Chapter 12 - Substitute Consent to Medical and Dental Treatment

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12. 1. Introduction

The judges in the common law world have not developed a regime for substitute decision-making for medical and dental treatment. Rather they have asserted that there are circumstances in which adults unable to give a valid consent to their own treatment can be treated without consent and the treating doctor is absolved from liability for trespass to the person in the form of battery or false imprisonment, but not necessarily from negligence.

The lack of a sufficient answer in the common law has led to the development, in the Australian States and the Australian Capital Territory, of legislative

regimes for substitute decision-making in relation to the medical and dental treatment of those unable to give a valid consent to their own treatment. [1] These regimes are discussed in this chapter, but first it is useful to consider the state of the common law as it applies to fill in any gaps in these regimes, some of which are more comprehensive than others.

The Northern Territory has not as yet developed such a legislative regime, but it does have some legislative provisions that apply to some limited situations.[2] Consequently, the common law, insofar as it has been stated by judges, applies in the Northern Territory to a far greater extent than it does elsewhere in Australia.

12. 2. The common law and treating without consent

As is apparent from Chapter 11, the starting point of the common law is that, subject to some exceptions, adults cannot be given medical treatment without their consent. Mc Hugh J of the High Court of Australia pointed out in 1992 in *Marion's Case*:

> It is the central thesis of the common law doctrine of trespass to the person that the voluntary choices and decisions of an adult person of sound mind concerning what is or is not done to his or her body must be respected and accepted, irrespective of what others, including doctors, may think is in the best interests of that particular person.[3]

In 1984, Goff LJ, as he then was, stated in the Divisional Court of Queen's Bench that there was a general exception to trespass to the person in the form of battery, and possibly also to assault and false imprisonment, embracing all physical contact which is generally acceptable in the ordinary conduct of daily life. He said:

> In each case, the test must be whether the physical contact so persisted in has in the circumstances gone beyond generally acceptable standards of conduct; and the answer to that question will depend upon the facts of the particular case.[4]

In a 1986 case the English Court of Appeal said of this "rationalisation" by Goff LJ:

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[1] *Guardianship Act 1987 (NSW)* Pt 5; *Guardianship and Administration Act 2000 (Qld)* Ch 5 and *Powers of Attorney Act 1998 (Qld)* Chs 3 and 4; *Guardianship and Administration Act 1993 (SA)* Pt 5; *Guardianship and Administration Act 1995 (Tas)* Pt 6; *Guardianship and Administration Act 1986 (Vic)* Pt 4A; *Guardianship and Management of Property Act 1991 (ACT)* Pt 2A; *Guardianship and Administration Act 1990 (WA)* Pt 9C.

[2] *Emergency Medical Operations Act 1973 (NT)* generally, *Natural Death Act 1988 (NT)* generally and *Adult Guardianship Act* 1988 (NT) s 21.

[3] *Secretary, Department of Health and Community Services v. JWB and SMB* (*Marion's Case*) [1992] HCA 15, McHugh [3], 175 CLR 218, 309.

[4] *Collins v Wilcock* [1984] 3 All ER 374, 378.

> It provides a solution to the old problem of what legal rule allows a casualty surgeon to perform an urgent operation on an unconscious patient who is brought into hospital. The patient cannot consent, and there may be no next of kin available to do it for him. Hitherto it has been customary to say in such cases that consent is to be implied for what would otherwise be a battery on the unconscious body. It is better simply to say that the surgeon's action is acceptable in the ordinary conduct of everyday life, and not a battery.[5]

12. 2. 1. Emergence of the principle of necessity

By 1990 Goff LJ had become Lord Goff of Chieveley and in the House of Lords in the case *In re F*, he made statements about how doctors could lawfully treat those incapable of giving a valid consent to their own treatment. He adapted from the law of agency the principle of necessity which upholds the actions of agents who are unable to get instructions from their principals but must act in an emergency provided they act in a way that in the judgment of a wise and prudent person is in the best interests of the principal. He indicated that doctors dealing with patients who were likely to be incapable only for a short period because, for example, they were unconscious or delirious and, with care and treatment, would soon regain capacity could treat such patients by doing no more than was reasonably required in their best interests.[6]

Lord Goff of Chieveley extended the principle of necessity to the effect that, if a person's incapacity was permanent or more or less so, their doctor could treat them by acting in their best interests and treating them in accordance with a responsible and competent body of relevant professional opinion. He noted that it was good practice to consult relatives and others who are concerned with the care of the person.[7]

It would be unwise to treat the principle of necessity, in either its adapted or extended form, as enabling a doctor to give treatment that is contrary to the known wishes of the person.[8]

It is unclear how far the extended principle of necessity articulated by Lord Goff of Chieveley can be relied upon in Australia. In *Marion's Case* the High Court did not accept that necessity extended to the sterilisation of a child.[9] The wider implications of the *In re F Case* were not in issue in *Marion's Case*. Nevertheless, it would be safe to say that the general exception to actions for trespass to the person and the adapted principle of necessity would come the

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[5] *Wilson v Pringle* [1986] QB 237, 252.
[6] *In re F* (1990) 2 AC 1, 77. See also *Re T* [1993] Fam 95, 117 (Butler-Sloss LJ) and 117 (Staughton LJ).
[7] Ibid. 78.
[8] Ibid. 76. See also, *Malette v Shulman* (1990) 67 DLR (4th) 321.
[9] *Secretary, Department of Health and Community Services v. JWB and SMB* [1992] HCA 15, 175 CLR 218. See also, *BCB* [2002] WAGAB 1, [46], *Re BCB, Application for Guardianship Order* [2002] SR (NSW) 338.

aid of a doctor or other health professional who acted in an emergency to give urgent treatment to an adult unable to give a valid consent to their own treatment, provided that such treatment was not negligently provided in the circumstances.

In 2002, after considering this line of authority and other cases, a Full Board of the then Guardianship and Administration Board of Western Australia noted, that under the doctrine of necessity where there was an urgent need for medical treatment, the common law allowed a doctor, as an agent of necessity, to carry out such treatment as was necessary to meet the emergency without the need to obtain the incapable person's consent.[10] This view was supported by a subsequent Full Board.[11]

12. 2. 2. The defence of justified intervention, detention and restraint

Another line of authority, arising from the 19th century law relating to mentally ill people, and applied in the 20th century in Australia may be able to be called in aid in relation to keeping people currently or permanently incapable of giving a valid consent to their own treatment, in order for them to be kept under observation after head injuries or drug overuse, where harm that will need medical treatment is strongly suspected and where mental health legislation does not apply.

In an action for trespass to the person in the form of false imprisonment and restraint as well as assault and battery brought, by a man addicted to drinking and subject to fits of delirium tremens, against the doctor who came to his house at his wife's request and had another man attend the delirious man over night, Bramwell B, using the language of 1862, stated that the doctor would have a defence if the delirious man was:

> [A]t the time of the original restraint a dangerous lunatic in such a state that it was likely that he might do mischief to any one, the [doctor] was justified in putting a restraint on him, not merely at the moment of the original danger, but until there was reasonable grounds to believe that the danger was over…[12]

In a 1971 an action was taken in the High Court of Australia, in its original jurisdiction, for trespass to the person and false imprisonment by a man who was admitted to a psychiatric hospital in Victoria and kept there for about a week.[13] Walsh J applied the statement of Harvey J of the Supreme Court of New South Wales that whether detention (of a mentally ill person) was lawful or not depended on the extent to which the person submitted to it or on the overriding necessity for the protection of himself or others.[14] Walsh J

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[10] *BCB* [2002] WAGAB 1 [28], [2002] SR (WA) 338.
[11] *BTO* [2004] WAGAB 2 [20].
[12] *Scott v Wakem* (1862) 176 ER 147, 149.
[13] *Watson v Marshall* [1971] HCA 33, (1971) CLR 621.
[14] *In re Hawke* (1923) 40 WN (NSW) 58, 59.

considered that the evidence in the case fell short of establishing that there was a necessity to protect the man himself or others such as would justify the steps taken by the doctor. While the doctor thought it was right that the man should be admitted to a hospital, it was not shown that the doctor apprehended an immediate danger of injury to the man himself or to others, if he were not taken into custody immediately.[15]

12. 3. The Australian legislative regimes for substitute decision-making in relation to medical and dental treatment for incapable people

The legislative regimes for substitute decision-making in relation to the medical and dental treatment of those unable to give a valid consent to their own treatment of the States and the Australian Capital Territory have many similarities, but the different drafting of their provisions causes many differences in the way they operate. Consequently, except for New South Wales and Tasmania, it has been necessary to describe them all separately. Nevertheless, some of the common ground between them is discussed at the end of this chapter. The decided cases in the various States, with exceptions, can be of assistance in elucidating the legislation in other States. These are dealt with at the end of the chapter.

12. 4. The substitute consent regime in New South Wales and Tasmania

Part 5 of the *Guardianship Act 1987 (NSW)* which came into force in August 1989 established a regime for substitute decision-making in relation to the medical and dental treatment of people 16 years and above who are incapable of giving a valid consent to their own treatment.[16] The regime operates without the need for the intervention of the Guardianship Tribunal or the Supreme Court.

Tasmania adopted essentially the same regime as Part 6 of its *Guardianship and Administration Act (Tas) 1995* which commenced in September 1997. However, that Part applies to a person of any age, including minors, persons less than 18 years, whatever their age.[17]

The legislation in both States sets down the test for incapacity to consent to one's own medical or dental treatment and nominates who is an incapable person's substitute decision-maker for such treatment. The legislation defines medical treatment and divides it into five categories, treatment which is outside the regime and doesn't require consent, urgent treatment, minor, major (there is no distinction between major and minor treatments in Tasmania) and special treatment. The legislation provides for the consent arrangements in relation to those categories of treatment as well as setting out a number of other related matters.

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[15] *Watson v Marshall* [1971] HCA 33 [7], (1971) 124 CLR 621.
[16] *Guardianship Act 1989 (NSW)* s 34.
[17] *Guardianship and Administration Act 1995 (Tas)* s 4.

12. 4. 1. Objects of the legislation

The New South Wales *Act*, but not the Tasmanian *Act*, sets out the objects of this Part of the Act as being to ensure that:

1. people are not deprived of necessary medical or dental treatment merely because they lack the capacity to consent to the carrying out of such treatment, and
2. any medical or dental treatment that is carried out on such people is carried out for the purpose of promoting and maintaining their health and well-being.[18]

The Tasmanian *Act* states that one of its general objects is "to make better provision for the authorization and approval of medical and dental treatment for persons with a disability who are incapable of giving informed consent to any such treatment".[19]

12. 4. 2. The legal test for incapacity to consent to medical or dental treatment

A person is incapable of giving a valid consent to their own medical or dental treatment if:

1. they are incapable of understanding;
   (a) the general nature of the treatment, or
   (b) the effect of the treatment, or
2. they are incapable of indicating whether or not they consent to the carrying out of the treatment.[20]

If a person is incapable of understanding the general nature of a particular treatment or the effect of that treatment, or they are unable to communicate their consent (which can be done by oral or other means) they are incapable of giving consent to it. In particular, a person must understand the nature and effect of treatment not on patients in general, but on themselves.

Some people lack insight into their medical condition. This can result in them being incapable of giving a valid consent, or refusal of consent to their own treatment on the ground that they are incapable of understanding the effect, on them, of the proposed treatment. This was demonstrated in a 2002 appeal against a decision of the Tasmanian Guardianship and Administration Board in which Blow J of the Supreme Court of Tasmania noted that the appellant was capable of understanding the general nature of the proposed treatment. He recognised that schizophrenia was a disorder that he had suffered from in the past and understood that the drugs that were proposed for him were drugs for the treatment of schizophrenia. However, he was firmly of the belief that he did

[18] *Guardianship Act 1989 (NSW)* s 32.
[19] *Guardianship and Administration Act 1995 (Tas)* s 5.
[20] *Guardianship Act 1989 (NSW)* s 33(2) and *Guardianship and Administration Act 1995 (Tas)* s 36.

not suffer from schizophrenia and therefore did not need that treatment. Blow J was of the view that the legislative test was not about the effect of proposed treatment on patients in general but referred to a person's understanding as to the effect of the proposed treatment on them.[21]

Consequently, where a person understood the nature and effect of treatment by particular drugs in general terms in relation to patients in general, but do not have insight into their own condition and therefore opposed the use of such treatment in relation to them, they lacked the capacity to give a valid consent to their own treatment.

A useful way of determining whether or not a person is capable of understanding the general nature or effect of a particular treatment or of indicating whether or not they consent to the carrying out of that treatment is to apply the approach proposed by a Dr Eastman, a forensic psychologist, and adopted by Thorpe J of the High Court of Justice and the Court of Appeal in England and by the Guardianship Tribunal of New South Wales.[22]

Thorpe J stated the test twice in his judgment, in slightly different ways. Put together, they clarify the meaning of the test. The test has three elements. To be capable of giving a valid consent to medical treatment, the person must be able to:

1. take in (and comprehend) and retain the treatment information,
2. believe that information, and
3. weigh that information, balancing risks and needs.
   (weigh it in the balance and arrive at a choice) [23]

The person must not only be able to take in the information, they must be able to understand it, to a reasonable degree. They must not only believe that information as true but also be able to hold it long enough in their memories to weigh up the benefits and risks and then make a choice as to whether to give or refuse consent to the proposed treatment. A person is entitled to be ambivalent about a decision whether or not to consent to a particular treatment, and to vacillate on the subject.[24] However, if they are not able to come to a decision at all, that is likely to be evidence of incapacity.

