The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)

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This is the final article in a series of three that examines the legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity. This article considers the position in Victoria. A review of the law in this State reveals that medical professionals play significant legal roles in these decisions. However, the law is problematic in a number of respects and this is likely to impede medical professionals' legal knowledge in this area. The article examines the level of training that medical professionals receive on issues such as refusal of treatment certificates and substitute decision-making, and the available empirical evidence as to the state of medical professionals' knowledge of the law at the end of life. It concludes that there are gaps in legal knowledge and that law reform is needed in Victoria. The article also draws together themes from the series as a whole, including conclusions about the need for more and better medical education and about law reform generally.

INTRODUCTION

This is the third and final article of this series which examines the legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity. The focus of this article is Victoria. In line with the goals of this series, this article argues that medical professionals play a significant legal role in these decisions, but that the state of the law in this area is problematic, and this contributes to deficits in the legal knowledge of medical professionals.

The article begins by examining the relevant Victorian legal framework, specifically the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic). It concludes that medical professionals play significant legal roles in this area and also that there are problems with the law that are likely to impede medical professionals knowing and understanding it. It then considers what medical professionals do know of Victorian law. The formal training in medical school and beyond is considered, along with some limited empirical evidence which suggests that medical professionals' knowledge in this area is lacking.

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The final part of this article considers the problems identified earlier in relation to Victorian law and suggests reforms. It also concludes the series of articles as a whole and so also makes some observations about all three jurisdictions. In particular, the complexity of the law is discussed and there are also some recommendations as to how education might be improved to enhance medical professionals' understanding of the law in this area.

THE LAW IN VICTORIA

<DIV>MEDICAL CONTEXT AND LEGAL DECISION-MAKING MECHANISMS

The first article[1] in this series provided the foundation for how the law in each of the three jurisdictions would be examined. The legal position depends on two variables. The first variable that a medical professional must consider is the *medical context*, which includes the condition of the adult, and three categories of context were devised as possibly arising in relation to decisions to withhold or withdraw life-sustaining treatment. The first is where the medical professional would consider it medically appropriate to offer life-sustaining treatment to an adult. The second is where the medical professional regards life-sustaining treatment to be futile. The third category is where an urgent decision about whether or not to provide life-sustaining treatment is required. Each of these three categories was illustrated by an example in the first article.

Having determined the relevant medical context, the medical professional then needs to consider the appropriate *legal decision-making mechanism*. These mechanisms could include where the adult has made the decision herself or himself in advance, where an adult has appointed an agent to make the decision or where the Victorian Civil and Administrative Tribunal (VCAT) appoints a guardian. These medical contexts and their corresponding legal decision-making mechanisms in Victoria are considered below.

<DIV>GUARDIANSHIP LAW IN VICTORIA

<subdiv>The legal framework: An overview

The relevant legislation in Victoria is the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic). The *Guardianship and Administration Act 1986* (Vic) deals generally with decision-making for adults who lack capacity. It provides for the appointment of a guardian by VCAT on a plenary basis or on a more limited basis, eg, to consent to "health care" that is in the adult's best interests. The legislation also facilitates the appointment by an adult of an enduring guardian. Further, the legislation provides for a "person responsible" to consent to "medical or dental treatment". "Health care" is not defined in the legislation but the relevant aspect of "medical treatment" is defined to include:

<blockquote>

> any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care ... normally carried out by, or under, the supervision of a registered practitioner.[2]

</blockquote>

This definition does not refer to refusing life-sustaining treatment and neither does the *Guardianship and Administration Act 1986* (Vic) specifically address this issue. Instead, the *Medical Treatment Act 1988* (Vic) deals with the refusal of treatment, and sets out a mechanism for a competent adult to complete a refusal of treatment certificate. That legislation also facilitates that refusal being given by an agent who has been appointed by the adult under an enduring power of attorney (medical treatment) pursuant to the Act, or by a guardian who has been conferred with power under an "appropriate" order of VCAT.[3] The *Medical Treatment Act 1988* (Vic) defines "medical treatment" in the following terms:[4]

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[1] White B, Willmott L, Trowse P, Parker M and Cartwright C, 'The Legal Role of Medical Professionals in Decisions to Withhold or Withdraw Life-sustaining Treatment: Part 1 (New South Wales)' (2011) 18 JLM 498 at 503-506.

[2] *Guardianship and Administration Act 1986* (Vic), s 3(1).

[3] *Medical Treatment Act 1988* (Vic), s 5A(1)(b).

[4] *Medical Treatment Act 1988* (Vic), s 3.

<blockquote>

medical treatment means the carrying out of –

(a) an operation; or

(b) the administration of a drug or other like substance; or

(c) any other medical procedure –

but does not include palliative care

</blockquote>

The term "palliative care" is also defined as including:

<blockquote>

(a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or

(b) the reasonable provision of food and water.[5]

</blockquote>

This area of law is presently under review by the Victorian Law Reform Commission (VLRC) as part of its Guardianship Review. The VLRC's terms of reference include:[6]

<blockquote>

the appropriateness of the current requirements for and criteria pertaining to, the treatment of a represented person under the Act, including a consideration of the existing provisions dealing with medical research, non-medical research, medical and other treatment, the appropriateness of the existing "person responsible" model in ... the Act and a consideration of any area of overlap between the operation of the Act and the *Medical Treatment Act 1988* …

</blockquote>

However, issues relating to end-of-life decision-making other than those that are currently dealt with by the *Medical Treatment Act 1988* (Vic) are expressly excluded from the review.[7] The Victorian Parliament Law Reform Committee has also recently completed a review of some relevance to this article on powers of attorney. That inquiry included consideration of enduring guardians appointed under the *Guardianship and Administration Act 1986* (Vic), although enduring powers of attorney (medical treatment) under the *Medical Treatment Act 1988* (Vic) were not included in the inquiry's terms of reference.[8]

<subdiv>Capacity

Decisions about health care only need to be made on behalf of an adult if he or she lacks capacity. Although not expressly stated in either Victorian statute, it is likely that the common law presumption that an adult has capacity will be applied.[9]

There are four different terms used for determining when an adult will have or lack capacity. Part 4A of the *Guardianship and Administration Act 1986* (Vic), which provides for a person responsible to give consent to medical or dental treatment, applies when an adult "is incapable of giving consent".[10] This arises when:[11]

<blockquote>

(a) the person is incapable of understanding the general nature and effect of the proposed treatment; or

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[5] These terms were subject to judicial consideration in *Re BWV; Ex parte Gardner* (2003) 7 VR 487.

[6] Victorian Law Reform Commission, *Guardianship: Information Paper* (March 2010) p 6.

[7] Victorian Law Reform Commission, n 6, p 6.

[8] Victorian Parliament Law Reform Committee, *Inquiry into Powers of Attorney* (24 August 2010) pp iv, 3.

[9] See eg *AC (Guardianship)* [2009] VCAT 753 at [33].

[10] *Guardianship and Administration Act* (Vic), s 36(1)(b).

[11] *Guardianship and Administration Act* (Vic), s 36(2).

(b) the person is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment.

</blockquote>

Under the *Medical Treatment Act 1988* (Vic), a person must be of "sound mind" to be able to complete a refusal of treatment certificate[12] but there is no express requirement that a person must have lost capacity before the certificate can come into effect.[13] The position is different for an agent appointed under that Act as it is only once the adult "becomes incompetent" that the agent is able to complete a refusal of treatment certificate.[14] This term is not defined.

Finally, for a guardian to be appointed by VCAT[15] or for an enduring guardian's power to commence,[16] the adult must be "unable by reason of [the/a] disability to make reasonable judgments" in relation to the decisions that need to be made. Disability is defined as meaning "intellectual impairment, mental disorder, brain injury, physical disability or dementia".[17]

<group>Role of medical professional

A medical professional will need to assess an adult's capacity in relation to the relevant decision, which here is to refuse life-sustaining treatment. To determine whether an adult lacks this capacity (except where a guardian has been appointed by VCAT for the matter as then a finding of incapacity has already been made), the medical professional will need to select and apply the correct legal definition outlined above depending on the decision-making mechanism that applies.

<subdiv>Category 1: Medical professional considers offering life-sustaining treatment to be medically appropriate

The authors now turn to consider the three categories of medical context referred to above and the relevant decision-making mechanisms that apply to each, beginning with those cases where the medical professional considers that it is medically appropriate to offer life-sustaining treatment.

<group>The adult has completed a refusal of treatment certificate

While still of "sound mind", an adult in Victoria is able to complete a refusal of treatment certificate. The *Medical Treatment Act 1988* (Vic) permits the refusal to extend to medical treatment generally, or only to medical treatment of a particular kind.[18] One limitation on an adult's ability to refuse treatment in such a certificate is the requirement that the refusal relate to a current condition of the adult. This means that a refusal of treatment certificate cannot be completed in anticipation of contracting a disease or illness or of suffering a sudden catastrophic injury.

<subgroup>Role of medical professional

Although the adult is the decision-maker herself or himself through the refusal of treatment certificate, the medical professional has an important role to play in the completion of the certificate. The certificate must be witnessed by a medical professional (and another person) who must be satisfied that:[19]

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[12] *Medical Treatment Act 1988* (Vic), s 5(1)(d).

[13] Note that if common law advance directives continue to exist in Victoria (see discussion below), that potentially gives rise to another test for capacity. The test for capacity at common law is discussed in White, Willmott, Trowse, Parker and Cartwright, n 6 at 507.

[14] *Medical Treatment Act 1988* (Vic), s 5A(2)(b).

[15] *Guardianship and Administration Act 1986* (Vic), s 22(1)(b). To appoint a guardian, VCAT is also required to be satisfied that the adult has a disability and is in need of a guardian: *Guardianship and Administration Act 1986* (Vic), s 22(1). In relation to this test, see *Public Advocate v RCS (Guardianship)* [2004] VCAT 1880, and see also *XYZ v State Trustees Ltd* (2006) 25 VAR 402; [2006] VSC 444 (although in relation to the appointment of an administrator).

[16] *Guardianship and Administration Act 1986* (Vic), s 35B(1)-(2).

[17] *Guardianship and Administration Act 1986* (Vic), s 3(1).

[18] *Medical Treatment Act 1988* (Vic), s 5.

