis that the agent is not acting in the person's best interest. So there are some protections there that rely on VCAT acting. You would also have to get a doctor to then proceed. The law does tend to rely on the ethical and, I suppose, professional practices of the health professions as a sort of bulwark against abuse.

Dr CHESTERMAN — Just adding to that, we would not say there is rampant abuse of medical enduring powers of attorney in the way that there is public concern about financial powers of attorney, which has partly been addressed by our new legislation.

Ms PEARCE — In terms of when we do investigate cases that do involve enduring powers of attorney, they are often very difficult to substantiate, but our guardians would interview a range of people, including where possible the person concerned but also a range of family members if the family member has been appointed. They might speak to doctors, they might speak to the GP, so we try and get as much information as we can to enable us to make the decision or make a recommendation to VCAT.

The CHAIR — My question is beyond the scope of your submission, but I think it is relevant because — as you said, Ms Pearce — you are the guardian of last resort for many elderly people and many people who are particularly vulnerable in our community. We have heard a lot of evidence for and against a range of reforms at end of life, including voluntary euthanasia and other changes. One of the arguments proffered by those who are against such reforms is that vulnerable people may be exploited. Given that you represent so many vulnerable people — and whilst, as you say, your submission does not touch on this issue — do you have a view on that?

Dr CHESTERMAN — I am happy to address that. We could make two points on that. One is that voluntary euthanasia, for instance, is not something that is generally being sought, to our knowledge, by the people with whom we work, whether they are represented persons for whom we are guardian or other people with disability with whom we regularly interact. We have not gone out and asked people either, so we cannot say that this is something that the people with whom we work are clamouring for.

The other point is that, as an office that is devoted to protecting and promoting the rights of people with disability, we would have concerns about the effect that a move to legalise euthanasia might have on people

with disability generally. Our concern, I guess is that such people might increasingly face or even internalise a view, that they are a burden to society. That is just a concern that we would air. It is not a deal-breaker either way, but it is just a concern we would want to have aired. We would want to make sure that in any move down that track it would be a statement by our society to some extent about what constitutes a life worth living. We would be concerned that that did not impact unduly on people with disability.

Ms PEARCE — Already it is not uncommon for us to see where there is a person with a disability who may, for example, leave a group home and go to hospital. Decisions are made already about that person's quality of life, and decisions about whether or not treatment might be offered are often very subjective, and it is a person in power who is deciding whether or not the person with a disability should live based on what they think their quality of life is.

Mr GRANO — We have had a number of cases, but there was one matter which went to the Family Court. It was about a baby who had serious injuries arising from loss of oxygen at the time of birth — no, sorry, it was after birth. The baby had serious injuries, and the doctors put back in a tracheostomy to restore its breathing. Now the doctors had come a point where they had to remove the tracheostomy again. The question was at the time of removal: if the baby struggled to breathe again, would the doctors provide life support for the baby? It was a really complex question. We were concerned, initially, that the decision not to provide life support to the baby was being based on a view that the child would not have a reasonable quality of life. Was it that the life was futile, was it that the life was unduly burdensome and to whom?

I think it was because of our concern about that that we — Colleen — decided to push the envelope on that, and we sought our own expert advice. I think we have pushed the envelope. From our expert's advice, we concluded, that it was the treatment that was futile and the treatment was unduly burdensome, rather than the life being so. I think our concern is, for people with severe disabilities, people do make judgements that that life is not worth living. Subjectively, the person would say, 'Well, it is; my life is worth living'. So we have had to grapple with that, and often for people with an intellectual disability. I can think of one case that a person with an intellectual disability was not going to be offered surgery for a heart condition and I think with advocacy that situation was turned around, so they were offered the surgery. But there had been an assumption made about that person's quality of life. So quality of life, as opposed to the treatment that is being offered, is a really difficult area for everyone to deal with in this issue.

The CHAIR — Indeed, and that's why I think it is instructive to hear from your experiences.

Ms PATTEN — We are probably looking at, I guess, further mandating or regulating advance care planning and possibly amending how the Medical Treatment Act works, so people may be able to make those advance care directives for a broader range of matters and possibly when they do not actually have a condition. We have been talking about some of the circumstances where you have someone with power of attorney who may disagree with that advance care plan — 'I do not want to be resuscitated' but the power of attorney says, 'I want them resuscitated'. In your role, which one do you think we should be enforcing or giving precedence to?

Dr CHESTERMAN — In our submission we have supported the recommendations on this topic by the Victorian Law Reform Commission. The term they have used, which we think is a good one, is 'instructional directives', which can be binding or advisory, and we think binding instructional directives ought to be made about health matters. It is important to remember you have to provide some situations where you would not follow — which you are well aware of — and the three exceptions that the law reform commission gave, which we agree with, would be: where circumstances, including advances in medical science, have changed to such an extent you might think the person would not now make that directive; where the directive itself is uncertain; and also where there is some evidence to suggest that the directive is based on incorrect information or assumptions. So you would provide some situations where you would not be obliged to follow it but otherwise you would. So that would trump — if this was legalised and the person made it, that would trump a decision of someone they may have appointed.