In practice, it falls to the doctors to assess whether the person they are proposing the treatment for has the capacity to consent to or refuse treatment according to the test set out above. The starting point is that every adult is

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[21] *C v Guardianship and Administration Board* [2002] TASSC 29.
[22] *In re C* [1994] 1 All ER 819, 822 and 824; *Re MB* [1997] EWCA Civ 1361; *Re B* [EWHC 429 (Fam) [33]; *Re NK* (unreported Guardianship Tribunal NSW, C/28379, Matter Nos 2004/1672 and 2004/1673, 3 June 2004), 12. At the time of writing, Thorpe J's test had not been considered by either the Guardianship and Administration Board or the Supreme Court of Tasmania.
[23] *In re C* [1994] 1 All ER 819, 822 and 824.
[24] *Re B* [2002] EWHC 429 (Fam) [34] and [35].

assumed to have capacity.[25] That legal presumption can be set aside by evidence to the contrary. Because of this approach, it follows that the test is not to be applied harshly so as to prevent elderly, frail or ill people from making decisions about their own treatment because they may be slow to comprehend or may need time to come to terms with new or unexpected developments. Similarly, those with whole of life or acquired disabilities are not to be prevented from making their own decisions. Incapacity has to arise from the existence of evidence showing it. Also, a refusal of consent to proposed treatment is not necessarily evidence of incapacity to consent to treatment.[26] However, while the matter has not been determined in Australia, Lord Donaldson MR has noted in England that, in relation to the refusal of treatment at least, capacity to decide has to be commensurate with the gravity of the decision the person made. The more serious the decision, the greater the capacity required.[27]

These issues and the process for assessing capacity to consent or refuse treatment are discussed in detail at the end of this chapter.[28]

12. 4. 3. Medical and dental treatment defined

In New South Wales and Tasmania, medical and dental treatment are defined together. They are medical treatment, including 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 as well as dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a registered practitioner. They can also include any other act declared in the regulations to be "treatment" as just defined.[29]

12. 4. 4. The types of medical treatment

12. 4. 4. 1. Excluded treatments

The first group in both New South Wales and Tasmania are treatments that are excluded from the regime with the intention that they do not need consent. They are non-intrusive examinations made for diagnostic purposes including visual examinations of the mouth, throat, nasal cavity, eyes or ears. Also in the group are first-aid medical or dental treatments, and drugs for which a prescription is not required and which are normally self-administered when they are being used for the purpose, and in accordance with the dosage level, recommended in the manufacturer's instructions. Other treatments can be included in this group by being declared in the regulations, but none have been.[30]

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[25] *Re MB* [1997] 2 FCR 541, 553; *Re B* [2002] EWHC 429 (Fam) [28] and [100].
[26] *Lane v Candura* 376 NE 2d 1232.
[27] *Re T* [1993] Fam 95, 113; *Re MB* [1997] EWCA Civ 1361 and *Re B* [2002] EWHC 429 (Fam) [31].
[28] See 12. 11 and 12. 12.
[29] *Guardianship Act 1989 (NSW)* s 33(1) and *Guardianship and Administration Act 1995 (Tas)* s 3. The Victorian definition is almost identical. See, *Guardianship and Administration Act 1986 (Vic)* s 3.
[30] *Guardianship Act 1989 (NSW)* s 33(1) and *Guardianship and Administration Act 1995 (Tas)* s 3.

These treatments have been excluded largely because they are of such a minor nature or are so linked to day to day living and only carried out when necessary that it was inappropriate for consent to them to have to be sought through the substitute decision-making regime. However, this exclusion was not intended to cut across, or in anyway downplay, the importance of hospitals, aged care facilities, group homes or other places where care or treatment is provided to people who are incapable of giving a valid consent to their own treatment keeping accurate records of any form of medication or treatment given to a patient or resident or having protocols as to who may permit such treatments to be carried out.

12. 4. 4. 2. Urgent treatments
These are treatments which the doctor or dentist carrying out or supervising the treatment considers to be treatment that is necessary, as a matter of urgency:

> (a) to save the incapable person's life, or
> (b) to prevent serious damage to the incapable person's health, or
> (c) except in the case of special treatment, to prevent the incapable person from suffering or continuing to suffer significant pain or distress.[31]

These treatments may be carried out without consent when they are urgent. When they are not urgent they will be categorized as major or minor treatment and consent for them to be carried out will be required according to the category of treatment they fit, according to the statutory definition.

12. 4. 4. 3. Special treatments
For New South Wales these are:

> (a) any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, or
> (b) any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned (these are experimental treatments proposed to be given not within the ambit of a clinical trial and have a different test for consent from the other forms of special treatment referred to in (a) and (c)) [32], or
> (c) any other kind of treatment declared by the regulations to be special treatment.

In New South Wales treatments declared by the regulations to be special treatments are:

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[31] *Guardianship Act 1989 (NSW)* s 37(1) and *Guardianship and Administration Act 1995 (Tas)* s 4.
[32] *Guardianship Act 1989 (NSW)* s 33(1).

> a) any treatment that involves the administration of a drug of addiction (other than in association with the treatment of cancer or palliative care of a terminally ill patient) over a period or periods totaling more than 10 days in any period of 30 days,
> (b) any treatment that is carried out for the purpose of terminating pregnancy,
> (c) any treatment in the nature of a vasectomy or tubal occlusion,
> (d) any treatment that involves the use of an aversive stimulus, whether mechanical, chemical, physical or otherwise.[33]

In New South Wales there are some "prescribed special treatments" which are also found in the regulations. They are:

1. any treatment that involves the administration to an incapable person of one or more restricted substances for the purpose of affecting the central nervous system of that person, but only if the dosage levels, combinations or the numbers of restricted substances used or the duration of the treatment are outside the accepted mode of treatment for such a person, and
2. any treatment that involves the use of androgen reducing medication for the purpose of behavioural control.[34]

While Tasmania has not made the "prescribed special treatments" just referred to special treatments, most of the other treatments set out above have been made special treatments in that State. However, they are distributed differently between the *Act* and the *Regulations*.[35]

In both New South Wales and Tasmania, only the Guardianship Tribunal or Guardianship and Administration Board respectively may consent to special

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[33] *Guardianship Regulation 2010 (NSW)* reg 9. Note that palliative care and terminally ill were interpreted by the NSW Guardianship Tribunal in *FAM* [2007] NSWGT 13. The Tribunal noted, at [15], that palliative care "is generally understood to be provided to people of all ages who have a life limiting illness, with little or no prospect of a cure, for whom the primary treatment goal is quality of life". It also noted that the common medical understanding of a terminal illness involved end stage illness when death was imminent or reasonably foreseeable and there was no cure or (realistic) possibility of remission, [19]-[20]. As FAM had advanced dementia which would inevitably lead to her death in the reasonably foreseeable future and there was no cure for dementia or possibility of recovery or remission, the Tribunal was satisfied that she was a terminally ill patient, [21].

[34] Ibid. reg 10.

[35] In Tasmania, new (experimental) treatments are not defined as special treatment, but termination of pregnancy and removal of non-regenerative tissue for the purposes of transplantation have been made special treatment the Act. See, *Guardianship and Administration Act 1995 (Tas)* s 3. The *Guardianship and Administration Regulations 2007 (Tas)* reg 6 includes aversive treatments as they are defined in New South Wales as special treatment, but not termination of pregnancy which is in the Tasmanian *Act*. While vasectomy or tubal occlusion are not specifically referred to in the legislation in Tasmania, they are considered special treatments as such treatments are usually intended to and, in any event, are reasonably likely to render a the person they are carried out on permanently infertile. Psychosurgery, including any neurological procedure carried out for the relief of the symptoms of Parkinson's disease, is included as special treatment via the *Guardianship and Administration Regulations 2007 (Tas)* reg 6(a).

treatment.[36] However both tribunals, when giving consent to special treatment, may give the person's guardian, if there is one, authority to consent to the continuation of the treatment or further special treatment of a similar nature.[37]

In New South Wales before the Guardianship Tribunal may give consent as to the carrying out of special medical treatment, it must be satisfied as to certain matters. These matters are different depending on whether the treatment is special medical treatment or experimental medical treatment.[38]

As already noted, the Tasmanian *Act* provides that only the Guardianship and Administration Board may consent to such treatment. However, the test for all treatments that the Board may be called upon to consent to is that the Board is satisfied that the treatment is otherwise lawful and that it would be in the best interests of the person.[39]

12. 4. 4. 4. Major treatment

The Tasmanian *Act* does not differentiate between major and minor treatment, but the New South Wales *Act* does.[40] In New South Wales major medical is described in the Regulation as:

> (a) any treatment that involves the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation,
> (b) any treatment that involves the administration of a drug of addiction (but which is not special treatment as described under "*Special treatment*"),
> (c) any treatment that involves the administration of a general anaesthetic or other sedation, but not treatment involving:
>
> (i) sedation used to facilitate the management of fractured or dislocated limbs, or
>
> (ii) sedation used to facilitate the insertion of an endoscope into a patient's body for diagnostic purposes unless the endoscope is inserted through a breach or incision in the skin or a mucous membrane,
>
> (d) any treatment used for the purpose of eliminating menstruation (as different from any treatment which is intended to or is likely to render a person permanently infertile – which is special medical treatment)[41] ,
> (e) any treatment that involves the administration of a restricted

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[36] *Guardianship Act 1989 (NSW)* s 36 and *Guardianship and Administration Act 1995 (Tas)* s 39.
[37] *Guardianship Act 1989 (NSW)* s 45A and *Guardianship and Administration Act 1995 (Tas)* ss 39(2) and 46.
[38] For special medical treatment see, *Guardianship Act 1989 (NSW)* ss 33(1) and 45(1) and (2). For experimental medical treatment see, ss 33(1) and 45(1) and (3) of the *Act* and *Guardianship Regulation 2010 (NSW)* reg 10.
[39] *Guardianship and Administration Act 1995 (Tas)* s 45.
[40] *Guardianship Act 1989 (NSW)* s 33(1) and *Guardianship Regulation 2010 (NSW)* reg 11.
[41] *Guardianship Act 1989 (NSW)* s 33(1).

substance for the purpose of affecting the central nervous system, but not a treatment:

(i) involving a substance that is intended to be used for analgesic, antipyretic, antiparkinsonian, anticonvulsant, antiemetic, antinauseant or antihistaminic purposes, or

(ii) that is to be given only once, or

(iii) that is a PRN treatment (that is, given when required, according to the patient's needs) that may be given not more than 3 times a month, or

(iv) given for sedation in minor medical procedures,

(f) any treatment that involves a substantial risk to the patient (that is, a risk that amounts to more than a mere possibility) of:

(i) death, or

(ii) brain damage, or

(iii) paralysis, or

(iv) permanent loss of function of any organ or limb, or

(v) permanent and disfiguring scarring, or

(vi) exacerbation of the condition being treated, or

(vii) an unusually prolonged period of recovery, or

(viii) a detrimental change of personality, or

(ix) a high level of pain or stress,

(g) any treatment involving testing for the human immuno-deficiency virus (HIV).[42]

It should be noted that this definition of major medical treatment specifically excludes certain treatments which are clearly significant medical procedures from a medical perspective. These are surgical procedures to treat fractured or dislocated limbs, or the insertion of an endoscope into a patient's body for diagnostic purposes through an orifice and not involving the insertion of the endoscope through a breach or incision in the skin or a mucous membrane.[43] These treatments were made minor medical treatments so that the question of consent for them could be dealt with under the arrangements for minor treatment.[44]

Major dental treatment is described as:

(a) any treatment involving the administration of a general anaesthetic or simple sedation,

(b) any treatment intended, or likely, to result in the removal of all teeth,

(c) any treatment likely to result in the patient's ability to chew food being significantly impaired for an indefinite or prolonged period.[45]

Note that most dental treatments are minor treatments and subject to the

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[42] *Guardianship Regulation* 2005 (NSW) reg 10.
[43] Ibid. reg 10(c)(i) or (ii).
[44] See the next heading "*Minor treatment*" and the footnote under it.
[45] Ibid. reg 11.

arrangements for substitute consent to minor treatment.

The substitute decision-maker for these forms of major medical or dental treatment is the incapable person's "person responsible". However, as substitute consent must be obtained before such treatment may be carried out, if the person responsible is not available, any application for substitute consent must be made to the Guardianship Tribunal.[46]

12. 4. 4. 5. Minor treatment

Again in New South Wales, any medical or dental treatment that is not special or major treatment, or treatment not excluded from the substitute consent regime by the legislation, is minor treatment.[47] Most non-surgical medical treatments and some surgical treatments are in the category of minor medical treatment.

12. 4. 5. Who is the substitute decision-maker for medical and dental treatment?

As most medical and dental treatments fit into the categories of minor or major treatment, the substitute decision-maker for an incapable person in most cases will be their "person responsible".

It should be noted that while in most cases an incapable person's person responsible will also be their next of kin, being a person's next of kin has never given, and does not now give, the next of kin the right to act as substitute decision-maker for an incapable person.[48] The authority of a person responsible, or their equivalent in the other States and the Australian Capital Territory, arises from the legislation that empowers then, without having to be appointed or approved by a tribunal, to act as the incapable person's substitute decision-maker. A different approach is taken in the Northern Territory. See 12. 10.

In both New South Wales and Tasmania you determine who is a person's person responsible by consulting the list or hierarchy of persons responsible. The list, in order of priority, is:

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[46] This follows from the fact that the doctors proposing to carryout major medical treatment are not absolved from obtaining substitute consent as they are for urgent treatment or absolved from obtaining substitute consent in certain circumstances as they are for minor treatment and the fact that applications for any kind of treatment may be made to the Guardianship Tribunal. See, *Guardianship Act 1989 (NSW)* ss 37 and 42.

[47] *Guardianship Act 1989 (NSW)* s 33A(4)(a) empowers the guardian to act only if they have been given the function of consenting to medical and dental treatment on behalf of the person under their guardianship. See also s 3(1) of the *Act*. While the *Guardianship and Administration Act 1995 (Tas)* does not deal with this matter specifically, it may be implied into the *Act* that only guardians (including enduring guardians) with the function of giving or refusing consent to medical treatment may act as persons responsible.

[48] *In re T* [1993] Fam 95, 103.

1. the person's guardian, including enduring guardian;[49]
2. the person's her spouse, including their de facto partner and, in New South Wales, their same sex partner;[50]
3. the person having the care of the incapable person;[51]
4. a close friend or relative of the incapable person.[52]

There are special provisions in both New South Wales and Tasmania in relation to those who are in the care of a Minister or a Director-General or are a ward of the State.[53] In Tasmania if a person is under the age of 18 years and they have no spouse, their parents take the place of the spouse in the order of priority for persons responsible.[54]

12. 4. 6. How the list or hierarchy operates.

If there is a guardian, with power to consent to medical and dental treatment, then they are the person responsible and no one else may act as the person responsible. If there is no guardian, which is usually the case, the incapable person's spouse is their person responsible, unless they too are incapable: and so on down the list. If there is no one in any of the four stages of the hierarchy, then the incapable person has no person responsible. This happens occasionally, particularly if the person is living alone and has become isolated from their family or the community. In that case in both New South Wales and Tasmania, the Guardianship Tribunal or the Guardianship and Administration Board may act as the substitute decision-maker if an application is made to them. This matter is taken up again in 12. 4. 8.

In New South Wales, if a person who, in accordance with the hierarchy, is the person responsible for an incapable person declines in writing to act as person responsible, or if a doctor or another person qualified to give an expert opinion on their condition certifies in writing that that person is not capable of carrying out the functions of a person responsible, then the person next in the hierarchy becomes the person responsible for the incapable person.[55] Note that a person responsible, for example an elderly spouse, wishes to abdicate their role as person responsible, they cannot nominate their replacement. The position of

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[49] *Guardianship Act 1989 (NSW)* ss 3(1) and 33A(4)(a) and *Guardianship and Administration Act 1995 (Tas)* ss 3 and 4.