[19] *Medical Treatment Act 1988* (Vic), s 5(1). Although s 5(1) refers to the certificate being "witnessed" by a medical practitioner, the prescribed form refers to the medical practitioner "certifying" certain facts to be correct and makes provision for the medical practitioner to "sign" the form.

- the adult has clearly expressed a decision to refuse treatment for a current condition;
- this decision has been made voluntarily and without inducement or compulsion;
- the adult has been informed about her or his condition to enable a decision to be made about treatment, and the adult appears to have understood this information; and
- the adult is of sound mind and at least 18 years old.

Further, the medical professional would need to determine that the refusal of treatment certificate applies to the situation that had arisen, that the certificate has not been cancelled,[20] and that the adult's medical situation has not "changed to such an extent that the condition in relation to which the certificate was given is no longer current".[21]

<subgroup>Common law advance directives

Whether common law advance directives (which were examined in the first article of this series)[22] continue to have force in Victoria remains uncertain. The Office of the Public Advocate appears to take the view that advance directives would not be recognised by the common law.[23] While the position is not clear cut, the authors prefer the opposite view.

The statutory regime for refusing treatment as set out in the *Medical Treatment Act 1988* (Vic) is stated not to "affect any right of a person under any other law to refuse medical treatment".[24] It is not clear what is meant by "other law" in this provision. It may be a reference to the common law right of a competent adult to give a contemporaneous refusal of medical treatment. On a plain reading, it would also appear to preserve an adult's common law right to refuse treatment in advance of the medical situation arising. This would mean that a decision made by a competent adult to refuse treatment by way of a common law advance directive would continue to be binding on those who provided treatment.

While the *Medical Treatment Act 1988* (Vic) purports to retain common law rights, four arguments can be advanced in favour of the view that the force of common law directives might be negated because of the substitute decision-making regime established by the *Guardianship and Administration Act 1986* (Vic). First, the *Guardianship and Administration Act 1986* (Vic) facilitates a decision about medical treatment being made on behalf of a person who lacks capacity. The *Guardianship and Administration Act 1986* (Vic) requires the substitute decision-maker to take the views of the adult (eg, as expressed in an advance directive) into account,[25] but is not bound to make a decision that is consistent with these views. Secondly, there is no express statement in the *Guardianship and Administration Act 1986* (Vic) or the *Medical Treatment Act 1988* (Vic) that the previously existing common law right of a competent person to refuse medical treatment through an advance directive remains despite the enactment of the substitute decision-making regime by the *Guardianship and Administration Act 1986* (Vic). Thirdly, the consent regime established by the *Guardianship and Administration Act 1986* (Vic) provides that consent given under that Act has the same effect as if "the patient had been capable of giving consent to the carrying out of the procedure or consent"[26] and the "procedure or treatment had been carried out with the consent of the patient".[27]

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[20] *Medical Treatment Act 1988* (Vic), s 7.

[21] *Medical Treatment Act 1988* (Vic), s 7(3).

[22] White, Willmott, Trowse, Parker and Cartwright, n 6 at 508-509.

[23] Office of the Public Advocate, *Advocacy and Decision-making in Relation to Medical and Dental Treatment and Other Health Care* ([AQ: date? No date we could find]) at [6.5], http://www.publicadvocate.vic.gov.au/about-us/200/ viewed 11 November 2010: "In circumstances where a person when competent, indicated in some way (verbally or in writing in some format) that they did not want particular treatment, including to be resuscitated, then this will be a common law advance directive. In Victoria, it would seem to be that the common law regarding advance directives will be respected. However, once a person is defined as incompetent, their advance directive holds a much weaker position."

[24] *Medical Treatment Act 1988* (Vic), s 4.

[25] *Guardianship and Administration Act 1986* (Vic), ss 4(2)(c), 28(2)(e), 38(1)(a).

[26] *Guardianship and Administration Act 1986* (Vic), s 40(a).

[27] *Guardianship and Administration Act 1986* (Vic), s 40(b).

Therefore, because an adult with capacity can override her or his prior advance directive, so too can a substitute decision-maker who is granted the same powers. Fourthly, the *Guardianship and Administration Act 1986* (Vic) provides that a medical professional must not carry out treatment on the basis of substitute consent if "a refusal of treatment is in force in accordance with [the *Medical Treatment Act 1988*]".[28] Refusal of treatment, in this context, is likely to refer to the ways that treatment can be refused as prescribed by that Act, rather than a reference to the common law. By failing to refer to the common law, it could be argued that a common law advance directive would not prevail over consent given under the *Guardianship and Administration Act 1986* (Vic).

The alternative position, and one that the authors consider is the better view, is that the common law governing advance directives still applies, notwithstanding the implementation of the guardianship regime. This view can be supported on two bases. First, there is a presumption that express words or necessary implication are required before a statute is regarded as abolishing previously held common law rights.[29] This is particularly so given the fundamental nature of the right to bodily integrity that is embodied in an ability to make an advance directive. Yet, express words are not used in the *Guardianship and Administration Act 1986* (Vic) to suggest that the common law right to make an advance directive that refuses treatment is abolished by the statute and neither is such an outcome required by necessary implication. Secondly, the *Medical Treatment Act 1988* (Vic) is legislation that deals specifically with the refusal of treatment, and contains an express statement about other rights being unaffected by the Act. The *Guardianship and Administration Act 1986* (Vic) deals more generally with guardianship issues and not specifically with the refusal of treatment. Application of the statutory principle that the specific should prevail over the general (generalia specialibus non derogant)[30] would mean that the specific provision in the *Medical Treatment Act 1988* (Vic) preserving other rights to refuse medical treatment would prevail.

Role of medical professional

If the first interpretation outlined above is correct, the adult is not able to give a legally binding common law advance directive and a medical professional will not need to consider this possibility. However, if the second interpretation is correct and the common law continues to operate, the medical professional will need to know this and also fulfil the same roles discussed in the first article.[31]

<group>A person has been appointed by the Victorian Civil and Administrative Tribunal to make health care decisions on the adult's behalf

VCAT is empowered to appoint a guardian on behalf of an adult who lacks capacity.[32] The *Medical Treatment Act 1988* (Vic) provides that a guardian appointed by way of an "appropriate order" under the *Guardianship and Administration Act 1986* (Vic) may refuse treatment.[33] A VCAT order will be an "appropriate order" for the purpose of the *Medical Treatment Act 1988* (Vic) if the power conferred on the guardian is sufficiently broad to include the power to refuse treatment. It is therefore necessary to consider the kinds of appointment that VCAT can make.

- *Plenary guardian:* A person who is appointed as a plenary guardian has "all the powers and duties which the plenary guardian would have if he or she were a parent and the represented person his or her child".[34] This power is broad enough to authorise the guardian to refuse

[28] *Guardianship and Administration Act 1986* (Vic), s 41.

[29] *Melbourne Corp v Barry* (1922) 31 CLR 174 at 206; *Sargood Bros v Commonwealth* (1910) 11 CLR 258 at 279; *Pyneboard Pty Ltd v Trade Practices Commission* (1983) 152 CLR 328 at 341; *Coco v The Queen* (1994) 179 CLR 427 at 437-438.

[30] *Smith v The Queen* (1994) 181 CLR 338 at 348 (Mason CJ, Dawson, Gaudron and McHugh JJ).

[31] White, Willmott, Trowse, Parker and Cartwright, n 6 at 508-509.

[32] *Guardianship and Administration Act 1986* (Vic), s 22(1). For the criteria for appointing a guardian, see n 15. In addition to appointing a guardian, VCAT may appoint a person to make a decision in relation to the proposed procedure or treatment: *Guardianship and Administration Act 1986* (Vic), s 37(1)(b).

[33] *Medical Treatment Act 1988* (Vic), s 5A(1)(b).

[34] *Guardianship and Administration Act 1986* (Vic), s 24(1).

life-sustaining treatment for the adult.[35] As such, a plenary order is an "appropriate order" under the *Medical Treatment Act 1988* (Vic).

- *Limited guardian with power to make decisions about medical treatment:* Functions under the *Guardianship and Administration Act 1986* (Vic) must be performed in a way that is least restrictive of an adult's freedom of decision.[36] Therefore, a plenary appointment will not be made if it is sufficient for a guardian to be appointed with more limited powers.[37] One such appointment is that of a limited guardian with power to make decisions about medical treatment. This kind of appointment is broad enough to empower the guardian to refuse life-sustaining treatment under the *Medical Treatment Act 1988* (Vic).[38] In other words, the appointment of a limited guardian with power to make decisions about medical treatment is an "appropriate order" under the *Medical Treatment Act 1988* (Vic).
- *Limited guardian with power to consent to health care:* A distinction is made between the appointment of a guardian to "make decisions about medical treatment" (above) and the appointment of a guardian to "consent to health care". While the former appointment is regarded as sufficient to authorise the guardian to refuse treatment under the *Medical Treatment Act 1988* (Vic), the latter is not.[39]

<subgroup>Criteria applicable to the decision

One of the following two criteria must be satisfied before a guardian appointed by VCAT (either by way of a plenary appointment or appointed with authority to make decisions about medical treatment) is entitled to complete a refusal of treatment certificate under the *Medical Treatment Act 1988* (Vic) on behalf of an adult:

- the medical treatment would cause unreasonable distress to the adult; or
- there are reasonable grounds for believing that the adult, if competent, and after giving serious consideration to her or his health and wellbeing, would consider that the medical treatment is unwarranted.[40]

<subgroup>Role of medical professional

A medical professional will first need to determine whether a guardian has been appointed by VCAT and whether that guardian has power to refuse treatment. If so, although it is the guardian who is the relevant decision-maker, the medical professional has an important role in the completion of the refusal of treatment certificate. The certificate must be witnessed by a medical professional (and another person) who must be satisfied that:

- the guardian has been informed about the adult's condition to an extent that would be necessary for the adult, if competent, to have made a decision about refusing treatment; and
- the guardian appears to have understood this information.[41]

A medical professional also has an important role if he or she has concerns that treatment is being improperly refused by a guardian. This would occur, eg, if the medical professional is not of the view

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[35] Willmott L, White B and Then S-N, "Withholding and Withdrawing Life-sustaining Medical Treatment" in White B, McDonald F and Willmott L (eds), *Health Law in Australia* (Thomson Reuters, Sydney, 2010) at [13.210].