Ms PATTEN — Would you see your office as having a role in educating the community about these advance care plans or providing examples?

Dr CHESTERMAN — Yes, absolutely. We are the lead educator on powers of attorney, so it would make sense for us to have a key educative role here I think.

Ms PEARCE — Yes.

Mr GRANO — I think one of the things that you could do as well, though, is to create a mechanism in the legislation so that the attorney who is faced with that dilemma has somewhere to go, so can go and seek advice from the tribunal and have the matter thrashed out. At the moment you could have an agent who is appointed but the patient has already made a refusal of treatment certificate saying they do not want treatment, and that would be binding on the medical profession. But it would be, I think, important in the circumstances you outlined to have a dispute resolution mechanism. You can get all the help you can from the Office of the Public Advocate, but if people need something that actually has legal authority behind it, we cannot give them that. I think advice from the tribunal which you have under the Guardianship and Administration Act and under the powers of attorney legislation should be something that is in the Medical Treatment Act.

Ms PATTEN — Thank you.

The CHAIR — Could I just follow on from that. The legislation as it currently is is disjointed and contained in several different pieces of legislation. In the ideal world where would you centralise these various components?

Dr CHESTERMAN — Our view is a little bit flexible on this, but overall we have got new, as you know, powers of attorney legislation. It would make sense, in our view, to enhance that and give — create — the power in that legislation, as we have put in our submission, for an attorney to be able to refuse medical treatment where a person is specifically given that power to refuse medical treatment. So you could put that in the powers of attorney legislation, and you could put instructional directives in the guardianship legislation, as the law reform commission suggested. I am not sure. There are different ways in which you could cut it, and there are advantages and disadvantages to doing both. You do not want too many pieces of legislation I think but you do not want one piece that is too complex.

Ms PEARCE — One of the issues, however, is the issue of: who can a person appoint? Now for many of the people that we see, they do not have a person that they can appoint under an enduring power of attorney, and there are many people who either do not have a family member or a trusted person they can appoint or in fact are concerned about that person, that that person will not make a decision that is consistent with their wishes. Now the new powers of attorney legislation does enable a person to appoint the public advocate under those circumstances but that means myself and I cannot at this stage delegate that, and I also do not have the resources if you think about the number of people. So if a person really does want somebody, has specific concerns and can get all the way through the gatekeepers to my office, then I may agree, and I do have a filing cabinet full of enduring powers of attorney, but it is a responsibility that I hold personally. That means that there is only a limited number of people for whom I can accept an enduring power of attorney. I think that really is a significant issue in the system, because there are many vulnerable people or people who would like to put their affairs in order but for whom there is simply no-one that they feel comfortable about appointing.

Mr MELHEM — Just following on that, do you recommend having triggers for when an advance care plan is put in place — that is, when you enter the aged-care system or your 60th birthday or 70th birthday? Are there triggers when people should be encouraged to start looking at advance care plans? Should doctors be looking at that or aged care and various other people? Do you have any comment on that?

Ms PEARCE — We do encourage people to consider the importance of both enduring powers of attorney and also an advance care plan at a very young age. The reason for that is we know unexpected events can occur at any time in your life. It may be that a young person may find themselves in circumstances where decisions have to be made for them and they may want it to be their parents, they may not. We would encourage people to make these plans as early as possible, but to review them regularly.

John talked earlier about what some of the limitations are around an advance care directive where, for example, medical treatment might change or a person might change. Typically you might get a young person who is confined to a wheelchair. They might have said, ‘Mum, if that ever happened, I don’t want to continue’, but in fact finding themselves in a wheelchair they might be a Paralympian. There is a range of things that can happen and people’s ideas about disability change very much as they age. As we get older, we are willing to accept higher levels of disability than we might when we are 18. So we really encourage people to think about these things as young as 18 and for families and others to have those conversations.

Mr MELHEM — One final question from me. How do we compare, in relation to end-of-life choices, in Victoria with other jurisdictions? How do we rate out of 10, or whatever way you want to describe it?

Mr GRANO — I am not exactly sure because I am not so familiar with other jurisdictions, but we have not solved the common-law issue about the status of common-law advance care directions. If I have an advance care direction and I say I do not want a particular treatment and I write that out. At the moment I reach a point in my sickness where I lose capacity my person responsible has authority. They have to act in my best interests, under legislation. They have to take into account my advance care statement but they are not bound by it — but is the doctor bound by it? That is another problem that we have. Certainly if you were a doctor and you had a document signed by me refusing treatment, as opposed to the person responsible who is now saying, ‘No. Go ahead and provide the treatment’, you have one with legislative force behind them and another that does not. I think we are actually in a bit of a mess. Whatever the other states are doing, I think we need to try to get some clarity around this.