[50] *Guardianship Act 1989 (NSW)* ss 3(1) and 33A(4)(b) and *Guardianship and Administration Act 1995 (Tas)* ss 3 and 4(1)(c)(ii) and 5(a).

[51] *Guardianship Act 1989 (NSW)* s 3D which sets out the circumstances in which the person has the care of the incapable person and s 33A(4)(c) and *Guardianship and Administration Act 1995 (Tas)* s 4(1)(c)(iii) and (3) and (4). Brain damaged adults will sometimes be looked after by their parents, and if those adults receive substantial as a result of their injuries, their parents may receive money for looking after them. In *K v K* [2000] NSWSC 1052 Young J suggested that s 3D of the NSW *Act* not be narrowly construed. Consequently, in that State parent carers in that situation are considered not precluded from being persons responsible.

[52] *Guardianship Act 1989 (NSW)* s 3E which sets out the meaning of "close friend or relative" and s 33A(4)(d) and *Guardianship and Administration Act 1995 (Tas)* s 4(1)(c)(iv) and 5(b) to (d).

[53] *Guardianship Act 1989 (NSW)* s 33A(2) and (3) and *Guardianship and Administration Act 1995 (Tas)* s 4(2).

[54] *Guardianship and Administration Act 1995 (Tas)* s 4(1).

[55] *Guardianship Act 1989 (NSW)* s 33A(5).

person responsible is determined by operation of the hierarchy. However, any adult with the capacity to do so may appoint an enduring guardian and give them the function of consenting to medical and dental treatment. That enduring guardian will then become their person responsible.[56]

12. 4. 7. Seeking and obtaining substitute consent to medical and dental treatment – from the person responsible

In both New South Wales and Tasmania requests to the person responsible for substitute consent to treatment are to be in writing. However if, because of the need to provide the treatment quickly, it is not practicable to make the request in writing, it may be made orally. There are specific legislatively stipulated arrangements in each State about when an oral request has to be confirmed in writing and when substitute consent must be given in writing or when it may be given orally.[57]

In New South Wales, while a doctor will be responsible for carrying out or supervising the carrying out of any medical treatment and a dentist will be similarly responsible for dental treatment, any person may request the person responsible for consent to the carrying out of medical or dental treatment on the incapable person. Even if it is not in writing, the request must specify:

1. why the person cannot give a valid consent to their own treatment,
2. the particular condition they have that requires treatment,
3. alternative courses of treatment that are available in relation to that condition,
4. the general nature and effect of each of those courses of treatment,
5. the nature and degree of the significant risks (if any) associated with each of those courses of treatment, and
6. why the particular course of treatment is proposed.[58]

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The person responsible is required to have regard to the information supplied and the views of the incapable person, if they have any. It is suggested that if the incapable person has made an advance directive that is relevant to their current circumstances, the person responsible must give effect to that advance directive. The person responsible should consent only to medical or dental treatment that will promote the health and well-being of the incapable person.[59] However, it should be noted that any consent given by a person responsible has no effect if the proposed treatment is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the

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[56] For NSW see, *Guardianship Act 1989 (NSW)* ss 3(1) and 33A(4)(a) and Part 2 of the *Act* as to how to appoint an enduring guardian. For Tasmania see, *Guardianship and Administration Act 1995 (Tas)* ss 3 and 4 and Part 5 of the Act as to how to appoint an enduring guardian.

[57] Guardianship Regulation *2010 (NSW)* regs 13 and 14 and Guardianship and Administration Regulations *2007 (Tas)* reg 9.

[58] *Guardianship Act 1989 (NSW)* s 40(2).

[59] Ibid. s 40(3).

incapable person.[60]

The Tasmanian provisions are similar but not identical. While the person responsible must take into account the wishes of the incapable person, if these can be ascertained, they are not bound by those wishes. Again, it is suggested that if the incapable person has made an advance directive that is relevant to their current circumstances, the person responsible must give effect to that advance directive. The person responsible must consider the nature and degree of any significant risks associated with the proposed treatment or any alternative treatments and the consequences if treatment is not carried out. The person responsible must also be satisfied that the person is incapable of giving consent, that the treatment is in the best interests of the incapable person and that it is to be carried out only to promote and maintain their health and well-being.[61]

It should be noted that in both New South Wales and Tasmania persons responsible, including tribunal appointed and enduring guardians, make their own decisions as to the treatment they will consent to on behalf of the incapable person according to the statutory criteria. Except where they have a relevant advance directive to give effect to, they do not make a substituted judgment as to what the incapable person would have consented to in the circumstances.

12. 4. 8. Seeking and obtaining substitute consent to medical and dental treatment – from the tribunal

Both the Guardianship Tribunal of New South Wales and the Guardianship and Administration Board of Tasmania have the jurisdiction to deal with applications for substitute consent to medical and dental treatment. They both operate as the default or "fall back" substitute decision-maker when there is no person responsible or they cannot be contacted. Where an application comes to the Guardianship Tribunal of New South Wales and it becomes apparent that the incapable person probably needs a guardian, the Tribunal will request that an application for guardianship be lodged with it. If it appears to the Tribunal that the incapable person will require on-going treatment and a series of consents as the treatment is varied or changed, it may give its consent to the first treatment and request that an application for guardianship be lodged to see if a guardian should be appointed as the on-going substitute decision-maker for incapable person.

As already noted, the Tasmanian legislation does not differentiate between major and minor treatment, but it does set out a list of treatments that may not be carried out without consent. Consequently, if the incapable person does not have a person responsible, an application must be made to the Board by

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[60] Ibid. s 46(2)(b).
[61] *Guardianship and Administration Act 1995 (Tas)* s 43.

someone with a proper interest in the matter for consent to carry out the treatment. This applies to the following medical treatments:

1. treatment that is continuing or ongoing and involves the administration of a restricted substance primarily to control the conduct of the person to whom it is given; or
2. treatment that involves the administration of a drug of addiction other than in association with the treatment of cancer or palliative care of a terminally ill patient; or
3. electro convulsive therapy (ECT); or
4. treatment involving a substantial risk to the incapable person of -

   (i) death; or

   (ii) brain damage; or

   (iii) paralysis; or

   (iv) permanent loss of function of any organ or limb; or

   (v) permanent and disfiguring scarring; or

   (vi) extreme pain or distress.[62]

Also included is dental treatment that is intended, or likely, to result in the removal of all or a substantial number of teeth.[63]

The Guardianship Tribunal of New South Wales is the default substitute decision-maker for major medical and dental treatment. It should not be applied to if the person responsible is available. In exceptional circumstances where, for example, the capacity or general ability of the person responsible is in real doubt or it is likely that decisions of the person responsible will be opposed by other family members or significant others, then it may be appropriate to apply to the Tribunal in the first place.

The Guardianship Tribunal of New South Wales can be the default substitute decision-maker for minor medical and dental treatment, if there is a particular reason for applying to it. Normally this will not be required because the New South Wales *Act* provides that, minor treatment may be carried out on an incapable person without consent if the incapable person has no person responsible or they cannot be contacted or are unable or unwilling to make a decision concerning the request for their consent. However, before giving the treatment, the doctor or dentist carrying it out must certify in writing in the incapable person's clinical record that:

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[62] *Guardianship and Administration Act 1995 (Tas)* s 41(2) and *Guardianship and Administration Regulations 2007 (Tas)* reg 9.
[63] Ibid.

1. the treatment is necessary, and
2. is the form of treatment that will most successfully promote the incapable person's health and well-being, and
   the incapable person does not object to the carrying out of the treatment.[64]

As will be dealt with in section 12. 4. 10, if the person responsible refuses consent to the treatment and the treating doctor considers that the treatment will promote and maintain the incapable person's health and well-being or the incapable person objects to the treatment, the Tribunal becomes the substitute decision-maker. As has already been noted, in both New South Wales and Tasmania, only the Guardianship Tribunal or the Guardianship and Administration Board respectively may consent to special treatment.[65]

Applications to the Guardianship Tribunal of New South Wales and the Guardianship and Administration Board of Tasmania for substitute consent to medical and dental treatment must be in writing.[66] In New South Wales, as is the case with requests to persons responsible for substitute consent, while a doctor will be responsible for carrying out or supervising the carrying out of any medical treatment and a dentist will be similarly responsible for dental treatment, any person may apply to the Tribunal for consent to the carrying out of medical or dental treatment on the incapable person.[67]

The application must provide the Tribunal with information about the same six matters a person responsible must be informed about. These are:

1. why the person cannot give a valid consent to their own treatment,
2. the particular condition they have that requires treatment,
3. alternative courses of treatment that are available in relation to that condition,
4. the general nature and effect of each of those courses of treatment,
5. the nature and degree of the significant risks (if any) associated with each of those courses of treatment, and
6. why the particular course of treatment is proposed.[68]

The Tribunal is required to conduct a hearing into the application. When considering the application, the Tribunal must have regard to the information

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[64] *Guardianship Act 1989 (NSW)* s 37(2) and (3).
[65] *Guardianship Act 1989 (NSW)* s 36 and *Guardianship and Administration Act 1995 (Tas)* s 39.
[66] *Guardianship and Administration Act 1995 (Tas)* s 44. In NSW the legislation does not require this, but the Tribunal does. However, it provides an application form which is available on its website www.gt.nsw.gov.au/applications/medical-dental-consent-cfm. Also, if an application needs to be made urgently out of hours, the tribunal member on call will fill out the form as part of the information collecting process before the hearing.
[67] *Guardianship Act 1989 (NSW)* s 42(1). However, s 44(3) of the *Act* provides that the Tribunal is not required to consider an application if it is not satisfied that the applicant has sufficient interest in the health and well-being of the incapable person.
[68] Ibid. s 42(2).

supplied in the application, the views of the incapable person, if they have any, and the views of their person responsible, if there is one, and the views of the person proposing the treatment.[69] The Tribunal must also consider the objects of Part 5 of the *Act*. Before the Tribunal may give its consent to the carrying out of the treatment, it must be satisfied that:

1. it is appropriate that the treatment be carried out, and
2. the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being.[70]

Similarly, the Tasmanian Board is required to conduct a hearing into the application. As with persons responsible in Tasmania, the Board must take into account the wishes of the incapable person, if these can be ascertained. However, it is not bound by those wishes. The Board must consider the consequences if the treatment is not carried out. The Board must also be satisfied that the person is incapable of giving consent, that the treatment is otherwise lawful and that it is in the best interests of the incapable person.[71] Nevertheless, acknowledging those provisions, it is again suggested that if the incapable person has made an advance directive that is relevant to their current circumstances, the Board, as substitute decision-maker, must give effect to that advance directive.

Unlike the person responsible, the Board must consider whether the proposed treatment can be postponed on the ground that a better treatment may become available and whether the incapable person is likely to become capable of consenting to the treatment.[72] However, where the Board considers the treatment urgent, it may dispense with notice of the hearing and give its consent to the treatment being carried out immediately. This also dispenses with the usual requirement that the appeal period expires before the order consenting to the treatment comes into effect. [73]

12. 4. 9. Seeking and obtaining substitute consent to special medical treatment – from the tribunal

As has already been noted, in both New South Wales and Tasmania, only the Guardianship Tribunal or Guardianship and Administration Board respectively may consent to special treatment.[74] Also, when giving consent to special treatment, both tribunals may give the person's guardian, if there is one, authority to consent to the continuation of the treatment or further special

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[69] Ibid. s 44(2).
[70] Ibid. ss 44(1) and 45(1).
[71] *Guardianship and Administration Act 1995 (Tas)* s 45.
[72] Ibid. s 45(2)(e).
[73] Ibid. ss 69(3) and 45(3) and (4). For an example of an application to the Guardianship and Administration Board of Tasmania for consent to medical treatment, see *E.Q., on the application of Professor K Kirby* (16 January 2006), www.guardianship.tas.gov.au/decisions.
[74] *Guardianship Act 1989 (NSW)* s 36 and *Guardianship and Administration Act 1995 (Tas)* s 39.

treatment of a similar nature.[75] However, in Tasmania the tests for consent to special medical treatments are the same as for any other treatments, namely those that have just been set out. The question of treatment that will result in sterilization is dealt with in more detail in Chapter 15.

In New South Wales, the same information as for any other treatment must be provided to the Tribunal in the application, but the there is an extra element to the test that has to be satisfied before the Tribunal may give consent. The Tribunal must be satisfied that the treatment is not only the most appropriate form of treatment to promote and maintain the incapable person's health and well-being, but also that the treatment is necessary either to save the incapable person's life or to prevent serious damage to the their health.[76]

If the proposed treatment is experimental special medical treatment - no dental treatment has been declared to be "special dental treatment" – or is "prescribed special treatment", then the test is slightly different.[77] Not only must the Tribunal be satisfied that the treatment is the most appropriate form of treatment to promote and maintain the incapable person's health and well-being, but also that the treatment is the only or most appropriate way of treating the patient and is manifestly in the best interests of the incapable person. Also, if the National Health and Medical Research Council has prescribed guidelines that are relevant to the carrying out of that treatment - those guidelines have been or will be complied with as regards the incapable person.

12. 4. 10. Objections to treatment

The New South Wales *Act* has provisions dealing with objections to treatment. The Tasmanian legislation does not deal with this matter.

In New South Wales, while an incapable person cannot consent to medical or dental treatment, they can still "object" to it. A person is to be taken to object to the carrying out of treatment if they indicate, by whatever means, that they do not want the treatment or if they have previously indicated in similar circumstances that they do not want the treatment and have not subsequently indicated to the contrary.[78] If they do object to the treatment, any consent given by a person responsible, including a guardian, is of no effect.[79] However, the Tribunal may authorize a guardian of an incapable person to override their objection to certain treatments, but only if the Tribunal is satisfied that any such objection will be made because of the incapable person's lack of understanding of the nature of, or reason for, the treatment.[80]

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[75] *Guardianship Act 1989 (NSW)* s 45A and *Guardianship and Administration Act 1995 (Tas)* ss 39(2) and 46.
[76] *Guardianship Act 1989 (NSW)* s 45(1) and (2).
[77] Prescribed special treatment is set out in *Guardianship Regulation 2010 (NSW)* reg 10.
[78] *Guardianship Act 1989 (NSW)* s 33(3).
[79] Ibid. s 46(2).
[80] Ibid. s 46A. However, this authority will not always be given. See, *Re LK* (unreported, Guardianship Tribunal Matter Nos: 2004/1672, 2004/1673, 3 June 2004).