[36] *Guardianship and Administration Act 1986* (Vic), s 4(2)(a).

[37] *Guardianship and Administration Act 1986* (Vic), s 22(2), (4).

[38] See eg *EK (Guardianship)* [2005] VCAT 2520; *BK (Guardianship)* [2007] VCAT 332; *BWV* [2003] VCAT 121; and *Korp (Guardianship)* [2005] VCAT 779 where a guardian was appointed in each case with power to make decisions about medical treatment in situations where an end-of-life treatment decision was contemplated.

[39] See also *EK (Guardianship)* [2005] VCAT 2520 and *AV (Guardianship)* [2005] VCAT 2519 although the distinction between consent to health care and refusing treatment in these cases was being considered in the context of the powers of a "person responsible". A limited guardian with power only to consent to health care may, however, withhold such consent and the effect of this is considered in more detail below at XXX in section 2.3.4 when examining the powers of a person responsible.

[40] *Medical Treatment Act 1988* (Vic), s 5B(2).

[41] *Medical Treatment Act 1988* (Vic), s 5B(1).

that either of the criteria set out above (that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted) is satisfied.[42] In such a case, the medical professional may apply to VCAT under its power to hear applications generally in relation to medical or dental treatment[43] or for a reassessment of the guardian's appointment.[44]

<group>The adult has appointed an agent to make health care decisions on the adult's behalf

There are two avenues that an adult can adopt to appoint another to make health decisions on her or his behalf. One is where the adult executes an instrument to appoint an enduring guardian.[45] The authority conferred by this appointment will only take effect once the adult loses capacity.[46] The powers of an enduring guardian will depend on the nature of the appointment.[47] It is possible for the adult to confer very broad powers on an enduring guardian, including a power in relation to health care and the power to consent to medical treatment.[48] However, even the conferral of broad powers or specific powers in relation to health care would not appear to be sufficient to authorise an enduring guardian to refuse life-sustaining treatment.

This is because the right of an agent to refuse treatment on behalf of an adult is governed by the *Medical Treatment Act 1988* (Vic) and the *only* agent authorised by that statute to refuse treatment is an agent appointed pursuant to an enduring power of attorney (medical treatment). An appointment under such a document can only be authorised by the *Medical Treatment Act 1988* (Vic).[49] Accordingly, while an agent under an enduring power of attorney (medical treatment) can refuse treatment, an enduring guardian appointed under an enduring power of guardianship pursuant to the *Guardianship and Administration Act 1986* (Vic) cannot.[50]

<subgroup>Criteria applicable to the decision

An agent appointed under an enduring power of attorney (medical treatment) pursuant to the *Medical Treatment Act 1988* (Vic) can refuse treatment by completing a refusal of treatment certificate.[51] The agent must be satisfied of the same criteria that apply to a guardian appointed by VCAT discussed above, namely that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted.

<subgroup>Role of medical professional

A medical professional will need to ascertain whether an enduring guardian or an agent appointed under an enduring power of attorney (medical treatment) has been appointed, and know that the enduring guardian lacks the power to refuse treatment but that an agent does have such power. Where an agent is seeking to complete a refusal of treatment certificate, the medical professional's role is the

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[42] Also, as discussed above in relation to refusal of treatment certificates generally, the medical professional would need to determine that the adult's medical situation has not "changed to such an extent that the condition in relation to which the certificate was given is no longer current": *Medical Treatment Act 1988* (Vic), s 7(3).

[43] *Guardianship and Administration Act 1986* (Vic), s 42N. Although this power is expressed to apply to matters, questions or disputes arising under Pt 4A of the Act, a request for consent by a medical professional under this Part which is then refused by a guardian would be sufficient to give rise to the exercise of this power.

[44] *Guardianship and Administration Act 1986* (Vic), s 61.

[45] *Guardianship and Administration Act 1986* (Vic), s 35A. The instrument appointing the enduring guardian must be in the form of, or to the effect of, Form 1 in Sch 4: *Guardianship and Administration Act 1986* (Vic), s 35A(2)(a).

[46] *Guardianship and Administration Act 1986* (Vic), s 35B(1).

[47] *Guardianship and Administration Act 1986* (Vic), s 35B(2).

[48] If the instrument does not specify the matters for which the enduring guardian will have decision-making power, the enduring guardian will have all the powers of a guardian who has been given a plenary appointment by VCAT: *Guardianship and Administration Act 1986* (Vic), s 35B(2).

[49] *Medical Treatment Act 1988* (Vic), s 5A.

[50] An enduring guardian is, however, able to consent to medical treatment or withhold such consent under Pt 4A of the *Guardianship and Administration Act 1986* (Vic). The effect of withholding such consent is considered in more detail below at XXX section 2.3.4when examining the powers of a "person responsible".

[51] *Medical Treatment Act 1988* (Vic), s 5B.

same as for a guardian appointed by VCAT, namely to witness that the agent has been appropriately informed and understands that information.[52] As with guardians appointed by VCAT, a medical professional also has a legal role where he or she is concerned that treatment is being refused by an agent improperly. In such a case, the medical professional may apply to VCAT under its power to hear applications generally in relation to medical or dental treatment[53] or for suspension or revocation of the agent's appointment.[54]

<group>A person is nominated by the legislation as person responsible ("default decision-maker")

The Victorian statutory scheme also enables consent to "medical or dental treatment" to be given by a "person responsible".[55] "Person responsible" is defined to include the formal appointees discussed above: an agent under an enduring power of attorney (medical treatment), a guardian appointed by VCAT and an enduring guardian or person appointed in writing by the adult.[56] In the absence of a formal appointment, the person responsible will be the first of the following who is reasonably available and willing and able to make the relevant health care decision:

- the adult's spouse or domestic partner (if the relationship is close and continuing and the spouse or domestic partner is not under guardianship);[57]
- the adult's primary carer;
- the adult's nearest relative.[58]

A person responsible does not have power to *refuse treatment* under the *Medical Treatment Act 1988* (Vic).[59] Rather, the power of a person responsible is limited to providing consent to treatment, or *withholding consent* to that treatment.[60]

<subgroup>Criteria applicable to the decision

In deciding whether to consent to treatment or withhold that consent, the person responsible must act in the adult's best interests.[61] In determining whether medical treatment is in the adult's best interests, the person responsible is required to consider a list of factors including the wishes of the adult and her or his family, and the nature and degree of any significant risks associated with the treatment and any alternative treatment.[62]

<subgroup>Role of medical professional

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[52] *Medical Treatment Act 1988* (Vic), s 5B(1).

[53] *Guardianship and Administration Act 1986* (Vic), s 42N. Although this power is expressed to apply to matters, questions or disputes arising under Pt 4A of the Act, a request for consent by a medical professional under this Part which is then refused by an enduring guardian would be sufficient to give rise to the exercise of this power.

[54] *Medical Treatment Act 1988* (Vic), s 5C(2)(b). The ability of a medical professional to make such an application was recognised by Morris J in *Re BWV; Ex parte Gardner* (2003) 7 VR 487 at [88]. An unusual feature of this provision is that the test applied under s 5C of the *Medical Treatment Act 1988* (Vic) to remove an agent is "best interests". This is different from the criteria that an agent is required to apply which is more closely linked with a substituted judgment approach, namely that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted: *Medical Treatment Act 1988* (Vic), s 5B. This creates the possibility that an agent could be exercising her or his authority diligently in accordance with the Act but nevertheless have her or his appointment revoked or suspended.

[55] *Guardianship and Administration Act 1986* (Vic), s 39(1).

[56] *Guardianship and Administration Act 1986* (Vic), s 37(1)(a), (c)-(e).

[57] *Guardianship and Administration Act 1986* (Vic), s 37(4)(a).

[58] *Guardianship and Administration Act 1986* (Vic), s 37(1)(f)-(h). "Nearest relative" is defined in the *Guardianship and Administration Act 1986* (Vic), s 3(1).

[59] *EK (Guardianship)* [2005] VCAT 2520; *AV (Guardianship)* [2005] VCAT 2519.

[60] Section 42H(2) of the *Guardianship and Administration Act 1986* (Vic) contemplates the possibility of consent being withheld as it refers to "whether or not to consent to medical or dental treatment".

[61] *Guardianship and Administration Act 1986* (Vic), s 42H. See also *Guardianship and Administration Act 1986* (Vic), s 4(2), which sets out a list of principles which decision-makers under the Act must apply.

[62] *Guardianship and Administration Act 1986* (Vic), s 38.

Considered here is the way in which the limited power of the person responsible to *withhold consent* to treatment (as opposed to *refusing that treatment*) operates and the implications this has for medical professionals. Given that "person responsible" is defined to include guardians appointed by VCAT (who sometimes will be appointed without power to refuse treatment) and enduring guardians appointed by the adult (who will never have power to refuse treatment), this discussion will apply to all substitute decision-makers whose power is limited to withholding consent to treatment.

The role of the medical professional will be to identify the relevant person responsible in the hierarchy and to know that this role carries with it only the power to consent to treatment or withhold that consent, and not to refuse treatment. Where a person responsible exercises that power to withhold consent to recommended medical treatment, a medical professional may respond to that decision in one of two ways. The first is for the medical professional to accept that withholding of consent. This means that the treatment will not be given as consent or some other authorisation is required to provide treatment. The withholding of consent by the person responsible will be given effect.

The second option when confronted with a withholding of consent is for the medical professional to seek authorisation to provide the treatment from another source and the *Guardianship and Administration Act 1986* (Vic) provides a mechanism for obtaining such authority.[63] It permits a medical professional who is confronted with a withholding of consent, to serve the person responsible (and the Public Advocate) with a statement – a "section 42M form" – that advises of the medical professional's intention to provide the treatment for which consent is being withheld.[64] The person responsible may then, if he or she chooses to do so, make an application to VCAT for it to consider the matter. If such action is not taken within seven days, the medical professional may then provide treatment.

A medical professional will need to be aware of these two options and the necessary procedural steps that accompany the second option. The medical professional will also need to be aware that in these circumstances, he or she is effectively the de facto decision-maker. He or she is able to accept that withholding of consent and not provide treatment, or he or she can follow a procedure which, if not contested, will allow her or him to ignore that withholding of consent and provide treatment.