Dr CHESTERMAN — As we said in our submission, the only advance directive that is certainly legally binding is a refusal of treatment certificate, and that process, as you know, is flawed in its own way.

Mr GRANO — The other thing that is difficult in this area is that advance care planning can have some black-and-white bits but it has a lot of grey in it too. For instance, the research, as I understand it, sort of indicates that you need at least three things for a good advance care plan. You need to appoint someone as an agent, you need to have a document, but you need to have conversations which inform everyone of what is going on. In that document, there are different ways of doing it. Many of the advance care planning regimes will try to give the decision-maker some idea about what to do, from saying, ‘What’s the outcome of the treatment?’. You look at the outcome and you think, ‘Oh, well that’s going to guide my practice here’. Then some advance care statements will say, ‘I don’t want CPR; I don’t want this; I don’t want PEG feeding’, so they will be very specific about things. People have combinations of these as well.

When we are thinking of legislating advance care directions and advance care planning, it is actually quite a complex thing as to how that is going to be framed and shaped so that there are truly flexible documents and amenable documents and yet documents that really express the person’s autonomy.

Dr CHESTERMAN — Can I just come in on that and add a point, which is that the research very much tells us that what is important in advance care planning is not the document but the conversation. That is the key thing, and that is why the Victorian strategy is called ‘Have the conversation’. We would need to be mindful. I can cast aspersions about lawyers, but we do not want to be too reliant on just the documentation. You can imagine a person being presented with a checklist of things they do and do not want and just filling it in uninformed. It does not really help us in terms of improving the person’s quality of care.

The CHAIR — Is that the risk or the issue with giving legislative force to advance care directives? How do you reconcile future changing circumstances with providing certainty now for the future? Again, the government has foreshadowed change in that regard. Do you think we can craft legislation that accommodates those two issues? Again, to go to your proposition, Ms Pearce, about the individual in a wheelchair who may have said, ‘That’s not for me’, but then if it happens, you adjust and change and accept.

Dr CHESTERMAN — I think we can, and I think we would need to have those exceptions and, as Phil said, the problem solving, the capacity for people around an individual, be they appointed or be they just family members or friends, to be able to go somewhere. The guardianship list tribunal at VCAT — the guardianship tribunal — is the obvious place where people could go to have the matter solved and if necessary a guardianship order could be made, but having that element to it I think would be important.

Mr GRANO — Can I tell you a story? I did not have personal involvement in this particular matter, but it is one that I think is really quite telling. It was of a man who was in his 30s and he was assaulted. He ended up with a brain injury and in hospital. His partner and his family said, and for good reason, that if he were in this circumstance, he would not want to go on living, that it would be appropriate to turn off life support and he would be very happy to donate his organs. He did not want to be dependent. They went to the tribunal to be appointed guardian. We ended up being appointed guardian — the public advocate did — and it resulted in the guardian being faced with a very difficult situation, because the person started to make some small gains in health, and you have got all this very clear evidence of his wishes. The guardian told me once that he delayed and dallied so long that the person had made quite significant gains by the time that they went to see him. He

could not talk. The guardian took his hand. They asked him a series of questions, and he pressed the hand just yes or no, and he made coherent — he wanted to go on and get the treatment. so he made that decision. This is the dilemma you get. I think it is a salutary sort of story, because he made that clear choice, and fortunately we did not have to.

Dr CHESTERMAN — You can cater for that in legislation, as you know, by providing one of those exemptions around if there is evidence the person has changed their mind, and there was in this case some evidence.

The CHAIR — What if the person is not competent to do so? That is a situation where that person was able to give instruction.

Ms PEARCE — An indication rather than an instruction.

Dr CHESTERMAN — Yes, there is a question, and you know this case. The person was not in a position then to have the capacity to make decisions but could give an indication.

Mr GRANO — I think this is the question about whether the old self binds the current self. You have made a document that you think is going to bind you in the future, and if you reach a point where you cannot communicate that you no longer want to be bound by it, I suppose you live with the consequences of it. I think the difficulty around this was the reason why in the current Medical Treatment Act it was limited to current conditions. You were not projecting your life so far in advance into the future, so I think that was constructed as, ‘This is how we’ll manage that situation’. But I think that has other problems with it as well, because then you might not have a current condition but you are very likely to get it. You cannot make an advance care statement in relation to it but you do want to bind everyone, and you want to bind it when you are that real point of turning off life support.