Also, an objection by an incapable person to the carrying out of proposed medical or dental treatment can be disregarded if:

1. the incapable person has minimal or no understanding of what the treatment entails, and
2. the treatment will cause them no distress or, if it will cause them some distress, that distress is likely to be reasonably tolerable and only transitory.[81]

If the objection is one that the Tribunal must deal with, it accepts an application for consent to the proposed treatment and deals with it according to the criteria set down in the *Act* for consenting to treatment. The Tribunal takes evidence about the objection and determines whether or not to give consent to the proposed treatment overriding the incapable person's objection. If the Tribunal gives consent to the treatment in these circumstances, its consent allows the treatment to be carried out. The Tribunal's consent does not require the treatment to be carried out.

The case of Mrs BB shows how the Tribunal deals with objections to treatment by an incapable person. Mrs BB developed gangrene in her right foot after attempts to increase the blood flow there failed. Her treating doctors recommended that her right leg be amputated below the knee. The evidence showed that she was unable to understand the nature and effect of the treatment. Nevertheless, she indicated that she didn't want the treatment. Consent was given by her person responsible, a family member and then withdrawn in the light of her objection. Her treating doctors applied to the Tribunal for consent to the amputation overriding Mrs BB's objection.

The Tribunal took evidence from Mrs BB, the applicant and other doctors and members of her family. After consideration of the evidence, the Tribunal was satisfied that Mrs BB could not give a valid consent to her own treatment, and that the proposed treatment, while not without its risks, was the most appropriate form of treatment to promote and maintain her health and well-being. The Tribunal, without resistance from her family, gave its consent to the carrying out of the proposed amputation, overriding Mrs BB's objection.[82]

In 2001 the Tribunal refused to give consent to a blood transfusion for an 84 year old woman who was a Jehovah's Witness, but who was incapable of consenting to or refusing consent to her own treatment because of dementia. One reason was that she had refused a transfusion seven years previously and had not subsequently indicated to the contrary. Indeed she had maintained her

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[81] Ibid. s 46(4).

[82] *Re BB* (unreported, Guardianship Tribunal Matter No. 2000/3642, 18 July 2000). Sometimes an application is made for a guardianship order and consent to medical treatment. The Tribunal can the either make the medical treatment decision itself or appoint a guardian to do so. For an example see, *Re SR* (unreported, Guardianship Tribunal Matter Nos: 2000/5289, 2000/5326, 2000/5343, 26 September 2005).

objection to receiving blood products because of her religious convictions. Other considerations were that the proposed blood transfusion was palliative in nature and would have little effect on the progress of her underlying renal condition. In addition there was an alternative treatment, Erythropoietin, which was acceptable to Jehovah's Witnesses but which had not yet been tried.[83]

If the person responsible refuses consent to the treatment and the treating doctor considers that the treatment should be given because it will promote and maintain the incapable person's health and well-being and the failure to receive the treatment will be disadvantageous to the incapable person, the treating doctor may make an application to the Tribunal for consent to the carrying out of the treatment. The Tribunal then becomes the substitute decision-maker. It deals with the matter as it would any other application for consent to treatment except that it would ensure that it obtained and had particular regard to the views of the person responsible.[84]

The *Guardianship and Administration Act 2000 (Qld)* contains a similar provision which has been interpreted in a different manner by the Queensland Guardianship and Administration Tribunal.[85] However, the Queensland tribunal does not have jurisdiction to deal directly with applications for consent to medical and dental treatment, except for forms of special medical treatment, while the New South Wales Guardianship Tribunal does have such a role, as has just been demonstrated. This absence of a for mechanism for giving appropriate consideration to the person's objection but yet being able to override it and give an effective consent to the proposed treatment in appropriate cases, which can be done in New South Wales, may have contributed to the interpretation given to the relevant provision in Queensland.

12. 4. 11. Discretion of the substitute decision-maker to consent or to refuse to consent to the proposed treatment

Substitute decision-makers, whether persons responsible or the Guardianship Tribunal, have a discretion as to whether or not to consent to what might appear from a medical perspective to be the most appropriate treatment for promoting and maintaining the health and well-being of the incapable person. This is because not only do they have to consider the information about the treatment, but also they are required to have regard to the views of the incapable person and the objects of Part 5 of the *Guardianship Act 1987 (NSW).*[86] As far back as 1994, the Tribunal (still then called the Guardianship Board) noted, in an application relating to a Christian Scientist, that it was not required under Part 5 "to impose medication on a person contrary to religious beliefs that were deeply held for a long time prior to the person acquiring their incapacity".[87]

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[83] *Re FF* (unreported, Guardianship Tribunal Matter No. 2001/1482, 27 March 2001).
[84] *Guardianship Act 1989 (NSW)* ss 42, 44 and 45(1).
[85] *Re CJ* [2006] QGAAT 11.
[86] Ibid. ss 40(3) and 44(2).
[87] *Re RD* (unreported, Guardianship Board, C/5887, Matter No. 94/1858, 22 June 1994).

As has already been suggested a number of times in this chapter, if the incapable person has made an advance directive that is relevant to their current circumstances, and which has been put beyond doubt by McDougall J's decision in *Hunter and New England Area Health Service v A*[88], the substitute decision-maker must give effect to that advance directive. However, it is conceded that considerable difficulties arise in cases involving Jehovah's Witnesses where the Witness the subject of the application has not got a current "blood card" – a form of advance directive carried by many Jehovah's Witnesses setting out that they do not wish to receive blood products and what substitute non-blood products they are willing to receive. The Tribunal has stated that:

> [W]hilst it has an obligation to have regard to the views of the patient and to take them very seriously indeed, it was not bound by those views and could make a decision in relation to treatment which was contrary to the views of the patient if the Tribunal believed there were strong reasons for doing so. [89]

The matter in which the Tribunal made that statement, and other cases involving the Tribunal in either giving or refusing substitute consent to blood transfusions, are discussed at the end of this chapter at 12. 13.

12. 4. 12. Special powers under the Mental Health Act 1996 (Tas) of persons responsible and the Guardianship and Administration Board

Under the *Mental Health Act 1996 (Tas)*, if a person has a mental illness and meets certain other criteria, they may be admitted to an approved hospital as an involuntary patient.[90] Their person responsible may apply to a doctor for an order for their admission.[91] When in an approved hospital, a mentally ill person may be given medical treatment, although certain medical treatments are excluded, either with their consent or if the treatment has been authorised by or under the *Guardianship and Administration Act 1995 (Tas)*.[92] If the mentally ill person is incapable of giving "informed consent" to their medical treatment and they have a person responsible, their person responsible, to the extent of their powers and according to the requirements of the *Guardianship and Administration Act 1995 (Tas)*, may give substitute consent to the proposed

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[88] [2009] NSWSC 761.

[89] *Re DD* (unreported, Guardianship Tribunal Matter No. 1999/3501, 18 August 1999), 9. The Tribunal might well take a different view in cases where either the patient has a current and relevant "blood card" or other advance directive, or where the patient's views have been clearly stated and proved to the Tribunal's comfortable satisfaction.

[90] *Mental Health Act 1996 (Tas)* s 24. Mental illness is defined in s 4 of the Act.

[91] Ibid. s 25. The term "person responsible" is defined in s 5 of the *Mental Health Act 1996 (Tas)* in the same terms as in s 4 of the *Guardianship and Administration Act 1995 (Tas)* (except for minor differences that are not relevant here).

[92] *Mental Health Act 1996 (Tas)* ss 31, 32 and 72G. The term "medical treatment" is not defined in the Act except to exclude certain treatments from the term.

treatment.[93] However, if the mentally ill person has refused or failed to undergo the treatment, or is likely to refuse or fail to undergo it, the Board may make an order authorizing the giving of the medical treatment regardless of whether or not the mentally ill person has lost capacity to give a valid consent to their own treatment. The Board has to be satisfied that:

1. the mentally ill person's mental illness that is amenable to the proposed medical treatment; and
2. a doctor has recommended medical treatment for the illness but the person has refused or failed, or is likely to refuse or fail, to undergo the treatment; and
3. the mentally ill person should be given the treatment in their own interests or for the protection of others.[94]

12. 5. South Australia

Part 5 of the *Guardianship and Administration Act 1993 (SA)* came into force in March 1995. It provides most of the regime for substitute decision-making in relation to the medical and dental treatment of people 18 years and above who are incapable of giving a valid consent to their own treatment. Most of the rest of the regime is provided for in the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*. As in the other States, the regime operates without the need for the intervention of the Guardianship Board or the Supreme Court.

12. 5. 1. The test for incapacity to consent to medical or dental treatment

Part 5 applies in relation to a person who, because of their mental incapacity, is incapable of giving effective consent to their own medical or dental treatment.[95] The South Australian *Act* defines "mental incapacity" to mean the inability of a person to look after their own health, safety or welfare or to manage their own affairs, as a result of:

1. any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind; or
2. any physical illness or condition that renders the person unable to communicate their intentions or wishes in any manner whatsoever.[96]

While no test determining whether a person has mental incapacity has been adopted in South Australia, Thorpe J's test, which has been described earlier in this chapter and which has been adopted in England and by the Guardianship

[93] The term "informed consent" in defined in s 5AA of the *Mental Health Act 1996 (Tas)*.
[94] Ibid. s 32(2).
[95] *Guardianship and Administration Act 1993 (SA)* s 58.
[96] Ibid. s 3.

Tribunal of New South Wales, would be a useful tool to use in deciding that matter.[97]

12. 5. 2. Medical and dental treatment defined

Consistent with the trend in the other States, both medical and dental treatment are given broad definitions in South Australia. Medical treatment is defined to mean treatment or procedures administered or carried out by a medical practitioner or other health professional in the course of professional practice and includes the prescription or supply of drugs.[98] Dental treatment means treatment or procedures carried out by a dentist in the course of dental practice.[99]

12. 5. 3 The types of medical treatment

12. 5. 3. 1. Emergency medical treatment.

In South Australia urgent or emergency medical treatment is provided for in the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*.[100] Under that *Act*, a doctor may, lawfully, administer medical treatment to mentally incapacitated person if:

1. they are incapable of consenting to the treatment; and
2. the doctor who is to administer the treatment is of the opinion that the treatment is necessary to meet an imminent risk to life or health and
3. that opinion is supported by the written opinion of another doctor who has personally examined the mentally incapacitated person; and
4. if that person is 16 years of age or over and has not, to the best of the doctor's knowledge, refused to consent to the treatment.[101]

Fortunately, a supporting opinion is not necessary if, in the circumstances of the case, it is not practicable to obtain such an opinion.[102]

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[97] *In re C* [1994] 1 All ER 819, 822 and 824; *Re MB* [1997] EWCA Civ 1361; *Re B* [EWHC 429 (Fam) [33]; *Re NK* (unreported Guardianship Tribunal NSW, C/28379, Matter Nos 2004/1672 and 2004/1673, 3 June 2004), 12.
[98] Ibid.
[99] Ibid.
[100] *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s 13.
[101] Ibid. s 13(1).
[102] Ibid. s 13(2).

The administration of emergency medical treatment is further complicated if the mentally incapacitated person has appointed a medical agent, that is an attorney appointed under a medical power of attorney made under the provisions of *the Consent to Medical Treatment and Palliative Care Act 1995 (SA)*. This is because, if the doctor proposing to administer the treatment is aware of that appointment and of the conditions and directions contained in that medical power of attorney and the medical agent is available to decide whether the medical treatment should be administered, then the medical treatment may not be administered without the agent's consent.[103] A similar difficulty arises if the mentally incapacitated person has a guardian whether an enduring guardian appointed by the now incapable person or a guardian appointed by the Guardianship Board. If such a guardian is available, the medical treatment may not be administered without their consent.[104]

These limitations on the immediate provision of emergency treatment to the mentally incapacitated person impose a duty on doctors to make inquiries that are reasonable in the circumstances, as to whether or not the person has a medical agent or guardian and if they have, to make reasonable efforts to obtain their consent to the treatment.

12. 5. 3. 2. Prescribed treatments.

Termination of pregnancy and sterilisation are treatments prescribed in the *Guardianship and Administration Act 1993 (SA)* as treatments that may not be carried out without the consent of the Guardianship Board and only in accordance with the regulations.[105] However, no relevant regulations have been made, nor have any further medical treatments been prescribed in the regulations.[106]

The Guardianship Board cannot consent to a termination of pregnancy unless it is satisfied as to a number of matters. These are that:

1. the carrying out of the termination would not constitute an offence under the *Criminal Law Consolidation Act 1935 (SA)*; and
2. there is no likelihood of the woman acquiring the capacity to give an effective consent within the period that is reasonably available for the safe carrying out of the termination, and
3. the Board has no knowledge of any refusal on the part of the woman to consent to the termination, being a refusal that was made while capable of giving effective consent and that was communicated by her to a medical practitioner.[107]

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[103] Ibid. s 13(3).
[104] Ibid. s 13(4).
[105] Ibid. ss 3 and 61.
[106] Ibid. s 61 and *Guardianship and Administration Regulation 1995 (SA).*
[107] *Guardianship and Administration Act 1993 (SA)* s 61(3).

Also, before consenting to the carrying out of a termination of pregnancy, the Board must put its mind to whether or not it is appropriate to allow such of the woman's parents whose whereabouts are reasonably ascertainable a reasonable opportunity to make submissions to the Board on the matter. However, the Board is not required to allow this opportunity if it is of the opinion that to do so would not be in the best interests of the mentally incapacitated person.[108]

Furthermore, the decision of the Board to give consent a termination of pregnancy cannot be carried out until the period for appeal against the decision has expired or, if an appeal has been instituted, until the appeal has been dismissed or withdrawn.[109] As the period in which an appeal may be lodged is 28 days, the carrying out of the procedure to terminate the incapable woman's pregnancy must be delayed for at least that time. Because pregnancies in women with decision-making disabilities are often not discovered until they are well advanced, obtaining consent under this provision must be a difficult matter raising serious medical and ethical questions at the time when the treatment can be carried out lawfully.

There are also detailed limitations on the Board's power to consent to sterilisation. These are dealt with in Chapter 15 dealing with sterilisation.

12. 5. 3. 3. Treatments that are neither urgent nor prescribed

All medical treatments that are neither urgent nor prescribed and all dental treatments, no matter how significant or how minor in nature, require the consent of the "appropriate authority".

12. 5. 4. Who is the "appropriate authority" to act as substitute decision-maker for medical and dental treatment?