A medical professional will also need to know how the distinction between the power to withhold consent and refuse treatment impacts upon withdrawing treatment as opposed to withholding treatment. The provision of treatment requires consent or some other authorisation. Accordingly, the withholding of consent by a person responsible is capable of preventing that treatment being instituted (subject to the medical professional taking the steps described above). However, once consent or authorisation is obtained and treatment instituted, further consent or authorisation may not be required. In this case, a person responsible who does not wish for treatment to continue will not be in a position to prevent that treatment continuing if there is already in place lawful justification for treating. To require that treatment be withdrawn, it would be necessary to have a power to refuse treatment and require that it be stopped. Accordingly, a medical professional will need to be aware of how a power to withhold consent may operate differently where treatment is being withdrawn as opposed to withheld.

Finally, as was the case with other decision-makers, a medical professional who is concerned about a proposed decision may apply to VCAT under its power to hear applications generally in relation to medical or dental treatment.[65]

<group>Decision by the Public Advocate

The *Guardianship and Administration Act 1986* (Vic) establishes a statutory office, the Public Advocate.[66] The Public Advocate's functions include acting as a guardian for an adult when

[63] See *Guardianship and Administration Act 1986* (Vic), ss 42L, 42M.

[64] The requirements of that statement are set out in *Guardianship and Administration Act 1986* (Vic), s 42M.

[65] *Guardianship and Administration Act 1986* (Vic), s 42N. Although this power is expressed to apply to matters, questions or disputes arising under Pt 4A of the Act (which does not grant power to persons responsible to refuse treatment), a request for consent by a medical professional under this Part which is then refused by a person responsible would be sufficient to give rise to the exercise of this power.

appointed by VCAT;[67] therefore, depending on the nature of the appointment, he or she may have power to refuse life-sustaining treatment when acting in that role. Unlike in Queensland, however, the Victorian legislation does not contain equivalent provisions that enable the Public Advocate to intervene and make decisions where there is a disagreement as to what decision should be made or where decisions are being made inappropriately.[68]

<subgroup>Criteria applicable to the decision

The criteria that must be applied by the Public Advocate in refusing treatment as guardian is the same as that applied by any other person acting in that role, namely that the treatment would cause unreasonable distress to the adult, or that the adult would have regarded the treatment as unwarranted.[69]

<subgroup>Role of medical professional

Again, the role of the medical professional in this situation is the same as for guardians generally discussed above.[70]

<group>Order of the Victorian Civil and Administrative Tribunal

The *Guardianship and Administration Act 1986* (Vic) confers on VCAT very wide powers in relation to medical treatment of an adult upon the making of an application to it.[71] In addition to being able to appoint a person to make decisions concerning medical treatment, VCAT is able to provide declaratory relief regarding the validity of a medical treatment decision. VCAT is also able to give an advisory opinion concerning the best interests of an adult, and make any other orders considered to be in the best interests of an adult. VCAT also has power generally to give directions to substitute decision-makers.[72]

Despite the broad nature of these powers, VCAT itself is not empowered to order that life-sustaining treatment be withheld or withdrawn from an adult. It has power to consent under Pt 4A of the *Guardianship and Administration Act 1986* (Vic)[73] in the same way that a person responsible does, as discussed above,[74] but not power to refuse medical treatment. Having said that, a decision by VCAT that treatment should not be given (with the result that consent is therefore withheld) is likely to act as a de facto refusal of treatment. In practice, however, where such a decision may be required, VCAT has tended to appoint the Public Advocate as guardian to make the relevant treatment decision.[75]

<subgroup>Criteria applicable to the decision

The criteria applicable to the decision depend on which of the various VCAT powers are exercised, but will include best interests, as noted above.[76] In relation to what appears to be VCAT's usual

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[66] *Guardianship and Administration Act 1986* (Vic), s 14.

[67] *Guardianship and Administration Act 1986* (Vic), ss 16, 23(4).

[68] Willmott L, White B, Parker M and Cartwright C, "The Legal Role of Medical Professionals in Decisions to Withhold or Withdraw Life-sustaining Treatment: Part 2 (Queensland)" (2011) 18 JLM 523 at 531-532.

[69] See above at XXX section 2.3.2.

[70] See above at XXX section 2.3.2.

[71] *Guardianship and Administration Act 1986* (Vic), s 42N(6).

[72] *Guardianship and Administration Act 1986* (Vic), ss 30, 35E, 42I.

[73] *Guardianship and Administration Act 1986* (Vic), s 39(1)(a).

[74] See above at XXX section 2.3.4.

[75] See eg *BK (Guardianship)* [2007] VCAT 332; *Korp (Guardianship)* [2005] VCAT 779; *EK (Guardianship)* [2005] VCAT 2520; *BWV* [2003] VCAT 121.

[76] In determining whether medical treatment is in the adult's best interests, consideration must be given to the factors listed in s 38 of the *Guardianship and Administration Act 1986* (Vic). See also *Guardianship and Administration Act 1986* (Vic), s 4(2), which sets out a list of principles which decision-makers under the Act must apply.

approach in these situations (the appointment of a guardian), the criteria for such an appointment are discussed above,[77] as are the criteria to be employed by the guardian who then makes the decision.[78]

<subgroup>Role of medical professional

The medical professional will need to know that it is possible to apply to VCAT in cases where there is a dispute or where he or she has concerns about the treatment decisions being made.

<subdiv>Category 2: Medical professional considers life-sustaining treatment to be futile

The statutory regime in Victoria does not alter the common law in relation to futile treatment. Thus, a medical professional is under no obligation to provide treatment to an adult where "no benefit at all would be conferred".[79] Treatment regarded as futile is not considered to be in a person's best interests and so need not be provided. Disputes as to assessments of futility can arise[80] and those close to the adult may wish to challenge a medical professional's determination of futility in the Supreme Court in its parens patriae jurisdiction (discussed below).[81]

<group>Role of medical professional

The medical professional is the initial decision-maker in this context and must therefore be aware that the law does not require provision of futile treatment. He or she also needs to be aware of avenues for legal review before VCAT and the Supreme Court.

<subdiv>Category 3: Urgent decision about life-sustaining treatment is required

A medical professional is authorised by the *Guardianship and Administration Act 1986* (Vic) to provide medical treatment without consent if he or she believes on reasonable grounds that the treatment is necessary, as a matter of urgency, to save the adult's life, or to prevent serious damage to the adult's health, or to prevent the adult from suffering or continuing to suffer significant pain or distress.[82] The Victorian legislation does not address the situation where a decision to withhold or withdraw treatment may need to be made on an urgent basis. However, if the treatment is futile as discussed above, there is no obligation to treat.

<group>Role of medical professional

In the context of an urgent decision concerning life-sustaining treatment, the medical professional is the legal decision-maker. While he or she is not expressly authorised to withhold or withdraw treatment in an emergency situation, if the treatment is assessed as being futile, it can be lawfully withheld under the common law. If treatment is not futile, the medical professional has power to provide treatment without consent.

<DIV>ORDER OF THE SUPREME COURT EXERCISING ITS PARENS PATRIAE JURISDICTION

In addition to the statutory mechanisms so far considered, the Victorian Supreme Court has power to make decisions in relation to life-sustaining treatment for adults who lack capacity by virtue of its parens patriae jurisdiction.[83] This jurisdiction was discussed in more detail in the second article in this

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[77] See n 15 above.

[78] See above at XXX section 2.3.2.

[79] *Airedale NHS Trust v Bland* [1993] AC 789 at 858-859 (Lord Keith), at 869 (Lord Goff), at 884-885 (Lord Browne-Wilkinson), at 898 (Lord Mustill). See also *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 at 251; and *Messiha v South East Health* [2004] NSWSC 1061.

[80] See eg in Victoria, *Re Herrington* [2007] VSC 151.

[81] See above at XXX Section 3.

[82] *Guardianship and Administration Act 1986* (Vic), s 42A. Note, however, that the medical professional is not empowered to do so if treatment has been refused pursuant to the *Medical Treatment Act 1988* (Vic): *Guardianship and Administration Act 1986* (Vic) s 41.

[83] This was the basis on which *Slaveski v Austin Health* [2010] VSC 493 and *Re Herrington* [2007] VSC 151 were heard.

series.[84] It is sufficient here to note that the parens patriae jurisdiction continues in Victoria despite the enactment of guardianship legislation[85] and that the criterion employed by the court is "the protection of the best interest of the health and welfare of the person the subject of its exercise".[86]

Role of medical professional

The role of the medical professional is that he or she (or the relevant treating hospital) may bring an application to the Supreme Court for its consideration.

<DIV>CONCLUSIONS ON THE LAW

<subdiv>Some problems with the law in Victoria

The above examination of the law that governs withholding and withdrawing life-sustaining treatment from adults who lack capacity demonstrates that it is problematic in some respects. As with the other articles in this series, this section does not review comprehensively all of the problems with Victorian law in this area, only those relevant to the focus of this article, namely problems that are likely to act as obstacles to medical professionals knowing the law. This section also does not address the issue of the complexity of the law generally as this is considered below.

<group>Distinction between withholding consent and refusing treatment

As discussed above, the law in Victoria distinguishes between the power to withhold consent to treatment and the power to refuse that treatment. There are a number of problems that flow from this. The first is that this distinction is a fine one and is unlikely to be understood by medical professionals. The submission of the Office of the Public Advocate to the VLRC's review of guardianship law reported its experience that "even skilled practitioners are unable to distinguish withholding consent to treatment from refusing treatment"[87] and noted this distinction is subject to "widespread uncertainty".[88] The VLRC's Information Paper also identifies this distinction as a source of confusion.[89]

A second problem for medical professionals' knowledge of the law is that this distinction creates a situation where some substitute decision-makers will have power to refuse treatment but others only power to withhold consent. This will present challenges for medical professionals seeking to know and comply with the law. This is particularly so in relation to a guardian appointed by VCAT as this type of decision-maker can have the relevant power needed to refuse treatment but will not always do so. A medical professional will need to know this and check the scope of the guardian's appointment.