Ms PATTEN — Just going back to that decision on the PEG feeding case, which was quite groundbreaking, you still cannot refuse some palliative care in any circumstance. When we are moving forward, do you think that it would be appropriate for people, in an advance care, to be able to refuse food and hydration? I am thinking of someone very far down the dementia path who is only kept alive because they are being spoonfed — they are not down to PEG feeding but they are being spoonfed. They can refuse PEG feeding, but do you think we should enable people to refuse treatments like that?

Mr GRANO — I suppose it is not a treatment. The way the current law is, that is actually a normal human activity; it is not medical treatment. It is about the refusal of medical treatment. So I guess I am ducking your question, aren’t I?

Ms PATTEN — I am seeing a medical practitioner providing sustenance.

Dr CHESTERMAN — This is a way of answering. One of the concerns we would air about a move down that path is unintended consequences. Legalising that situation of refusal would then have pretty significant implications for all sorts of other things that people could refuse in the palliative care realm, which might be quite unconscionable when it came to actually implementing them. I am just thinking of someone who created an advance directive and said, ‘I don’t want any palliative care’. If we were then forced to recognise that and saw the person in great pain, that would become quite difficult. Without formulating a firm answer, I would just be saying that the unintended consequences would concern me.

Ms PEARCE — What it brings up for me is the absolute necessity for education for the health sector. We commonly come across situations where the medical practitioners, hospital staff are unaware of the law, and if they are aware of the law, say, ‘I’m making my own decisions anyway’. I think it is really imperative that whatever the committee comes up with there is a focus on education for the health sector. It is really critical.

Dr CHESTERMAN — I point you to the research discussed in our submission published by academics at the Queensland University of Technology. People like Ben White and Lindy Willmott have made their own submission and have done convincing research where they have polled medical professionals. The average answer out of seven questions was 3.26 correct.

The CHAIR — Can I just go to the 42M process, which you talk about in your submission. We heard evidence from the law institute this morning that that is confusing and often not followed, just to go to that point again. Do you think that needs legislative change? What would you see to fix that scenario?

Dr CHESTERMAN — Do you mean the 42K process? There is a 42M process too, which is hardly ever used. The 42K process is non-emergency treatment where a person cannot consent to it and there is no person responsible around. A form gets submitted to our office. We think there are real problems with that one. There are some hospitals and health services that never make use of it, which either means they are never treating people in that situation, which is highly unlikely — so yes, there is uneven usage of that process.

We think a better process is the one that the Victorian Law Reform Commission has recommended — in fact one of the ones we suggested to them — which was to separate treatment into significant and routine treatment. For significant treatment there would be a process where in the end we would make the call if there was no-one around for the person to make a decision, but routine treatment could be progressed by using notes on the clinical record and getting another doctor to agree. We think the 42K process is flawed.

The CHAIR — It requires legislative change?

Dr CHESTERMAN — Yes.

Mr GRANO — The 42M process that you mentioned though — remember before I said that if a medical professional wanted to challenge the decision of an agent under the Medical Treatment Act, the doctor had to go to VCAT?

The CHAIR — Yes.

Mr GRANO — With the 42M process, if you want to challenge the decision of a person responsible, because the person responsible does not have that status of an agent, the doctor can say to the person responsible, 'We think you got it wrong. We are going to provide this treatment to the patient whether you like it or not and we are going to serve you a notice that if you do not take it to VCAT in seven days, we will provide the treatment'. It puts it on the person responsible to go off to VCAT. So the burden falls differently from the way it does if you are an agent.

Who knows that? Do the doctors know there is this subtle distinction between an agent and a person responsible? No. Does anyone use the 42M process? No, because it is obscure. It really does not work and it is not particularly helpful. So I think we need legislative reform, and we need to stop having different systems for different bits. I understand why it is done that way, because the agent has much higher status, but it is really hard for people in the field to know the subtleties.

Dr CHESTERMAN — There has been one valid section 42M notice.

The CHAIR — Okay. Is there anything further you would like to add for our deliberations before we conclude? Any other issues that we have not covered or any other perspectives you want to provide to us?

Dr CHESTERMAN — We of course have in the background the 440 recommendations made by the Victorian Law Reform Commission in its guardianship report, and we are in furious agreement with most of those recommendations that we think would improve our system of care for very vulnerable members of the community. A significant chapter of that report dealt with medical treatment, and again we have quoted quite a few sections and recommendations from that report. I think it is important to remember that aspect of the legislation as well as the knowledge and information that comes from health professionals in relation to the Medical Treatment Act.

The CHAIR — Ms Pearce, Dr Chesterman and Mr Grano, thank you very much for your evidence today. On behalf of all of us I acknowledge the remarkable work that the Office of the Public Advocate does in protecting vulnerable Victorians. Thank you.

Dr CHESTERMAN — Thanks so much.

Witnesses withdrew.