If a person with a mental incapacity cannot consent to their own treatment, consent must be sought from a substitute decision-maker, who can be:

1. their medical agent appointed by them under a medical power of attorney;[110]
2. their enduring guardian appointed by them under an enduring power of guardianship under an appointment that does not exclude the guardian from giving consent to medical and dental treatment;[111]
3. a guardian appointed for them by the Guardianship Board under an order that does not exclude the guardian from giving consent to medical and dental treatment;[112]
4. if there is no medical agent, guardian or enduring guardian, then the following specified relatives can provide consent to medical or dental treatment
    (i) a spouse, including a "putative" spouse;[113]

[108] Ibid. s 61(5).
[109] Ibid. s 61(6).
[110] *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* ss 8(7) and (8) and 8.
[111] *Guardianship and Administration Act 1993 (SA)* Part 3 and s 59(2)(a).
[112] Ibid. s 59(2)(a).

(ii) a parent;
(iii) a brother or sister of or over 18 years;
(iv) a daughter or son of or over 18 years;
(v) a person who acts in loco parentis i.e. the person who provides the main ongoing day to day care and supervision of the person (not being the person who is going to provide the treatment).[114]

5. Where no one is available in the above categories to provide substitute consent, or where there is a dispute or conflict about the treatment, the Guardianship Board can provide consent to medical or dental treatment. This involves an application being made to, and a hearing conducted by, the Board. The application to the Board has to be made by:
   (i) a relative of the mentally incapacitated person; or
   (ii) the doctor, dentist or other health professional proposing to give the treatment; or
   (iii) any other person who the Board is satisfied has a proper interest in the matter.[115]

12. 5. 5. How the list or hierarchy operates.

If a person has appointed a medical agent, they may or may not have been given the authority to deal with the particular kind of treatment for which consent is sought. If they have the authority, they will take precedence as the appropriate authority. If they do not have the authority, then if there is a guardian, they will be the appropriate authority provided their appointment is not limited so as to exclude the guardian from giving consent to medical and dental treatment. If not, then if there is an enduring guardian they will be the appropriate authority unless their appointment excludes them from giving consent to medical and dental treatment or the Guardianship Board revokes their appointment and appoints a guardian for the mentally incapacitated person under an order that does not exclude the guardian from giving consent to medical and dental treatment.[116]

If the mentally incapacitated person does not have either a medical agent or a guardian, then either a relative of the mentally incapacitated person or the Guardianship Board is the appropriate authority. The list of relatives does not operate as a hierarchy so that if there is a spouse they are the appropriate authority to the exclusion of other the other relatives. The practice in South Australia is for consent to be obtained from any relative in the list. However, it should be noted that those in the list are either married to or in a marriage like

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[113] Ibid. ss 3 and 59(2)(b)(i). A "putative" spouse is a person who has been cohabiting as a husband or wife of a member of the opposite sex currently for a continuous period of five years, or for periods amounting to at least five years in the last six years or has been cohabiting with a member of the opposite sex and they are the parents of a child who has been born. See, Family Relationships Act 1975 (SA) s 11.
[114] *Guardianship and Administration Act 1993 (SA)* s 3.
[115] Ibid. s 59(2)(b)(ii).
[116] Ibid. s 26.

relationship with the mentally incapacitated person or are closely related by blood to them.

The *Act* allows for a choice between seeking substitute consent from the relatives or the Board. There will be situations in which it is more appropriate to go to the Board. Two examples show situations in which applying to the Board makes sense. The first is where the mentally incapacitated person or the substitute decision-maker is objecting to the treatment, and this puts the mentally incapacitated person's health or safety at risk. The second is where there is dispute or conflict about the treatment and all reasonable attempts to resolve the dispute have failed.

12. 5. 6. Seeking and obtaining substitute consent to medical and dental treatment – from the appropriate authority other than the Board

While the *Guardianship and Administration Act 1993 (SA)* does not provide any specific criteria for the "appropriate authority" substitute decision-makers to consider and apply when deciding whether or not to consent to medical or dental treatment to be carried out on a mentally incapacitated person, at least two of the principles of the *Act* are relevant. The first principle requires them to consider what, in their opinion, the wishes of the mentally incapacitated person would be in relation to the proposed treatment if they were able to make the decision.[117] However, they are required to do this only when there is reasonably ascertainable evidence upon which to base their opinion. The second principle requires them to seek the present wishes of the mentally incapacitated person about the proposed treatment and to give consideration to those wishes, unless it is not possible or reasonably practicable to do so.[118] While there is an obligation to give consideration to the wishes of the person while they were competent and also now when they are mentally incapacitated, the substitute decision-maker is not bound by those wishes and so can make a decision that is the least restrictive of the mentally incapacitated person's rights and personal autonomy as is consistent with their care and protection, consistent with the fourth principle of the *Act*.[119] However, it is suggested that if the mentally incapacitated person has made an advance directive that is relevant to their current circumstances, the "appropriate authority" as substitute decision-maker, must give effect to that advance directive.

Public Advocate of South Australia has also suggested that the substitute decision-maker should ask the treating doctor to explain the proposed treatment, whether there are any risks with it, what the alternative treatments are, if any, and what are the likely outcomes of the treatment and what are the likely consequences of not undertaking the treatment. The Public Advocate also notes that it is important to consider whether the treatment will be of benefit to the mentally incapacitated person and how it will affect their quality

[117] Ibid. s 5(a).
[118] Ibid. s 5(b).
[119] Ibid. s 5(d).

of life.[120] The Public Advocate's suggestions are consistent with the obligation imposed on any substitute decision-maker operating under the *Act* to apply certain principles.[121]

12. 5. 7. Seeking and obtaining substitute consent to medical and dental treatment – from the Guardianship Board

As already noted, consent of the Board must be obtained before prescribed medical treatment may be carried out on a mentally incapacitated person. Consent to other medical and all dental treatment may be sought from the Board either if there is no other appropriate authority to consider the matter or if there is no medical agent or guardian to act as the appropriate authority and an application is made to the Board rather than to the appropriate relative.

While there are no direct statutory criteria for the Board to apply in dealing with an application made to it, the Board conducts a hearing and applies the principles of the *Act*. These require it to consider what, in its opinion, the wishes of the mentally incapacitated person would be if there was reasonably ascertainable evidence upon which to base such an opinion. They also require the Board to seek and consider the current wishes of the mentally incapacitated person unless it is not possible or reasonably practicable to do so. The decision the Board made in relation to the treatment must be the one that is the least restrictive of the person's rights and personal autonomy that is consistent with their proper care and protection.[122]

12. 5. 8. Objections to treatment

The *Guardianship and Administration Act 1993 (SA)* does not deal with objections by the mentally incapacitated person to the proposed treatment directly, but again, the principles of the Act are relevant here.[123] As already noted, this is a situation in which it is appropriate to make an application to the Board for it, through its ability to take evidence from all relevant sources, the treating doctors, the mentally incapacitated person, their relatives and others, to consider that evidence, is in the best position to make the decision as to whether to consent to the proposed treatment or not. In doing so, the Board must give consideration to what the wishes of the mentally incapacitated person would be if they were not mentally incapacitated, and to their present wishes. The Board's decision in relation to the treatment must be the one that is the least restrictive of the mentally incapacitated person's rights and personal autonomy that is consistent with their proper care and protection.[124] It is suggested that the "appropriate authority" as substitute decision-maker, must give effect to any advance directive that is relevant to their current circumstances made by the mentally incapacitated person when still capable.

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[120] The website for the Office of the Public Advocate in South Australia is: www.opa.sa.gov.au , then go to Consent.
[121] *Guardianship and Administration Act 1993 (SA)* s 5.
[122] Ibid.
[123] Ibid.
[124] Ibid.

12. 6. Victoria

The regime established in Victoria for substitute decision-making in relation to medical and dental treatment on behalf of adults incapable of giving a valid consent to their own treatment commenced on New Years Day 2000.[125] It is based in the New South Wales model and, while there are important similarities, there are significant differences between the two regimes. The definitions of medical and dental treatment are the same as for New South Wales as is the statutory test for incapacity to consent to treatment. The differences include how the "person responsible" hierarchy operates in Victoria and the process for treating without consent if no person responsible can be found. The Victorian regime operates without the need for the intervention of the Guardianship List of the Victorian Civil and Administrative Tribunal (VCAT) or the Supreme Court and, as will be seen, VCAT is called upon to give substitute consent on many fewer occasions than the New South Wales tribunal. Another difference is the role the *Medical Treatment Act 1988 (Vic)* plays in relation to the refusal of treatment by the "agent" for a now incapable person who has appointed an agent under a power of attorney (medical treatment) under the provisions of that Victorian *Act*.[126]

12. 6. 1. Objects of the legislation

The objects of the *Guardianship and Administration Act 1986 (Vic)* not only refer to the regime for substitute consent to medical and dental treatment on behalf of adults incapable of giving a valid consent to their own treatment established by the *Act* but also require substitute decision-makers to exercise their functions in a manner that is the least restrictive of the incapable person's freedom of decision and action as is possible in the circumstances. They are also required to promote the best interests of the incapable person and to give effect to their wishes wherever possible.[127]

12. 6. 2. The test for incapacity to consent to medical or dental treatment

In Victoria, an adult is incapable of giving a valid consent to their own medical or dental treatment if:

1 they are incapable of understanding;
  (a) the general nature of the treatment, or
  (b) the effect of the treatment, or
2 they are incapable of indicating whether or not they consent to the carrying out of the treatment.[128]

12. 6. 3. Medical and dental treatment defined

As in New South Wales, medical treatment is defined in Victoria to mean medical treatment, including any medical or surgical procedure, operation or

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[125] *Guardianship and Administration (Amendment) Act* 1999 (Vic).
[126] *Medical Treatment Act* 1988 (Vic) s 5A and Schedule 2.
[127] *Guardianship and Administration Act 1986 (Vic)* s 4.
[128] Ibid. s 36(2).

examination and any prophylactic, palliative or rehabilitative care, normally carried out by, or under, the supervision of a registered practitioner, while dental treatment is defined as dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a registered practitioner.[129]

12. 6. 4. The types of medical treatment

12. 6. 4. 1. Excluded treatments.

As in New South Wales and Tasmania certain treatments are excluded from the regime in Victoria with the intention that they do not have to be consented to before they are given. They are non-intrusive examinations made for diagnostic purposes including visual examinations of the mouth, throat, nasal cavity, eyes or ears. Also in this group are first-aid medical or dental treatments, and drugs for which a prescription is not required and which is normally self-administered when they are being used for the purpose, and in accordance with the dosage level, recommended in the manufacturer's instructions. Other treatments can be included in this group by being declared in the regulations, but none have been.[130]

These treatments have been excluded largely because they are of such a minor nature or are so linked to day to day living and only carried out when necessary that it was inappropriate for consent to them to have to be sought through the substitute decision-making regime. However, their exclusion was not intended to cut across, or in anyway downplay, the importance of hospitals, aged care facilities, supported residential units, community residential units or other places where care or treatment is provided to people who are incapable of giving a valid consent to their own treatment keeping accurate records of any form of medication or treatment given to a patient or resident or having protocols as to who may permit such treatments to be carried out.

12. 6. 4. 2. Emergency treatment.

In New South Wales and Victoria, these treatments are described as urgent treatments. They are treatments which the doctor or dentist carrying out or supervising the treatment considers to be treatment that is necessary, as a matter of urgency:

> (a) to save the incapable person's life, or
> (b) to prevent serious damage to the incapable person's health, or
> (c) except in the case of special treatment, to prevent the incapable person from suffering or continuing to suffer significant pain or distress.[131]

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[129] *Guardianship and Administration Act 1986 (Vic)* s 3.
[130] Ibid.
[131] Ibid. s 42A.

These treatments may be carried out without consent when they are urgent. However when they are not urgent, the consent of the substitute decision-maker must be sought before they can be given.

12. 6. 4. 3. Special procedures.
Since prior to, but confirmed by the High Court in *Marion's Case*, it has been accepted that the carrying out of some treatments on incapable people must be approved by a court or tribunal before they may be given. In Victoria there are a group of treatments that may be carried out only after VCAT has given its consent. Persons responsible and similar substitute decision-makers cannot give consent to these treatments. These treatments, called "special procedures" in Victoria, are:

1 any procedure that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out;
2 termination of pregnancy;
3 any removal of tissue for the purposes of transplantation to another person; or
4 any other medical or dental treatment that is prescribed by the regulations to be a special procedure.[132]

It is convenient to deal with these procedures here and the special procedural and other requirements that must be complied with before VCAT may give its consent to the carrying out of a special procedure. First, applications for such consent may be made to VCAT only by the person responsible for the incapable person or by a person who, in the opinion of the Tribunal, has a special interest in the affairs of the patient.[133] Who is "person responsible" for an incapable person is described below at 12. 6. 5.

The incapable person the subject of the application is a party to the proceedings.[134] Notice of the application must be given to them or to others on their behalf. VCAT must also give notice of the application and of the hearing to the Public Advocate and any other person whom VCAT considers has a special interest in the affairs of the patient.[135] VCAT must commence to hear the application within 30 days after receiving the application.[136]

VCAT may consent to the carrying out of a special procedure only if it is satisfied that:

1 the person the subject of the application is incapable of giving a valid consent to the proposed treatment,

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[132] Ibid. s 3. Note, no treatments have been prescribed as special treatments in regulations.
[133] Ibid. s 42B(1). Compare the *Guardianship Act 1987 (NSW)* s 44 which provides that any person may make an application to the Guardianship Tribunal for consent to any category of medical treatment.
[134] *Guardianship and Administration Act 1986 (Vic)* s 42B(2).
[135] Ibid. s 42B(3).
[136] Ibid. s 42D.

2 they are not likely to be capable, within a reasonable time, and

3 the special procedure would be in their best interests .[137]

When VCAT is determining whether or not any special procedure is in the best interests of the person the subject of the application, it must take the following matters into account:

1. the wishes of the person the subject of the application, so far as they can be ascertained; and
2. the wishes of any nearest relative or any other family members of the person the subject of the application; and
3. the consequences to the person the subject of the application if the treatment is not carried out; and
4. any alternative treatment available; and
5. the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
6. whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient.[138]

The process VCAT must go through in order to determine the best interests of the person the subject of the application is further complicated by the fact that if that person is likely to be capable, within a reasonable time, of giving consent to the carrying out of the special procedure, and, they object to the relative or another family member (other than their spouse or domestic partner) being involved in decisions concerning the special procedure proposed to be carried out on them, then that relative or family member is taken not to be the nearest relative or a family member of the person the subject of the application. The effect of this provision appears to be that the views of the relative or family member do not have to be considered.

Sterilising treatment for incapable persons is discussed further in Chapter 15.

Applications to consent to special procedures are small in number. A more significant group of treatments are those that are neither excluded nor emergency treatments nor special procedures. They are not given a generic name in Victoria.

12. 6. 4. 4. Treatments other than excluded or emergency treatments or special procedures

Where an adult cannot give a valid consent to the medical or dental treatment proposed for them and that treatment is not one of the excluded treatments or a special procedure and is not a treatment that must be carried out in urgent

[137] Ibid. s 42E.