A third problem is that this distinction creates a gap in the law in that the default decision-maker does not have power to refuse treatment. While there is a mechanism to resolve disputes where consent to treatment is being withheld by a substitute decision-maker through the giving of a "section 42M form",[90] it appears that this process, which is described by the VLRC as "rather complex",[91] is not being utilised by medical professionals.[92] To illustrate, the relevant form must be filed with the

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[84] Willmott, White, Parker and Cartwright, n 68 at 535-537.

[85] *Re BWV; Ex parte Gardner* (2003) 7 VR 487 at 510.

[86] *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 at 554; and *Slaveski v Austin Health* [2010] VSC 493 at [34], referring to the criterion as discussed by the High Court in *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case)* (1992) 175 CLR 218 at 240, 249, 252, 270-273, 295, 300, 316. There are many other formulations of this criterion. See eg *Re Herrington* [2007] VSC 151 at [22]; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197; [2007] NTSC 71 at [25]; *Messiha v South East Health* [2004] NSWSC 1061 at [25].

[87] Office of the Public Advocate, *Submission to the Victorian Law Reform Commission in Response to the Guardianship Information Paper* (May 2010) p 36, http://www.publicadvocate.vic.gov.au/file/file/Research/Submissions/2010/OPA-Submission-to-VLRC-May-2010.pdf viewed 11 November 2011.

[88] Office of the Public Advocate, n 87, p 35.

[89] Victorian Law Reform Commission, n 6, p 38. See also evidence to this effect in Victorian Parliament Law Reform Committee, n 8, pp 161-162.

[90] See above at XXX section 2.3.4.

[91] Victorian Law Reform Commission, n 6, p 32.

[92] Office of the Public Advocate, n 87, pp 33-34.

Office of the Public Advocate but none were filed in the last financial year.[93] Instead, it is suggested that medical professionals are initiating guardianship applications, which is undesirable as it is contrary to the least restrictive approach.[94] While the authors are not aware of any empirical research that has been carried out on this point, it may also be the case that treatment is being provided in the absence of the appropriate consent or authorisation.

A fourth problem is that this distinction adds further complexity because it treats withholding treatment differently from withdrawing treatment. As discussed above, a person responsible has the ability to *withhold consent* to the commencement of life-sustaining treatment which may lead to the measure being withheld if it is not challenged by the medical professional, but withholding consent to treatment that has commenced and is being lawfully provided will not, of itself, lead to that treatment being stopped. An awareness not only of the distinction between withholding consent and refusing treatment is required by medical professionals, but also of the way in which that distinction plays out in practice depending on whether the relevant treatment has been started or not.

<group>Health care substitute decision-making spread over two statutes

A related problem is that the law that governs health care substitute decision-making is contained in two statutes: the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic). One deals with substitute decision-making generally (including decisions about health care) and grants power to consent to treatment, while the other deals with decisions about medical treatment and specifically provides for refusal of that treatment. The two pieces of legislation are the source of the problematic distinction between withholding consent and refusing treatment discussed above.

The existence of this parallel legislation has been identified by the VLRC as being a potential source of confusion[95] and the relationship between the two statutes has been described as "complex".[96] This is likely to be an impediment to a medical professional's knowledge of the law. Contributing to this confusion is that the two pieces of legislation do not sit well together. For example, there are different definitions of "medical treatment"[97] and different approaches are taken to capacity.[98]

A particular problem is that both pieces of legislation provide for the appointment by the adult of a substitute decision-maker: an enduring guardian under the *Guardianship and Administration Act 1986* (Vic) and an agent under the *Medical Treatment Act 1988* (Vic). The VLRC has noted that this "overlap creates confusion amongst medical practitioners and the community".[99] Adding to the confusion is that it is only the agent who has power to refuse treatment; an enduring guardian may only withhold consent.

<group>Multiple definitions of capacity

Another challenge for medical professionals seeking to know Victorian law in this area is the multiple definitions of "capacity". The various approaches described above,[100] depending on the legal context, are that an adult "is incapable of giving consent", an adult is of "sound mind", an adult "becomes incompetent", and that an adult is "unable by reason of [the/a] disability to make reasonable judgments" in relation to the decisions that need to be made. A medical professional would be required to know these different definitions and which one to apply depending on the legal context. Although its review focused on powers of attorney, the Victorian Parliament Law Reform Committee noted, in the context of its review, that the "different approaches to capacity contained in the various

[93] Office of the Public Advocate, n 87, p 33.

[94] Office of the Public Advocate, n 87, p 34.

[95] Victorian Law Reform Commission, n 6, p 53.

[96] Victorian Law Reform Commission, n 6, p 31.

[97] Office of the Public Advocate, n 87, pp 31-33.

[98] See below at XXX section 4.1.3.

[99] Victorian Law Reform Commission, n 6, p38.

[100] See above at XXX section 2.2.

statutes cause widespread confusion and uncertainty".[101] The Australian Medical Association submission to that inquiry also described the current definitions of capacity as "varied and erratic" and "unhelpful to a donor, witness, [and] doctor".[102]

<group>Uncertain status of common law advance directives

While the *Medical Treatment Act 1988* (Vic) makes provision for refusal of treatment certificates, it is unclear whether advance directives at common law still have legal force in Victoria. The arguments for and against recognition of such directives are discussed above.[103] Uncertainty as to the legal effect of a statement refusing medical treatment that is not contained in a refusal of treatment certificate is likely to make knowing the law in this area more difficult for medical professionals.

<subdiv>Legal role of medical professionals

The above analysis of the law in Victoria also demonstrates that medical professionals play a significant legal role in these decisions. As in the articles on New South Wales and Queensland, the legal roles of medical professionals can be characterised in three ways.

<group>Medical professional as legal decision-maker

There is no duty to provide futile treatment so if a medical professional reaches the view that treatment can be characterised in this way, he or she is the legal decision-maker and may decline to treat. The Victorian legislation also grants the medical professional decision-making power to provide life-sustaining treatment in an emergency situation. Finally, it can be argued that a medical professional may act as a de facto *decision-maker* in circumstances where a substitute decision-maker withholds consent to treatment. As noted above, the medical professional may choose not to treat or alternatively may decide to treat after filing a s 42M form.

<group>Medical professional making decisions about how to apply the law

Medical professionals also play a range of other formal legal roles that affect how or what law is applied in these decisions. First, a medical professional will often be required to make an assessment as to the adult's capacity. This will determine whether or not the substitute decision-making regime described above applies or whether the adult can make her or his own decisions. Secondly, if an adult lacks capacity, a medical professional will need to determine the appropriate decision-making mechanism that applies, whether that be a valid refusal of treatment certificate or a substitute decision-maker. Thirdly, it will also be necessary to establish that the relevant decision-making mechanism has the requisite authority to refuse life-sustaining treatment. This means that medical professionals will need to know whether substitute decision-makers possess the power to refuse treatment (as opposed to merely withholding consent) and whether refusal of treatment certificates are applicable to the situation (eg, ascertaining whether the adult continues to have a "current condition").

<group>Medical professional as legal gatekeeper

A medical professional also plays a gatekeeper role for decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity. Where concerns arise that improper decisions are being made, a medical professional is empowered to approach VCAT or the Supreme Court to scrutinise the proposed course of action. There is also scope for review of the appropriateness of the appointment of a substitute decision-maker.

Medical professionals also play a gatekeeping role at an earlier stage in decision-making, namely when a refusal of treatment certificate is completed. They are required to be satisfied of certain matters before witnessing the document and so, eg, are able to prevent such certificates being completed without sufficient information to understand the nature of the decision being made. Of course, the extent to which medical professionals are able to exercise these roles depends on their being aware of these legal gatekeeping functions.

MEDICAL PROFESSIONALS' KNOWLEDGE OF THEIR LEGAL ROLE

[101] Victorian Parliament Law Reform Committee, n 8, p 108.

[102] Victorian Parliament Law Reform Committee, n 8, p 110.

[103] See above at XXX section 2.3.1.

<DIV>WHAT ARE MEDICAL PROFESSIONALS TAUGHT ABOUT THIS AREA OF LAW?

Medical education in Victoria has undergone the same changes in recent decades as described in the first two articles in this series, in relation to medical ethics and health law.[104] Students are made aware of the expectations of the community and of the profession in relation to their individual and collective obligations in the numerous fields that raise ethical questions and that are governed, inter alia, by either or both legislation and the common law. The end-of-life area has seen a significant body of legislation passed in recent decades, and it has begun to receive considerable exposure in undergraduate medical education.

There are now three medical schools in Victoria. The authors received responses from all of these schools to their informal survey requesting information on teaching in the areas of decision-making capacity and capacity determination, ethical and legal aspects of withdrawing and withholding treatment (patients with and without capacity), substitute decision-making and guardianship, and advance care planning. Two schools provide significant coverage of ethical and legal aspects of withdrawing and withholding treatment, with one requiring students specifically to understand the legal requirements of appointing a guardian or an agent pursuant to an enduring power of attorney (medical treatment) under the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic), the role of guardians and appointed agents, and indeed to recognise the complexities regarding the law in withdrawal of treatment. The third school also covered these areas, but in less depth. As with schools in the other States considered in this series of articles, whether they responded to the survey or not,[105] these topics are covered formally in the earlier years of the programs of the Victorian schools. This is mainly as a result of the structure of medical education which universally sees year cohorts receiving lectures together in the earlier phases, but much more separated in the clinical years, making systematic provision of instruction more difficult at the time when it would seem more relevant. Again, the depth of knowledge attained via these undergraduate teaching sessions will not be equivalent to what has been described in this series of articles as necessary for medical professionals to practise in compliance with the relevant legal regimes. At the earlier stages of medical education, instruction is, necessarily and correctly, more introductory and theoretical.

One responding Victorian university also has a strong postgraduate program in Health and Medical Law, provided by the law school. In 2010, in three of the courses offered, there were two, three and three medical professionals enrolled.[106] It is not certain, although it is likely, that one or two of those enrolled were the same medical professionals across the courses. These medical professionals will clearly become very well versed in the details of the law at the end of life but they are, of course, individuals who have specific interests, often based in occupational roles, in developing their knowledge in the medical and health law area. As was the case in the other two States described in the previous articles, there is no systematic teaching in these areas for junior doctors, specialist trainees, or those in private practice in Victoria.

It can be reasonably assumed that in recent times and from now on, medical students have and will continue to graduate to practice with at least a sound theoretical grounding in the ethical and legal requirements of decision-making at the end of life, including those focused on in this series. However, the lack of knowledge possessed by, and of education provided for, medical professionals generally was emphasised in the recent inquiry into powers of attorney by the Victorian Parliament Law Reform Committee. The committee stated that it "did not receive any evidence that such education is being provided to health care professionals in relation to the types of powers of attorney under review in this Inquiry", but that participants in the inquiry "were generally strongly supportive of providing more education about powers of attorney for GPs and staff in hospitals and aged care facilities".[107]

<DIV>WHAT DO MEDICAL PROFESSIONALS KNOW OF THIS AREA OF LAW?

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[104] White, Willmott, Trowse, Parker and Cartwright, n 1 at 518-520; Willmott, White, Parker and Cartwright, n 68 at 540.

[105] Personal communication with teaching colleagues.

[106] Personal communication with program director, Professor L Skene.

[107] Victorian Parliament Law Reform Committee, n 8, p p 278.

Although there is only limited evidence available as to what medical professionals know of this area of law, the position in Victoria appears similar to that described in New South Wales and Queensland: there are clear knowledge gaps. Some of the anecdotal evidence discussed above when identifying problems in the law suggests this is the case.[108] For example, the submission by the Office of the Public Advocate to the VLRC's Guardianship Review recorded the uncertainty of medical professionals in relation to the distinction between withholding consent and refusing treatment.[109] There was also a suggestion that refusal of treatment certificates were being completed in circumstances outside those permitted by the legislation[110] which could reflect a lack of legal knowledge by the medical professionals witnessing them. Finally, the Office of the Public Advocate also called for an education campaign targeted at medical professionals to advise them of the "section 42M form" process discussed above.[111]

Gaps in medical professionals' knowledge of the law in this area are also revealed in what the authors believe to be the only empirical study on the topic in relation to Victorian law. In 1998, Darvall et al conducted a survey of Victorian general practitioners as to their knowledge of three areas of law, one of which was substitute decision-making under the *Medical Treatment Act 1988* (Vic).[112] A questionnaire, developed through four focus groups, was sent to a random sample of 983 general practitioners in Victoria, to which there was a 55% response rate.

While the research revealed that nearly all respondents knew that a legally appointed guardian had power to provide consent on behalf of an adult who lacked capacity, "considerable error and uncertainty existed in relation to the legal status of consent obtained from patients' spouses, other family members and friends".[113] For example, 74% of respondents thought that an adult's spouse could provide a valid consent on behalf of the adult and 62% believed that consent could be provided by an adult child – both of which were incorrect as the law stood at the time. This lack of understanding is also consistent with respondents' self-perception of their legal knowledge in this area: 44% of respondents described themselves as having no or little understanding of the "legal effects of *Medical Treatment (Enduring Power of Attorney) Act*" while a further 48% described themselves as having only "some" knowledge.[114]

While the results of this research reveal that medical professionals' knowledge of the law in this area is lacking, it should be noted that the law has changed significantly since 1998. There may be limits on the extent to which these findings reflect legal knowledge of medical professionals of the current law. For example, an adult's spouse and adult children are now capable of providing substituted consent so the answers given wrongly by a majority of medical professionals in 1998 would, in fact, be correct today. Nevertheless, of continuing interest for this series of articles is that this research identified two variables that were significantly related to a medical professional's level of legal knowledge.[115] The first is that accurate knowledge of the law decreased with the medical

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[108] See above at XXX section 4.1. See also Victorian Parliament Law Reform Committee, n 8, p 278.

[109] Office of the Public Advocate, n 87, pp 35-36.

[110] Office of the Public Advocate, n 87, p 36.

[111] Office of the Public Advocate, n 87, p 34.

[112] Darvall L, McMahon M and Piterman L, "Medico-legal Knowledge of General Practitioners: Disjunctions, Errors and Uncertainties" (2001) 9 JLM 167.

[113] Darvall, McMahon and Piterman, n 112 at 176.

[114] Darvall, McMahon and Piterman, n 112 at 177. It should be noted that it appears from the article that general practitioners were asked about the amending Act (the *Medical Treatment (Enduring Power of Attorney) Act 1990* (Vic)) rather than the *Medical Treatment Act 1988* (Vic) itself (see the above quote as to what respondents were asked). The goal was to assess legal knowledge specifically in relation to the appointment of an agent under an enduring power of attorney (medical treatment) and the provisions governing such appointments were introduced by this amending Act. However, it is possible, depending on the wording used in the questionnaire, that this reference to the amending Act may have confused respondents. For example, some respondents may have known about the *Medical Treatment Act 1988* (Vic) and felt they understood the relevant provisions relating to the appointment of agents but were confused by the reference to this later amending Act and so lowered their rating of knowledge.

[115] Darvall, McMahon and Piterman, n 112 at 181.

professional's age and the second is that those with postgraduate qualifications possessed a higher level of knowledge of the law.[116]

CONCLUSION

This section concludes the series of articles examining medical professionals' legal knowledge in relation to decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity in New South Wales, Queensland and Victoria. First, the authors reach conclusions about the legal problems identified in Victorian law before turning to the more general conclusion for the series of articles with a particular focus on the need for more medical education and general observations on the law and potential law reform.

<DIV>CONCLUSIONS ABOUT VICTORIAN LAW

The focus of this article is on medical professionals' knowledge of the law in relation to withholding or withdrawing life-sustaining treatment and four problems were identified above where the law was likely to impede this knowledge. The authors make some observations here as to possible reform guided by the focus of this article to improve medical professionals' knowledge of the law. They are not undertaking a wider analysis and justification of the reforms suggested below.

In relation to the first problem, namely the distinction made in Victorian law between withholding consent and refusing treatment, it is suggested that this distinction be removed. As discussed above, this is a long-standing and entrenched source of confusion for medical professionals and leads to a number of undesirable outcomes. Granting all substitute decision-makers the power to refuse treatment would avoid the need for this distinction. The principal concern that is raised in response to this is the potential for improper decisions to be made by people who gain decision-making power through being the person responsible.[117] There is no evidence that these concerns have played out in Queensland where all decision-makers, including the default decision-maker (statutory health attorney), have power to refuse treatment. Further, as this article has demonstrated, there are a number of safeguards on decision-making, the most significant of which is the legal gatekeeping role played by medical professionals. If medical professionals are worried about such decisions, they have a range of legal avenues at their disposal to raise their concerns and have decisions scrutinised.

The second problem with Victorian law identified above was that substitute decision-making about health care is spread across two statutes that sit awkwardly together. A partial solution to this is to widen the powers of an enduring guardian to include refusing treatment so at least the two health substitute decision-makers that an adult can appoint under Victorian law would have the same power.[118] The authors would endorse such an approach but, as stated above, would also go further and propose that all substitute decision-makers should have such power. Adopting such an approach would mean it is possible to deal with health substitute decision-making comprehensively and consistently in a single statute, eg, by incorporating and adapting the relevant aspects of the *Medical Treatment Act 1988* (Vic) into the *Guardianship and Administration Act 1986* (Vic).[119] The authors do, however, recognise the political sensitivities that would accompany such an approach as this would require reviewing the *Medical Treatment Act 1988* (Vic).[120] Nevertheless, this would undoubtedly make knowing the law easier for medical professionals (and the community generally).

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[116] Darvall, McMahon and Piterman, n 112 at 181.

[117] Office of the Public Advocate, n 87, p 36.

[118] This was recommended in Office of the Public Advocate, n 87, p 37. This possibility was also raised by the Victorian Parliament Law Reform Committee, n 8, p 162.

[119] The Victorian Parliament Law Reform Committee considered the related issue of whether there should be a single Act dealing with all powers of attorney (including non-enduring powers of attorney and those in relation to financial matters): Victorian Parliament Law Reform Committee, n 8, pp 33-35. Whether this should occur involves consideration of issues wider than withholding and withdrawing life-sustaining treatment and so is beyond the scope of this article; it is sufficient to say here that substitute decision-making about health care should not be spread across two inconsistent pieces of legislation.

[120] For example, the terms of reference for the recent review of powers of attorney did not include considering enduring powers of attorney (medical treatment) under the *Medical Treatment Act 1988* (Vic): Victorian Parliament Law Reform Committee, n 8, pp iv, 3.

The third problem with Victorian law was the inconsistent approach to defining capacity. Outlined above were four definitions of when an adult is not able to make her or his own decisions spread across the *Medical Treatment Act 1988* (Vic) and the *Guardianship and Administration Act 1986* (Vic). This is obviously undesirable and likely to confuse medical professionals. Accordingly, the authors suggest that a single definition of capacity be adopted, and preferably in the consolidated *Guardianship and Administration Act 1986* (Vic), as proposed above. That definition should reflect the functional approach to capacity[121] as part of taking the least restrictive approach and this is a position that one of the authors has argued for elsewhere.[122]

The fourth and final problem identified as likely to impede medical professionals' knowledge of the law was the uncertain status of common law advance directives. The authors favour resolving this uncertainty by recognising common law advance directives primarily because, as elsewhere two of them have argued, this gives greater weight to individual autonomy.[123] They recognise, however, that this "two-tiered approach" does introduce the possibility of confusion for medical professionals and others in that they would have to be aware that an adult could refuse treatment in both a refusal of treatment certificate and a common law advance directive.

However, the authors consider that clarifying the law to *exclude* common law directives would also cause confusion and uncertainty. For example, this would mean that medical professionals would need to respect a contemporaneous refusal of treatment given by an adult but not if that was given at a time sufficiently prior to the treatment choice arising such that it constituted an advance directive. But the dividing line between these two concepts is unclear. For example, how long before surgery does a refusal of blood transfusions need to be made to count as a contemporaneous refusal rather than an advance directive? Requiring a medical professional to know of this distinction and be able to apply it in practice is not reasonable. On balance, they favour clarifying the law to recognise common law advance directives.

<DIV>CONCLUSIONS FOR THE SERIES OF ARTICLES

<subdiv>Four claims of this series of articles

It is appropriate at this point to return to the four claims the authors sought to make in this series of articles. The first was that medical professionals play significant legal roles in relation to decisions to withhold or withdraw life-sustaining treatment. In each of the jurisdictions reviewed, three categories of legal roles for medical professionals were identified and discussed:

- when the medical professional is the legal decision-maker;
- when the medical professional is making decisions as to how to apply the law; and
- when the medical professional acts as a legal gatekeeper.