[138] Ibid. s 38(1). Other matters to be taken into account may be prescribed in the regulations, but none have been.

circumstances so that it becomes an emergency treatment, consent must be sought from a substitute decision-maker. However, as will be described below, it is not always required that substitute consent must be obtained. There are circumstances in which the treatment can be given without consent first having been obtained. However, this matter is better explained after the term for the usual substitute decision-maker the "person responsible" is explained.

12. 6. 5. Who is the substitute decision-maker for medical and dental treatment?

In Victoria, as in New South Wales, the substitute decision-maker for medical and dental treatment for a person who is incapable of giving a valid consent to their own treatment is called their "person responsible". However, as will be shown below, there is a difference between the two States as to how the doctors seeking substitute consent in order to treat an incapable person determine who is person responsible.

In Victoria, the incapable person's "person responsible" is the first person listed who, in the circumstances, is not only reasonably available but also willing and able to make medical and dental treatment decisions on behalf of the incapable person. The list is as follows:

1. An agent - appointed by the patient under enduring power of attorney (medical treatment)[139]
2. A person - appointed by VCAT to make decisions about the proposed treatment;[140]
3. A guardian - appointed by VCAT with health care powers;[141]
4. An enduring guardian - appointed by the incapable person with health care powers;[142]
5. A person - appointed by the incapable person in writing to make decisions about medical and dental treatment including the proposed treatment;[143]
6. The incapable person's spouse or domestic partner;[144]

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[139] Ibid. s 37(1)(a) and *Medical Treatment Act 1988 (Vic)* s 5A.
[140] *Guardianship and Administration Act 1986 (Vic)* s 37(1)(b).
[141] Ibid. s 37(1)(c).
[142] Ibid. s 37(1)(d).
[143] Ibid. s 37(1)(e).
[144] Ibid. s 37(1)(f). "Spouse" means the person to whom the incapable person is married. "Domestic partner" means an adult person to whom the incapable person is not married but with whom the incapable person is in a relationship as a couple where one or each of them provides personal or financial commitment and support of a domestic nature for the material benefit of the other, irrespective of their genders and whether or not they are living under the same roof. But a "domestic partner" does not include a person who provides domestic support and personal care to the person for fee or reward or on behalf of another person or an organisation (including a government or government agency, a body corporate or a charitable or benevolent organisation). See s 3. Both the spouse and the domestic partner must not themselves be under guardianship and must have a close and continuing relationship with the incapable person. See s 37(4).

7. The incapable person's primary carer, including carers in receipt of a Centrelink carer's payment but excluding paid carers or service providers; [145]
8. The incapable person 's nearest relative over the age of 18, meaning, in order of preference:
    (a) son or daughter;
    (b) father or mother;
    (c) brother or sister (including adopted siblings and 'step' siblings);
    (d) grandfather or grandmother;
    (e) grandson or granddaughter;
    (f) uncle or aunt;
    (g) nephew or niece.[146]

12. 6. 6. How the list or hierarchy operates.

If there is an agent and, in the circumstances they are reasonably available and willing and able to make decisions about the incapable person's medical treatment, then they are the person responsible. If there is no agent or in the circumstances they are not reasonably available or are not willing and able to make decisions about the incapable person's medical treatment, then the treating doctor must work their way down the list until they find a person who in the circumstances is reasonably available and is willing and able to make decisions about the incapable person's medical treatment. This means that it is possible, at least in theory, that an incapable person's agent may be called upon to give substitute consent to their medical treatment one day and their niece or nephew may be called up on the next day for the same purpose.

If there is no one in any of the eight stages of the hierarchy, then the incapable person has no person responsible. If this happens and the person needs medical or dental treatment, VCAT may appoint another person as their person responsible or as their guardian.[147] VCAT may appoint a person as guardian of the incapable person either generally or for matters relating to their medical or dental treatment. Also it may vary a guardianship order "to make provision for matters relating to the medical or dental treatment of a patient", including giving the guardian functions in relation to medical and dental treatment that they did not have before.[148] VCAT has a limited role as a substitute decision-maker itself. See 12. 6. 9 below.

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[145] Ibid. s 37(1)(g). The circumstances in which a person is to be regarded as the carer of the incapable person include, but are not limited to, the case where the carer regularly provides domestic services and support to the incapable person or arranges for them to be provided with domestic services and support, other than wholly or substantially on a commercial basis. Where the incapable person is cared for in an institution (such as a hospital, community residential unit, residential care service, supported residential service or State funded residential care service), they are not to be regarded as being in the care of that institution and they remain in the care of the person in whose care they were immediately before being cared for in that institution. See s 37(2) and (3).

[146] Ibid. s 37(1)(h).

[147] Ibid.

[148] *Guardianship and Administration Act 1986 (Vic)* s 42N(6) (a)-(c).

12. 6. 7. Seeking and obtaining substitute consent to medical and dental treatment – from the person responsible

In most cases the incapable person will have lost their capacity to give a valid consent to all or at least most of the medical or dental treatments proposed for them. This will be because the effects of their dementia, brain injury or whole of life intellectual disability and, sometimes, because of their psychiatric condition. In these cases their person responsible will proceed to decide whether or not to consent to the medical or dental treatment proposed for them on their behalf.[149]

In doing so the person responsible must act in the best interests of the incapable person.[150] However, in determining what is in the best interests of the incapable person, the person responsible must take the following matters into account:

1. the wishes of the incapable person, so far as they can be ascertained; and
2. the wishes of any nearest relative or any other family members of the incapable person; and
3. the consequences to the incapable person if the treatment is not carried out; and
4. any alternative treatment available; and
5. the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
6. whether the treatment to be carried out is only to promote and maintain the health and well-being of the incapable person.[151]

The will be a number of situations in which the now incapable person is likely to become capable again in a reasonable time. Examples would include where the person is incapable because they are unconscious as a result of an accident or an anaesthetic and are likely to recover consciousness soon. At other times they may be delirious as a result of an infection or some other cause which will resolve as a result of treatment. They may have an episodic mental illness which responds to medication. In these situations the person responsible may consent to the carrying out of the treatment only if:

1. the incapable person’s treating doctor reasonably believes, and states in writing in the incapable person's clinical records, that a further delay in carrying out the treatment would result in a significant deterioration of the incapable person's condition; and
2. neither the incapable person’s treating doctor nor the person responsible has any reason to believe that the carrying out of the treatment would be against the incapable person 's wishes, and

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[149] Ibid. s 42H(1).
[150] Ibid. s 42H(2).
[151] Ibid. s 38(1). Other matters to be taken into account may be prescribed in the regulations, but none have been.

3. the proposed treatment is not against the wishes of the incapable person.[152]

12. 6. 8. Person responsible may seek advice.

Persons responsible often face difficult decisions when being asked to consent to medical treatment for an incapable person. In Victoria, they may apply VCAT for directions or an advisory opinion on the scope of or the exercise of their authority to consent to medical or dental treatment for the incapable person.[153] Also VCAT may, on its own initiative, direct, or give an advisory opinion to, a person responsible.[154]

After giving notice of the hearing to any person whom VCAT considers has a special interest in the affairs of the person the subject of the application, and after conducting a hearing, VCAT may give any directions or advisory opinion or make any order it considers necessary and communicate that to anyone sent notice of the application.[155]

12. 6. 9. The limited role of VCAT as a substitute decision-maker for medical and dental treatment

As already noted at 12. 6. 4. 3, VCAT is the substitute decision-maker for special procedures. It can become the substitute decision-maker where the incapable person is likely to become capable again in a reasonable time and either their treating doctor or person responsible has reason to believe that the carrying out of the treatment would be against the incapable person's wishes and either of them makes an application to VCAT.[156] VCAT may consent to the carrying out of such treatment if it is satisfied that:

1. the person is incapable of giving consent,
2. further delay in the carrying out of such treatment would result in a significant deterioration of their condition, and
3. the treatment would be in their best interests having regard to their view about the proposed treatment.[157]

VCAT may also become the substitute decision-maker for medical and dental treatment where either the incapable person's doctor or their person responsible had reason to believe that the proposed treatment would be against the incapable person's wishes and either of them makes an application to VCAT.

12. 6. 10. Can persons responsible refuse consent to medical and dental treatment?

This question arises because, if a now incapable person has appointed an agent (and an alternative agent) under the *Medical Treatment Act 1988 (Vic)* or has a

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[152] Ibid. s 42HA(2) and (3).
[153] Ibid. s 42I(1).
[154] Ibid. s 42I(4).
[155] Ibid. s 42I(2) and (3).
[156] *Guardianship and Administration Act 1986 (Vic)* s 42HA(3).
[157] Ibid. s 42HA(6).

guardian, appointed by VCAT, the *Medical Treatment Act 1988 (Vic)* sets out a process to be complied with and limits on the power to refuse if the agent or guardian wished to refuse consent to treatment under that *Act*. The process is that both a doctor and another person have to be satisfied that the agent or guardian has been informed of the nature of the condition sufficiently to make that decision and that they appear to understand that information.[158] The power of the agent or guardian to refuse medical treatment on behalf of the incapable person is limited to where the medical treatment would cause unreasonable distress to the incapable person or where there are reasonable grounds for believing that the incapable person, if competent, and after giving serious consideration to their health and well-being, would consider that the medical treatment was unwarranted.[159]

However, Part 4A of the *Guardianship and Administration Act 1986 (Vic)* sets out a regime for dealing with circumstances in which people who are incapable of giving a valid consent to their own treatment may be given access to medical and dental treatment. The *Medical Treatment Act 1988 (Vic)* states that it does not affect any right of a person under any other law to refuse medical treatment.[160] There is no basis for confining this right to adults exercising their common law right to refuse treatment. It can apply to persons responsible exercising their responsibilities to deal with requests to consent to treatment on behalf of the person they are person responsible for. Also, the *Guardianship and Administration Act 1986 (Vic)* states that, if the person responsible for an incapable person is an agent appointed under the *Medical Treatment Act 1988 (Vic)*, the powers the agent may exercise under that *Act* are in addition to the powers they may exercise under the *Guardianship and Administration Act 1986 (Vic)*.[161]

While this provision does not apply to guardians appointed by VCAT under the *Guardianship and Administration Act 1986 (Vic)*, it would be absurd, and against the purpose of that *Act* to interpret it as operating so that a guardian appointed under its provisions and authorised by VCAT to make substitute decisions in relation to the medical or dental treatment proposed for the person under guardianship to take the view that such guardians could only consent to any treatment proposed by a doctor and never be able to refuse consent to treatment no matter how inappropriate and how unwanted by the person under guardianship.[162]

In any event, the section in *Guardianship and Administration Act 1986 (Vic)* that empowers persons responsible to consent to medical treatment states that in determining whether or not to consent to medical or dental treatment, the

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[158] *Medical Treatment Act 1988 (Vic)* s 5B(1).
[159] Ibid. s 5B(2).
[160] Ibid. s 4(1).
[161] *Guardianship and Administration Act 1986 (Vic)* s 37(5).
[162] *Interpretation of Legislation Act 1984 (Vic)*. For a case in which VCAT appointed joint guardians knowing that they might refuse medical treatment see, *Public Advocate v RCS* [2004] VCAT 1880.

person responsible must act in the best interests of the incapable person.[163] It should also be noted that VCAT when appointing either a person responsible or a guardian authorised to made decisions about medical or dental treatment is appointed for "for matters relating to the medical or dental treatment", not just to consent to such treatment.[164] Consequently, persons responsible, no matter what category they are in, subject to acting in the best interests of the incapable person, may give or refuse consent to the treatment proposed for the person they are person responsible for.

12. 6. 11. Treating when the person responsible refuses consent

There will be cases where a person responsible refuses consent to treatment proposed for the incapable person and the treating doctor considers that the treatment should still be carried out on the incapable person, despite the refusal of their person responsible.

The treating doctor may still carry out the treatment if they believe, on reasonable grounds, that the proposed treatment is in the best interests of the incapable person. However, they must follow a process. They must, within three days after being advised by the person responsible of their refusal, give the person responsible and the Public Advocate a statement asserting that the doctor has informed the person responsible of the nature of the incapable person's condition and believes on reasonable grounds that the proposed treatment is in the best interests of the incapable person. The statement must also advise that the doctor intends carry out the treatment after seven days have elapsed and how the person responsible may make an application to VCAT.[165] The effect of this process is to put the onus on the person responsible to go to VCAT for an order which has the effect of stopping the treatment from being carried out. If the person responsible does not make an application to VCAT within seven days, the doctor may carry out the treatment, but may do so only if the doctor states in writing in the incapable person's clinical record:

1. why the treatment is considered to be in the best interests of the incapable person; and
2. how the treatment is considered to promote or maintain the health and well-being of the incapable person.[166]

If the Tribunal receives an application**,** it will deal with it in the manner set out below, under the next heading 12. 6. 13.

12. 6. 12. Treating without the consent of the person responsible

Some people will not have a person responsible and in some circumstances it will not be possible to make contact with a person responsible for them.

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[163] *Guardianship and Administration Act 1986 (Vic)* s 42H(2).
[164] Ibid. s 42A(6)(a) to (c).
[165] Ibid. s 42M. Section 42M forms may be obtained from the Office of the Public Advocate and downloaded from that Office's website, www.publicadvocate.vic.gov.au.
[166] Ibid. s 42L(3).

However, *Guardianship and Administration Act 1986 (Vic)* provides a process which the treating doctor may use if they believe on reasonable grounds that the proposed treatment is in the best interests of the incapable person.[167] This process cannot be used if either the incapable person or their agent appointed under an enduring power of attorney (medical treatment) has put a refusal of treatment certificate in place in relation to that treatment.[168]

In the majority of cases no such certificate will exist. In those cases the treating doctor (or dentist) has to make reasonable efforts to find out if there is a person responsible and who they are. The treating doctor (or dentist) must then make reasonable efforts to contact them. If they are unable to do this and believe on reasonable grounds that the proposed treatment is in the best interests of the incapable person, they must give a notice to the Public Advocate, called a "Section 42K Notice".[169]

While the Public Advocate requires more information, that notice must include the following:

1. the nature of the incapable person's condition;
2. the proposed medical or dental treatment;
3. that the treating doctor (or dentist) believes on reasonable grounds that the proposed treatment is in the best interests of the incapable person;
4. that despite reasonable efforts by the treating doctor (or dentist), they have been unable to find out whether there is a person responsible for the incapable person or to contact that them.[170]

The treating doctor (or dentist) must also state in writing in the incapable person's clinical records:

1. why the treatment is considered to be in the best interests of the incapable person; and
2. how the treatment is considered to promote or maintain the health and well-being of the incapable person.[171]

Having given the notice, the treating doctor (or dentist) may then carry out the treatment.