It was demonstrated that these are important legal roles and they have a significant impact on who makes these decisions, and how, in New South Wales, Queensland and Victoria.

The second claim was that it is important that medical professionals know the law in this area. An ability to fulfil the significant legal roles that medical professionals play in these decisions depends on having sufficient knowledge of the law. Further, in the first article, it was explained as part of setting the context for this series that a lack of knowledge can lead to non-compliance with the law. This can lead to adverse outcomes for the adult, either by being unlawfully deprived of treatment

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[121] See also Office of the Public Advocate, n 87, pp 15-17, which favours a broadly functional approach to defining capacity (in the context of the test for appointing a guardian). Likewise, the Victorian Parliament Law Reform Committee recommends a functional test (although the report does not use this term): Victorian Parliament Law Reform Committee, n 8, recommendations 34, 35.

[122] Devereux J and Parker M, "Competency Issues for Young Persons and Older Persons" in Freckelton I and Petersen K (eds), *Disputes and Dilemmas in Health Law* (Federation Press, Sydney, 2006) pp 54, 57-58.

[123] White B and Willmott L, "Will You Do as I Ask?" (2004) 4 QUTLJJ 77. The authors consider this to be particularly important given that only people who are experiencing a current condition can complete a refusal of treatment certificate. It is unclear, eg, where a failure to recognise common law directives leaves Jehovah's Witnesses who are not experiencing a current condition but may wish to refuse blood transfusions.

or by being subject to treatment that has been lawfully refused. Non-compliance can also have negative consequences for the medical professionals involved, including potential criminal, civil or disciplinary liability, and for the adult's family and the state.

The third claim of the series was that there are gaps in what medical professionals know of the law in this area. It is not possible to be definitive as to this claim as only relatively limited evidence exists. However, such evidence as there is points strongly to medical professionals' knowledge of the law being lacking. In New South Wales, anecdotal evidence from a New South Wales Health report suggested problems in understanding this area of law and this was supported by the only empirical study that the authors are aware of in this State. It concluded that there were significant gaps in medical professionals' knowledge and that further education was required.

In Queensland, there are no empirical studies directly on medical professionals' knowledge of the law in this area. However, a Queensland Health report found evidence that medical and health professionals' legal knowledge and understanding of the relevant legislative framework was lacking. Further, a case review of medical and health professionals' assessments of capacity suggested a lack of knowledge of the law as did the coronial case where a medical professional made a "not-for-resuscitation" order without the required consent of the substitute decision-maker on the basis of his legal understanding. That this decision occurred in a major tertiary hospital whose policy on this area was out of date suggests that this inaccurate view of the law is unlikely to be isolated.

The scope of the problem in Victoria is somewhat clearer. The VLRC and the Office of the Public Advocate have pointed to anecdotal evidence of a lack of understanding of the various components of health substitute decision-making in that State. Also, an empirical study which considered the legal knowledge of medical professionals in this area found considerable uncertainty and error in their understanding of the law. While further research is required in this area, there is a sufficient body of evidence to conclude that there are gaps in medical professionals' legal knowledge in this area in these three jurisdictions. This conclusion is consistent with the discussion of how the law in this area has been taught in the various medical schools (and in other formal training) in the three States.

The fourth and final claim in this series was that the current state of the law is likely to impede medical professionals' knowledge. In relation to each of the three States, problems with the law that are likely to impede medical professionals' knowledge were identified. There are five main types of problems that present barriers to medical professionals' knowledge. One is that sometimes it is uncertain as to what the law is. An example of this is the uncertain status of common law advance directives in Queensland and Victoria. It is difficult to know the law when what it requires is uncertain. Another type of problem is that the law deals with matters inconsistently. An example of this is the multiple definitions of "capacity" in New South Wales and Victoria. If medical professionals are required to know multiple definitions for the same concept and when and how to apply them, that is a barrier to accurate legal knowledge. A third type of problem is where the law is inconsistent with good medical and ethical practice, an example being the requirement to obtain consent to withhold or withdraw futile treatment in Queensland. Medical professionals might reasonably expect the law would follow what is relatively settled medical and ethical practice, and it presents challenges for them when this is not the case. A fourth type of problem in the law is where distinctions are made that are counterintuitive or regarded as unnecessarily fine. The distinction between withholding consent and refusing treatment in New South Wales and Victoria falls into this category.

The fifth type of problem with the law in this area, and one that has not been specifically considered to date, is that the law is generally complex. This issue was flagged in each of the articles but is dealt with here because it is a generic issue that spans all three jurisdictions. Although the other problems identified above exacerbate this situation, the current state of the law on its own also presents challenges for medical professionals wishing to know it. This emerges clearly from the extended discussion in each of the three articles needed to state the law. First, medical professionals would need to know that the legal position varies depending on which of the three categories of medical context applies. Secondly, spanning across these contexts, complexity arises from there being a range of potential decision-makers (the generic terms are used here) with power to withhold or withdraw life-sustaining treatment, or at least power to withhold consent for such treatment: a

medical professional, an adult through an advance directive, a guardian, an agent, a default decision-maker, the tribunal and the Supreme Court. Finally, the criteria employed by decision-makers may also vary depending on who is deciding and in what context.

The authors argue therefore that the current state of the law is likely to make it difficult for medical professionals to know it. There is also some evidence that goes further and crystallises this link between the state of the law and gaps in medical professionals' knowledge. In New South Wales, the *Conflict Resolution in End of Life Settings* report states that a lack of clarity in the law was adversely impacting upon the legal knowledge of medical professionals in this area.[124] In Queensland, the *Acute Resuscitation Plan Implementation Report* notes the complexity of the law in this area and that it is "not surprising" that there is inconsistent understanding of the legal position.[125] In Victoria, as noted above, both the VLRC and the Office of the Public Advocate have suggested that the legal distinction between withholding consent and refusing treatment results in uncertainty and confusion.[126] The existence of parallel legislation in the *Guardianship and Administration Act 1986* (Vic) and the *Medical Treatment Act 1988* (Vic) has been identified by the VLRC as being confusing, particularly given the ability of an adult to appoint different decision-makers (an enduring guardian or an agent respectively) under these Acts.[127] The Victorian Parliament Law Reform Committee also concluded that the different approaches to capacity being considered in that review caused widespread confusion and uncertainty.[128] Accordingly, the authors argue that the current state of the law is problematic and that this impedes medical professionals seeking to know it.

Having considered the four claims made by this series of articles, the authors turn now to their conclusions, namely that, in light of what has been discussed, law reform and more and better education of medical professionals is needed.

<subdiv>Conclusions as to medical education

Eight of the 14 medical schools in the three States responded to an informal survey of teaching in the areas under review in this series of articles. The authors established that, while teaching and assessment are inevitably variable, it is likely that there is reasonably strong emphasis across undergraduate medical education on issues including decision-making capacity, consent to and refusal of treatment, informed decision-making, futile treatment, and withdrawing and withholding treatment. This focus is a component of the increased emphasis over the past two decades on teaching and assessment in medical ethics, law and professional issues, against a social and cultural background of increased individual and patient rights, increased levels of community education, and a level of erosion of professional and clinical autonomy in the medical profession.

The authors thus identified a generational change in undergraduate medical education, together with a range of evidence of a lack of knowledge of the law on the part of currently practising medical professionals, derived from case reports,[129] a New South Wales Health report,[130] a Queensland Health report,[131] a report of the Victorian Parliament Law Reform Committee,[132] a small number of empirical studies,[133] and anecdotal reports.

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[124] New South Wales Health, *Conflict Resolution in End of Life Settings (CRELS): Final CRELS Project Working Group Report* (2010) pp 20, 24-25.

[125] Queensland Health, *Acute Resuscitation Plan Implementation Report* (April 2010) p 12.

[126] Office of the Public Advocate, n 87, pp 35-36. Victorian Law Reform Commission, n 6, p 38. See also evidence to this effect given to Victorian Parliament Law Reform Committee, n 8, pp 161-162.

[127] Victorian Law Reform Commission, n 6, pp 38, 53.

[128] Victorian Parliament Law Reform Committee, n 8, p 108.

[129] *Inquest into the Death of June Woo* (unrep, Queensland Coroner's Court, State Coroner Barnes SM, 1 June 2009).

[130] New South Wales Health, n 124.

[131] Queensland Health, n 125, p 12.

[132] Victorian Parliament Law Reform Committee, n 8, p 108.

[133] Cartwright C et al, *NSW Medical Practitioners Knowledge of and Attitudes to Advance Care Planning: Report to NSW Health* (November 2009); Parker M, "Patient Competence and Professional Incompetence: Disagreements in Capacity

Law is complex, and medical law is no exception. The law governing the withholding and withdrawing of life-sustaining treatment from adults who lack capacity is not only complex, it is also at times uncertain, internally inconsistent, inconsistent with good medical and ethical practice, and counterintuitive.[134] As suggested above, the current state of the law in this area is a distinct barrier to medical professionals' mastering its principles and application, and simplification and other reform of the law would improve this situation considerably, as discussed below. Together with reforms to the law itself, the authors contend that a range of educational reforms will enable medical professionals to more validly and consistently apply the law in practice. To this end, they identify two desirable cultural changes and make a further six specific suggestions in relation to improving medical education. We consider that these general and specific improvements are related (often causally) and advances in specific strategies will help drive change in the broader, cultural areas.

The traditions and cultures of medical and legal education and practice do not evolve rapidly. While we have identified inter-generational changes in medical education, with a greater emphasis on and integration of medical ethics and law, there remains considerable scepticism on the part of many practising clinicians towards these curricular components, which they see as having usurped valuable training time once reserved for the scientific and clinical aspects of medicine. We respond to that scepticism with the claim that the relevant knowledge and skills for effective and safe clinical practice must include ethical, legal and professional matters; these are simply inevitable and crucial aspects of practice. This is so because medicine is no longer an autonomous professional enterprise, but a social endeavour occurring within social, cultural and legal frameworks.