12. 6. 13. Applications to VCAT in relation to any matter, question or dispute concerning medical and dental treatment or the best interests of a patient

As already noted, VCAT does not become the substitute decision-maker for medical or dental treatment, except in a limited number of circumstances which are dealt with in 12. 6. 4. 3 and 12. 6. 9. Applications may be made to it in relation to any matter, question or dispute relating to medical or dental

[167] Ibid. s 42M.
[168] Ibid. ss 41 and 42K(1).
[169] Ibid. s 42K(1). For the Section 42K Notice see, www.publicadvocate.vic.gov.au.
[170] Ibid. s 42K(2).
[171] Ibid. s 42K(3).

treatment or to the best interests of an incapable person. However, such applications may be made only by a person responsible or a person who, in the opinion of VCAT, has a special interest in the affairs of the incapable person.[172]

VCAT must give notice of an application, when it is to be heard and of any order of the Tribunal in relation to the application to the Public Advocate and, since the incapable person is a party, to the incapable person, insofar as that is meaningful.[173] If a person responsible makes an application after the treating doctor has given the statement, which is the condition precedent to giving the treatment to the incapable person despite the refusal of the person responsible, VCAT must give notice of an application, when it is to be heard and of any order VCAT makes in relation to it to the doctor who gave the statement; and any other person whom VCAT considers has a special interest in the affairs of the patient.[174]

The person responsible must apply to VCAT within 7 days after receiving the treating doctor's statement and VCAT must hear and determine that application within 7 days after receiving it.[175]

VCAT may make a range of orders. It can:

1. Make a person the person responsible of an incapable person for matters relating to medical or dental treatment, either generally or of a particular kind;
2. appoint a person as guardian of the incapable person with a range of powers or just for matters relating to the medical or dental treatment of the incapable person;
3. vary an existing guardianship order to make provision for matters relating to the medical or dental treatment of the incapable person;
4. revoke, suspend or vary an instrument appointing a person as the enduring guardian to the extent that the instrument relates to medical or dental treatment of the incapable person;
5. make a declaratory order that any proposed medical or dental treatment is or is not in the best interests of the incapable person;
6. make any orders or give any directions it considers necessary to resolve any conflict between persons relating to the best interests of a patient;
7. make a declaration as to the validity or effect of any decision relating to medical or dental treatment;
8. give an advisory opinion in relation to the best interests of the incapable person;
9. make any other orders it considers to be in the best interests of the incapable person.[176]

[172] *Guardianship and Administration Act 1986 (Vic)* s 42N(1) and (2).
[173] Ibid. s 42N(3).
[174] Ibid. s 42N(4).
[175] Ibid. s 42N(5).

12. 6. 14. Objections to treatment

The *Guardianship and Administration Act 1986 (Vic)* deals with objections to the carrying out of treatment on the incapable person in a number of ways.

12. 6. 14. 1. Objection by the person responsible

The objection of the person responsible, manifested by their refusal to consent to the treatment proposed for the incapable person, is dealt with above in 12. 6. 10 and 12. 6. 11. However, if the person responsible makes an application to it, VCAT has a range of options available to it, as set out above in 12. 6. 13. These include VCAT making a declaratory order that the proposed medical or dental treatment is or is not in the best interests of the incapable person, but also any orders or give any directions it considers necessary to resolve any conflict between persons relating to the best interests of a patient.[177]

12. 6. 14. 2. Anticipated objection by the incapable person

If either the treating doctor or the person responsible has reason to believe that the carrying out of the proposed treatment would be against the incapable person's wishes, the doctor or person responsible must apply to VCAT for its consent if they want the treatment carried out.[178]

If either of them makes an application to VCAT, it must give notice of the application to the the incapable person, if appropriate, the Public Advocate, the incapable person's treating doctor, the incapable person's person responsible and any other person whom VCAT considers has a special interest in the incapable person's affairs. VCAT must start hearing the application within 14 days after receiving it.

After hearing the application, VCAT may consent to the carrying out of the proposed treatment, but only if it is satisfied that:

1. the person the application is about is incapable of giving consent; and
2. further delay in carrying out the treatment would result in a significant deterioration of the incapable person's condition; and
3. the treatment would be in their best interests, having regard to the evidence of the their views about such treatment.[179]

In addition, VCAT may make any of the orders set out above in 12. 6. 13.[180] Any orders VCAT makes must be given to those given notice of the application. If VCAT gives any direction or advisory opinion about the application that too must be given to the parties to the application.[181]

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[176] Ibid. s 42N(6).
[177] S 42N.
[178] Ibid. s 42HA(3)-(6).
[179] Ibid. s 42HA(4).
[180] Ibid. s 42N.
[181] Ibid. ss 42HA(4) and 42N(4).

12. 7. Queensland

The Queensland regime for substitute decision-making in relation to medical and dental treatment on behalf of adults incapable of giving a valid consent to their own treatment commenced on 1 July 2000 with the commencement of the *Guardianship and Administration Act 2000 (Qld).* Most aspects of the regime are found in Chapter 5 of that *Act*, but the *Powers of Attorney Act 1998 (Qld)* sets out the responsibilities of attorneys for personal matters and its Chapter 4 deals with statutory health attorneys.

While substitute decision-makers for medical and dental treatment are called persons responsible in New South Wales, Victoria and Tasmania, in Queensland, if the incapable person has no guardian or attorney for health matters, their substitute decision-makers for medical and dental treatment are called statutory health attorneys. However, as will be seen, statutory health attorneys in Queensland have more functions than persons responsible in the other States.[182]

12. 7. 1. Objects of the legislation

The *Guardianship and Administration Act 2000 (Qld)* seeks to strike an appropriate balance between the right of an incapable adult, called an adult with impaired capacity in Queensland, to have autonomy in decision making the greatest possible degree and their right to adequate and appropriate support for decision-making.[183]

Chapter 6 seeks to strike a balance between ensuring that a person is not deprived of necessary health care only because they are an adult with impaired capacity while ensuring that the health care that they are given is necessary and appropriate to maintain or promote their health or wellbeing or is, in all the circumstances, health care that is in their best interests.[184]

12. 7. 2. The test for incapacity to consent to medical or dental treatment

The Queensland legislation reflects strongly the common law presumption that an adult has capacity to make their own decisions. It requires treating doctors and dentists to consider whether or not a person has capacity to make a particular decision about a particular health matter or special health matter.[185] A person has impaired capacity for such a matter if they are:

1. incapable of understanding the nature and effect of decisions about the matter; or
2. cannot freely and voluntarily make decisions about the matter; or
3. cannot communicate their decisions in some way.[186]

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[182] See 12. 6. 5 and 12. 6. 7.
[183] *Guardianship and Administration Act 2000 (Qld)* s 6.
[184] Ibid. s 61.
[185] The term "health matter" is described in Schedule 2 ss 4 and 5 and "special health matter" in Schedule 2 ss 6 to 10 of the *Guardianship and Administration Act 2000 (Qld).*
[186] *Guardianship and Administration Act 2000 (Qld)* Schedule 4. For examples the test for capacity in action see, *Re IM* [2003] QGAAT 16, *Re L* [2005] QGAAT 13 and *Re MHE* [2006] QGAAT 9.

12. 7. 3. Health care defined

In Queensland the description of matters covered by the regime designed primarily to provide substitute decision-making for medical and dental treatment proposed for adults unable to give a valid consent to their own treatment is broader than elsewhere in Australia. The substitute decision-making relates to "matters relating to health care". Health care is described as, care or treatment of, or a service or a procedure for an adult:

1. to diagnose, maintain, or treat the adult's physical or mental condition; and
2. carried out by, or under the direction or supervision of, a health provider.[187]

Health care also includes withholding or withdrawal of a life-sustaining measure if the commencement or continuation of the measure would be inconsistent with good medical practice.[188]

The term "health provider" is defined to mean a person who provides health care, or special health care, in the practice of a profession or the ordinary course of business.[189] This definition covers doctors and dentists and other recognised health professionals including, psychologists, physiotherapists, optometrists, speech therapists and occupational therapists. While there has been no decided case on this as yet, because the definition of health provider includes those who provide health care in the ordinary course of business the term may include herbalists, particularly those qualified in Chinese medicine, counsellors and a range of others who run businesses offering to diagnose, maintain or treat physical or mental conditions.

All treatments that are not categorised as excluded or special health care are "health care".[190]

12. 7. 4. The types of health care

12. 7. 4. 1. Excluded health care.

As elsewhere in Australia, in Queensland a number of treatments are not included in the definition of health care with the intention that substitute consent in relation to them is not required. These treatments are:

1. first aid treatment;
2. non-intrusive examinations made for diagnostic purposes. For example a visual examination of an adult's mouth, throat, nasal cavity, eyes or ears.; or

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[187] Ibid. Schedule 2, s 5(1).
[188] Ibid. ss 5(2) and 5A. The Queensland law relating to care and treatment at the end of life is discussed in Chapter 14.
[189] Ibid. Schedule 4.
[190] Ibid. Schedule 2, ss 5 and 7.

3. the administration of a pharmaceutical drug which is normally self-administered and for which a prescription is not needed, provided the administration is for a recommended purpose and at a recommended dosage level.[191]

These types of health care have been excluded largely because they are of such a minor nature or are so linked to day to day living that they are carried out only when necessary that it is inappropriate for consent to them to have to be sought through the substitute decision-making regime. However, this exclusion is not intended to cut across, or in anyway downplay, the importance of hospitals, aged care facilities or other places where personal care and health care is provided to adults with impaired capacity, keeping accurate records of any form of health care given to a patient or resident or having protocols as to who may permit such treatments to be carried out.

12. 7. 4. 2. Urgent health care – substitute consent usually not required
Health care, but not special health care, may be carried out on an adult without their consent if their health provider reasonably considers they have impaired capacity for the health matter concerned; and either:

1. the health care should be carried out urgently to meet imminent risk to the adult's life or health; or
2. the health care should be carried out urgently to prevent significant pain or distress to the adult

and it is not reasonably practicable to get consent from their attorney for health matters or their guardian for health matters (if they have one) or their statutory health attorney.[192]

However, health care to deal with imminent risk to the adult's life or health may not be carried without consent if the health provider knows that the adult has objected to the health care proposed in an advance health directive.[193]

Health care to prevent significant pain or distress to the adult may not be carried out without consent if the health provider knows that the adult objects to the health care. However, if the adult has minimal or no understanding of what the health care involves or why it is required, and the health care is likely to cause either no distress to the adult or temporary distress that is outweighed by the benefit of the health care to them, then the health care can be carried out.[194]

[191] Ibid. Schedule 2, s 5(3).
[192] Ibid. s 63(1).
[193] Ibid. s 63(2).
[194] Ibid. s 63(3).

If the health care is carried out, the health provider must certify in the adult's clinical records as to the various things enabling it to be carried out because of this section.[195]

12. 7. 4. 3. Minor, uncontroversial health care – substitute consent usually not required

Proposed health care, that is not special health care but which is minor and uncontroversial, may be carried out without consent on an adult with impaired capacity if their health provider reasonably considers that:

1. the adult cannot make a valid decision about the health matter concerned; and
2. the health care that is necessary and is of the type that will best promote the adult's health and wellbeing.[196]

Also, the health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out.[197]

Nevertheless, such treatment cannot be carried out if the health provider knows (or could reasonably be expected to know) that the guardian or attorney for health matters of the adult with impaired capacity has made a decision about the health care in question or knows that there is a dispute among those who have a sufficient and continuing interest in the adult about the carrying out of the health care or about the capacity of the adult to make their own decision about the health care.[198]

Furthermore the health care cannot be carried out without consent if the health provider knows (or could reasonably be expected to know) that the adult objects to the health care.[199]

12. 7. 4. 4. Special health care

Special health care has been defined as:

1. removal of tissue from the adult while alive for donation to someone else;
2. sterilisation of the adult;
3. termination of a pregnancy of the adult;
4. participation by the adult in special medical research or experimental health care;
5. electroconvulsive therapy or psychosurgery for the adult;
6. prescribed special health care of the adult.[200]

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[195] Ibid. s 63(4).
[196] Ibid. s 64(1)(a) and (b).
[197] Ibid. s 64(3).
[198] Ibid. s 64(1)(c).
[199] Ibid. s 64(2).
[200] Ibid. Schedule 2, ss 7 to 10. There has been no special health care prescribed under Schedule 2, s 7.

12. 7. 5. Who is the substitute decision-maker for health care?

The issue of consent to special health matters is dealt with below. For other health matters there is an order of priority starting with the any advance health directive made by the adult with impaired capacity. If they have given a direction that covers the particular health matter in an advance directive then the question of consent is decided according to the direction.[201] Advance health directives will become more common as time goes on, particularly for older people.

If the adult with impaired capacity has not made an advance health directive, the substitute decision-maker for the adult will be the first person who qualifies in the following list:

1. any guardian for health matters appointed by the Queensland Civil and Administrative Tribunal (QCAT);
2. any enduring attorney for health matters appointed by the adult;
3. the first available and culturally appropriate statutory health attorney from the list below.[202]

The list of statutory health attorneys is as follows:

1. a spouse of the adult if the relationship between the adult and the spouse is close and continuing[203];
2. an adult person who has the care of the adult and is not a paid carer for the adult;[204]
3. an adult person is a close friend or relation of the adult and is not a paid carer for the adult.[205]

If no-one in this list is readily available and culturally appropriate, the Adult Guardian becomes the adult's statutory health attorney for the particular health matter.[206]

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[201] Ibid. s 66(2).
[202] Ibid. s 66(3) to (5).
[203] *Acts Interpretation Act 1954 (Qld)* ss 32DA and 36 define "spouse" to include a "de facto partner". De facto partners can be of the opposite or the same sex. The criteria for determining whether or not people are de facto partners are set out in s 32DA(2) of that *Act*.
[204] *Powers of Attorney Act 1998 (Qld)* s 63(1)(b). A person has the care of an adult if they provide domestic services and support to the adult or arrange for the adult to be provided with domestic services and support. Note also that where an adult resides in an institution (for example, a hospital, aged care facility home, group home, boarding-house or hostel) and is cared for there, they are not to be regarded as being in the care of that institution but remain in the care of the person in whose care they were immediately before residing in the institution. See, *Powers of Attorney Act 1998 (Qld)* s 64(3) and (4). See also *Re L* [2005] QGAAT 9 in which the then Guardianship and Administration Tribunal held that the Director of Mental Health could not be recognised as a carer under *Guardianship and Administration Act 2000 (Qld)* s 63(4).
[205] *Powers of Attorney Act 1998 (Qld)* s 63(1). A close friend, of an adult with impaired capacity, means another person who has a close personal relationship with the adult with impaired capacity and a personal interest in their welfare. See, *Guardianship and Administration Act 2000 (Qld)*, Schedule 4.
[206] Ibid. s 63(2).