A related change advocated in relation to medical culture (but also seen as inevitable) is the change from the perception by the medical profession of the law as adversarial and oppositional to a more sanguine or even positive view of law as facilitative of safe, ethical practice. While elements of the traditional perception will probably continue as long as fault-based negligence and other procedures remain in force, it is to be hoped that this will be diluted by increasing familiarity with those facilitative aspects of the law. One way that this change is currently being augmented is by adopting an approach to the law in undergraduate medical education that emphasises its role in representing community ethical consensus in preference to the "risk management" approach that is still commonly adopted in postgraduate continuing medical education. This change posits the avoidance of legal trouble as a side-benefit of ethical medical practice, rather than seeing risk management strategies as the primary educational focus.

This broad educational emphasis can be supported by a number of specific strategies. First, the relevant legal knowledge and skills for effective and safe clinical practice in the area of interest here should be strongly integrated into teaching about the end of life, so that discussions of the technical skills of pain and symptom management, communication and psychosomatic support[135] is linked to relevant legal matters. Knowledge of the relevant law should not be conceived as a technical addition to the central discussion, to be considered separately, but an integral component of clinical care. At the undergraduate level, this integration is already occurring to a significant, but still somewhat variable, extent in current programs. Secondly, the core curriculum document referred to in the first article in the series[136] should be reviewed and rewritten to emphasise, inter alia, not just the importance of the role of the law, particularly in end-of-life care, but also the importance of closely integrating ethical and legal considerations in clinical teaching.

Thirdly, one of the perennial difficulties of undergraduate medical programs is increasing the integration of areas like basic science and ethics and law, that are dealt with almost exclusively in the earlier, pre-clinical years, into the later clinical years. At this latter stage, student cohorts are

Assessments in One Australian Jurisdiction, and Educational Implications" in "Bioethical Issues" (2008) 16 JLM 25; Darvall, McMahon and Piterman, n 112.

[134] See above at XXX section 8.1.

[135] Sullivan AM et al, "The Status of Medical Education in End-of-life Care" (2003) 18 *Journal of General Internal Medicine* 685.

[136] A Working Group, on Behalf of the Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools (ATEAM), "An Ethics Core Curriculum for Australasian Medical Schools" (2001) 175(4) MJA 205.

dispersed, fragmented, focused on clinical work, and in the hands of clinicians who are not well versed in the law and usually not motivated to encourage students to include it in their clinical considerations. While the cultural changes discussed above will improve integration at this stage, these structural features will continue to make it extremely difficult. Smaller, more cohesive cohorts that can be brought together periodically are easier to reach in these later clinical years, but other strategies including concerted efforts at staff development and developing generic curricular elements may help improve the situation.

Fourthly, to build on the more theoretical teaching about capacity in the pre-clinical years, there should be specific teaching of capacity assessment in the later undergraduate program, and again in the junior doctor training period. This is a good example of integration between the theoretical and practical elements, which repeats a theme also applicable to the scientific aspects of practice. There is considerable discussion of improving educational continuities between the undergraduate and early postgraduate phases of medical education,[137] and (fifthly) medical law should be no exception to this endeavour.

Sixthly, the authors advocate greater systematisation of postgraduate medical education in the area of medical law generally, and the law concerning capacity and withdrawing and withholding treatment specifically. Postgraduate medical education councils are responsible to the Medical Board of Australia for accrediting intern and junior doctor training programs, and the accreditation process should become increasingly mindful of the place and importance of continuing legal education in the workplace. The same applies to specialist college training programs, with more specific emphasis in those colleges whose fellows deal with these end-of-life issues.

<subdiv>Final conclusions as to law reform

In each of the three articles in this series, suggestions have been made as to how the specific problems identified as being likely to impede medical professionals' knowledge of the law could be addressed. The purpose of this section is to move beyond law reform in each of the three jurisdictions and to make some more general observations on this topic.

The first observation relates to the complexity of the law in this area generally. This was noted above as being an issue of significance for all three jurisdictions. To some extent, some level of complexity may be unavoidable. For example, it is not desirable to reduce the number of ways in which decision-making can occur. The authors consider it appropriate that an adult can complete an advance directive and appoint another to make decisions on her or his behalf. Likewise, it is important that the relevant tribunal is able to appoint a substitute decision-maker where necessary (or make this decision itself) and the availability of a default decision-making mechanism is valuable because this helps to avoid drawing adults into the formal guardianship system unnecessarily. Finally, they are not suggesting that the Supreme Court's parens patriae jurisdiction be removed.

However, while acknowledging that some level of complexity may not be avoidable, where complexity is unnecessary the law should be reformed. Obvious examples discussed in this article that arise in Victoria are the complication added by having two decision-makers able to be appointed by an adult (an enduring guardian and an agent) and having two overlapping pieces of legislation. Neither duplication is necessary and both add to the complexity of the law.

The need to avoid unnecessary complexity is particularly important in areas like adult guardianship law and end-of-life decision-making. They are areas of law that are regularly used – and intended to be used – by non-lawyers, including medical professionals. As shown in this series, it is specifically contemplated that medical professionals will play significant legal roles in these decisions. It is critical that governments, law reform agencies and others charged with reform efforts keep this in mind when reframing new laws.

A second general comment that emerges from this review of these three jurisdictions is the merit of a national approach to the law in this area. There have been repeated calls for either uniform laws

[137] Dick ML et al, 'Vertical Integration in Teaching And Learning (VITAL): An Approach to Medical Education in General Practice' 2007 (187) MJA 133; Rosenthal DR et al, "Vertical Integration of Medical Education: Riverland Experience, South Australia" (2004) 4 *Rural and Remote Health* 228.

or harmonisation in this field. For example, the federal House of Representatives Standing Committee on Legal and Constitutional Affairs report, *Older People and the Law*, recommended that the Australian Government encourage the Standing Committee of Attorneys-General to work towards the implementation of nationally consistent guardianship and other relevant legislation throughout Australia.[138] For medical professionals, a single Australian legislative framework, or at least a harmonised approach nationally, is likely to be easier to know and this is particularly so given the high mobility rate of medical professionals working in different jurisdictions within Australia.

Although all three jurisdictions share a framework that is broadly similar at a global level for these decisions, it is noteworthy how different the three legal regimes are. One illustration is the legal regulation of advance directives (and for the moment, putting aside the issue of recognition of common law advance directives in Queensland and Victoria). In New South Wales, advance directives are recognised only by the common law and there is no statutory directive. In Queensland, an adult can complete an advance health directive under the *Powers of Attorney Act 1998* (Qld) but the circumstances in which it can operate are limited in a range of ways and a medical professional is entitled to disregard a directive when he or she reasonably believes its directions are inconsistent with good medical practice. Victoria has statutory refusal of treatment certificates but they are limited to adults refusing treatment in relation to a current condition. It is hard to imagine that the medical context in which these laws are operating is so different in these three States that the law should be regulated in such different ways.

A concluding observation is to note that the time is now ripe for reform. As has been discussed in each article, all three jurisdictions have either ongoing or very recent reform inquiries in this area. New South Wales has had the Legislative Council's Standing Committee on Social Issues report, *Substitute Decision-Making for People Lacking Capacity*,[139] Queensland has the Queensland Law Reform Commission's Guardianship Review,[140] and Victoria has had its Parliament Law Reform Committee's *Inquiry into Powers of Attorney*[141] and its current review of guardianship law by the VLRC.[142] In addition to these three States, South Australia and the Northern Territory have also been reviewing aspects of their guardianship law.[143]

There are two features of these sorts of law reform inquiries that are significant. The first is that they provide an opportunity for considered and thoughtful reflection on the future of this area of law. In particular, law reform commissions approach their task as bodies that are independent from the government of the day. These are important aspects of law reform given that the law that governs decisions to withhold or withdraw life-sustaining treatment is often regarded as controversial and politically sensitive. The nature of the law in this area can sometimes inhibit a careful and rational inquiry into how it can be improved. The second feature is that these sorts of inquiries provide an

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[138] House of Representatives Standing Committee on Legal and Constitutional Affairs, *Older People and the Law* (Parliament of Australia, 2007) at [3.42]-[3.44], [3.171]-[3.179], [3.198]-[3.200]. See also Victorian Parliament Law Reform Committee, n 8, pp 35-38. The current authors note also the ongoing efforts for national harmonisation in relation to advance care planning: Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council, *A National Framework for Advance Care Directives: Consultation Draft* (2010).

[139] New South Wales Parliament, Legislative Council, Standing Committee on Social Issues, *Substitute Decision-making for People Lacking Capacity* (2010).

[140] Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws, Report No 67* (2010) Vols 1-4; Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws, Discussion Paper No 68* (2009); and Queensland Law Reform Commission, *Shaping Queensland's Guardianship Legislation: Principles and Capacity, Discussion Paper No 64* (2008).

[141] Victorian Parliament Law Reform Committee, n 8.

[142] Victorian Law Reform Commission, n 6.

[143] Northern Territory Law Reform Committee, *Report on the Powers of Attorney Act and Medical Enduring Powers of Attorney, Report No 33* (2009); South Australian Advance Directives Review Committee, *Advance Directives Review – Planning Ahead: Your Health, Your Money, Your Life. First Report of the Review of South Australia's Advance Directives – Proposed Changes to Law and Policy* (2009); and South Australian Advance Directives Review Committee, *Advance Directives Review – Planning Ahead: Your Health, Your Money, Your Life. Second Report of the Review of South Australia's Advance Directives – Proposals for Implementation and Communication Strategies* (2009).

opportunity for looking at the law anew and reconsidering how legal frameworks are structured. This can be contrasted with much law reform which is incremental in nature and merely adds to, subtracts from or otherwise tinkers with the existing legal framework. The opportunity for law reform in these three (or more) jurisdictions is rare and must be seized to improve what is an important area of law for patients and their families, medical professionals and the community as a whole.

POSTSCRIPT

After submission of this article for publication, the VLRC released its consultation paper: Victorian Law Reform Commission, *Guardianship*, Consultation Paper 10 (February 2011). The consultation paper considers a range of issues discussed in this article but of particular significance are Chapters 8 (Personal Appointments), 9 (Documenting Wishes about Your Future), 10 (VCAT Appointments and Who They are For), 14 (Automatic Appointments – the Person Responsible) and 16 (Medical Treatment).