If there is a disagreement as to which of two or more people should be the statutory health attorney or how that power should be exercised, this can be referred to the Adult Guardian for resolution by way of mediation.[207]

Even though they come down the list, in most cases the substitute decision-maker for the adult with impaired capacity will be their spouse, their unpaid carer or a close friend or relation. This responsibility comes to them not because they have been appointed the person's guardian for health matters by QCATor their attorney for health matters by the now incapacitated person, but because of the operation of both the *Powers of Attorney Act 1998 (Qld)* and the *Guardianship and Administration Act 2000 (Qld)* which gives them the role of statutory health attorney.[208] They do not have to be appointed or approved by QCAT or the Supreme Court.

Anyone authorised to be a substitute decision-maker for the health matters under the *Guardianship and Administration Act 2000 (Qld)* to make substitute decisions in relation to health matters for an adult with impaired capacity must do so in accordance with both the general principles and the health care principle set out in that *Act*.[209] The health care principle requires that substitute decision-makers make their decisions:

1. in the way least restrictive of the adult's rights; and
2. only if the decision is necessary and appropriate to maintain or promote the adult's health or wellbeing; or is, in all the circumstances, in the adult's best interests.

When making a health care decision, the substitute decision-maker, namely the guardian, the adult guardian, QCAT or, in relation to special health care only, another entity, must, to the greatest extent practicable:

1. seek the adult's views and wishes and take them into account; and
2. take into account the information given by the adult's health provider.[210]

The health care principle states that it does not affect any right an adult has to refuse health care.[211]

12. 7. 6. Who is the substitute decision-maker for special health care?

As with other health matters, for special health matters there is an order of priority. It too starts with the any advance health directive made by the adult with impaired capacity. If they have given a direction in their advance directive

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[207] *Guardianship and Administration Act 2000 (Qld)* s 42.
[208] Powers of Attorney Act *1998 (Qld)* ss 62 and 63 and Schedule 3 and *Guardianship and Administration Act 2000 (Qld)* s 66.
[209] *Guardianship and Administration Act 2000 (Qld)* Schedule 1.
[210] Ibid. Schedule 1, s 12. The adult's views and wishes may be expressed orally or in writing, in an advance health directive or in another way, including, by conduct.
[211] Ibid. s 12(4).

that covers the particular special health matter then the question of consent is decided according to the direction.[212]

Because of the nature of the different kinds of special health care and the adults with impaired capacity for whom special health care is sought, it is unlikely that an adult whose capacity becomes impaired will have made an advance health directive which covers special health care. Consequently, it is more likely that a body authorised to act as the substitute decision-maker for special health care will be called upon to deal with the matter. Those bodies are QCAT and the Supreme Court.[213]

12. 7. 7. Seeking and obtaining substitute consent to health care – from the guardian, attorney or statutory health attorney

No substitute consent is needed for either health care excluded from the operation of Chapter 5 of the *Guardianship and Administration Act 2000 (Qld)* or for urgent health care, except under the limited circumstances set out above at 12. 7. 4. 2.

Also, consent is not required for minor, uncontroversial health care, again except under the limited circumstances set out above at 12. 7. 4. 3. Nevertheless, it is both ethically appropriate and useful in building rapport with the substitute decision-makers, family members or significant others of an adult with impaired capacity to seek consent for that health care from the appropriate substitute decision-maker whenever it is convenient to do so. If it is not possible to seek consent in advance of the treatment, it is wise to advise the substitute decision-maker of the more significant of such minor treatments that have been given, for example the administration of prescription antibiotics.

The *Guardianship and Administration Act 2000 (Qld)* creates an expectation on health providers to give to the guardian or attorney all the information necessary for them to exercise their power in relation to a health matter.[214] The *Act* also imposes a duty on health providers to give that information to the guardian or attorney unless the health provider has a reasonable excuse for not doing so.[215] The definition of "attorney" includes statutory health attorneys.[216] The definition of "guardian" includes the Adult Guardian.[217]

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[212] *Guardianship and Administration Act 2000 (Qld)* s 65(2).

[213] The Tribunal's authority comes from the *Guardianship and Administration Act 2000 (Qld)* s 65(4). The Supreme Court's authority arises from its parens patriae jurisdiction and the operation of s 65(3) of the same *Act*.

[214] *Guardianship and Administration Act* 2000 (Qld) s 76(1).

[215] Ibid. s 76(2).

[216] The *Powers of Attorney Act 1998 (Qld)* s 6A provides that that *Act* and the *Guardianship and Administration Act 2000 (Qld)* are to be read together. The definition of "attorney" in the *Powers of Attorney Act 1998 (Qld)* includes statutory health attorneys, see Schedule 3. Consequently, they are attorneys for the purposes the *Guardianship and Administration Act 2000 (Qld)* s 76.

[217] The term "guardian" means a guardian appointed under the *Guardianship and Administration Act 2000 (Qld)*. The Adult Guardian is appointed under s 199 of that *Act*. See, *Guardianship and Administration Act 2000 (Qld)*, Schedule 4.

The information which the health provider who is treating or has treated the adult with impaired capacity must give to the guardian or attorney includes information about the:

1. nature of the adult's condition at the time of the treatment; and
2. particular form of health care being, or that was, carried out; and
3. reasons why the particular form of health care is being, or was, carried out; and
4. alternative forms of health care available for the condition at the time of the treatment; and
5. general nature and effect of each form of health care at the time of the treatment; and
6. nature and extent of short-term, or long-term, significant risks associated with each form of health care; and
7. for a health provider who is treating the adult - the reasons why it is proposed a particular form of health care should be carried out.[218]

12. 7. 8. The role of QCAAT in relation to special health care and health care
QCAT is substitute decision-maker in relation to:

1. special health care for adults with impaired capacity for the special health matter, but not electroconvulsive therapy and psychosurgery;[219] and
2. consenting to the sterilisation of a child with an impairment.[220]

If QCAT consents to a form of special health care that needs to be continued, it may appoint a guardian for the adult and empower them to consent for the adult to continuation of the special health care or the carrying out on the adult of similar special health care. QCAT may also include in the appointment order a declaration, order, direction, recommendation, or advice about how the power is to be used.[221]

QCAT has other functions that can be useful in dealing with issues and problems arising in relation to health matters. These include:

1. making declarations about the capacity of an adult, guardian or attorney;
2. making declarations, orders or recommendations, or giving directions or advice, in relation to guardians and attorneys, enduring documents and related matters;[222]

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[218] *Guardianship and Administration Act* 2000 (Qld) s 76(4).
[219] Ibid. ss 63-68 and 82(1)(g).
[220] Ibid. ss 80A – 80Q and 82(1)(h).
[221] Ibid. s 74.
[222] Ibid. s 82(1)(a) and (d). S 82(3) specifically provides that in this section “attorney” includes both attorneys under enduring documents and statutory health attorneys.

3. consenting to the withholding or withdrawal of a life-sustaining measure for adults with impaired capacity for the health matter concerned.[223]

QCAT's role in relation to consenting to specific treatments is limited to treatments categorised as special health care and treatments involving the consenting to the withholding or withdrawal of a life-sustaining measure for adults with impaired capacity for the health matter concerned.

12. 7. 9. Objections to health care

In Queensland objections to treatment by the adult with impaired capacity or by their guardian, attorney or statutory health attorney are dealt with in different ways.

12. 7. 9. 1. Objections by the adult with impaired capacity

The *Guardianship and Administration Act 2000 (Qld)* states that generally substitute consent for a health matter or special health matter is ineffective if the health provider knows, or ought reasonably to know, the adult with impaired capacity objects to the health care.[224] However, the *Act* goes on to provide that the consent is effective, despite the objection:

1. if the adult has minimal or no understanding of what the health care involves and why it is required, and
2. the health care is likely to cause the adult either no distress or only temporary distress that is outweighed by the benefit of the proposed health care.[225]

As the Queensland Law Reform Commission's report upon which the *Act* is based shows, this provision was based on the New South Wales legislation which allows a person who cannot give a valid consent (or refusal) to their own medical or dental treatment to "object" nevertheless to the treatment.[226] However, while the New South Wales Guardianship Tribunal deals with these "objections" and decides whether or not to give its consent to the proposed treatment thereby overriding the objection of the incapable person, a different approach has been taken in Queensland.

In *Re CJ*, the then Queensland Guardianship and Administration Tribunal held that what is required before a person may object validly to health care "is not simply an ability to technically know what the procedure involves and what it is used for but an ability to understand the true nature and effect of a decision"

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[223] Ibid. s 82(f). This matter is dealt with in more detail in Chapter 16. 4. 3.
[224] Ibid. s 67(1).
[225] Ibid. s 67(2). Note that this provision does not apply to special health care involving removal of tissue for donation and participation in special medical research or experimental health care or approved clinical research. See s 67(3).
[226] Queensland Law Reform Commission, Report No 49, June 1996, 361-362. *Guardianship Act* 1987 (NSW) ss 33(3) and 46(1)(a). See 12. 3. 1. 10.

in a health matter.[227] In that case a person with a more than 20 year history of paranoid schizophrenia was held to have no understanding of the nature and effect of the decisions she was making because she consistently stated that she did not have a mental illness and that she did not have a physical illness, namely diabetes. This satisfied the Tribunal that she had no understanding of the proposed health care or why it was required, because she refused to accept the fact that she had any illnesses.[228] The Tribunal was also satisfied that the proposed health care would cause either no distress or minimal distress because it involved medication being supplied by a tablet form and the monitoring of CJ's diabetes via testing for her sugar levels. In addition, the medication and monitoring of her sugar diabetes would provide benefits which far outweighed the minimal distress that the treatment would cause her.[229]

The way to deal with the objection in these circumstances is to make an application to QCAT for a declaration about the capacity of the adult and other orders, including appointing guardians and obtaining directions or advice from QCAT if appropriate.[230]

As already noted, QCAT does not have jurisdiction to deal directly with applications for consent to health care, except for forms of special health care, while the New South Wales Guardianship Tribunal does have such a role and can and does occasionally override the objections to treatment of incapable people. This absence of a formal mechanism for giving appropriate consideration to the person's objection but yet being able to override it and give an effective consent to the proposed health care in appropriate cases may have contributed to the interpretation given to the relevant provision in Queensland.[231] However, QCAT may give directions to guardians and attorneys, including statutory health attorneys.[232]

There are specific provisions in the *Guardianship and Administration Act 2000 (Qld)* dealing with the objections of an adult with impaired capacity to urgent health care and minor, uncontroversial health care.

If the objection by the adult with impaired capacity is to urgent health care that the adult's health provider reasonably considers should be carried out urgently to meet imminent risk to the adult's life, and the objection to the treatment is in the adult's advance directive, then the treatment may not be carried out without consent.[233] However, as a direction in an advance directive to withhold or

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[227] [2006] QGAAT 11, [35].
[228] Ibid. [38].
[229] Ibid. [42].
[230] See *Re CJ* [2006] QGAAT 11.

[231] So might the impact of the common law. See *Re Bridges* [2000] QSC 188, [2001] Qd R 574 and *Re CJ* [2006] QGAAT 11.
[232] *Guardianship and Administration Act 2000 (Qld)* s 82(1)(d).
[233] Ibid. s 63(1) and (2). The complexity of this matter is further discussed in Chapter 14. 4. 3.

withdraw a life-sustaining measure applies only in certain circumstances, despite the maker's wishes, it may still be legal for the treatment to be carried out.[234] Nevertheless the adult's health provider may withhold or withdraw a life-sustaining measure if that is consistent with good medical practice, the decision must be taken immediately and the adult does not object to the withholding or withdrawal.[235] In such circumstances, the treating doctors should only give the treatment if it is consistent with good medical practice to do so and the treatment is not excessively burdensome, intrusive or futile.

If the adult's health provider reasonably considers that certain health care should be carried out urgently to prevent significant pain or distress to the adult, but the adult objects to that treatment and it is not reasonably practicable to get consent from their guardian, attorney or statutory health attorney, then the treatment may be carried out if the adult has minimal or no understanding of what the health care involves or why it is required, and the health care is likely to cause either no distress to the adult or temporary distress that is outweighed by the benefit of the health care to them.[236]

It should be noted that when an adult makes an advance health directive, they can anticipate the possibility of them objecting to future health care and give a direction consenting to particular future health care being given in specified circumstances despite their objection at that future time.[237]

As already noted, minor, uncontroversial health care cannot be carried out without consent if the health provider knows (or could reasonably be expected to know) that the adult objects to the health care.[238] Substitute consent for the health care must be obtained.

Finally in relation to a person objecting to being given particular medical or dental treatment, the *Guardianship and Administration Act 2000 (Qld)* specifically provides that a health provider or any person acting under their direction or supervision may use the minimum force that is both necessary and reasonable to carry out health care authorised under the *Act*.[239] The predecessor of QCAT, the Queensland Guardianship and Administration Tribunal has interpreted this provision to mean that only health providers or those acting under their direction or supervision may use force to carry out health care and that guardians, including the Adult Guardian, or others acting under their direction or supervision cannot use force for this purpose.[240]

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[234] *Powers of Attorney Act 1998 (Qld)* s 36(2).
[235] *Guardianship and Administration Act 2000 (Qld)* s 63A.
[236] *Guardianship and Administration Act 2000 (Qld)* s 63(3). The question of the adult's understanding of the proposed health care or why it was required would be determined according to the principles in *Re CJ* [2006] QGAAT 11.
[237] *Guardianship and Administration Act 2000 (Qld)* s 35(2).
[238] Ibid. s 64(2).
[239] Ibid. s 75.
[240] *Re CJ* [2006] QGAAT 11.

12. 7. 9. 2. Objections in the form of disagreements between guardians or attorneys

The *Guardianship and Administration Act 2000 (Qld)* specifically addresses disagreements between guardians or attorneys, where more than one has been appointed, or between two or more eligible statutory health attorneys about health matters for an adult with impaired capacity. The *Act* provides for the Adult Guardian to attempt mediation. If the disagreement cannot be resolved by mediation, the Adult Guardian can make the decision about the health matter and then advise QCAT.[241]

If the guardian, appointed attorney or statutory health attorney either makes or refuses to make a decision about a health matter, and their action is contrary to the health care principle, the Adult Guardian make the decision in relation to the health matter, in accordance with the health care principle.[242]

12. 8. Western Australia

As from 15 February 2010, Western Australia has had comprehensive regime for substitute decision-making in relation to the medical and dental treatment of those unable to give a valid consent to their own treatment.[243] That regime imported the concept of "person responsible" from New South Wales and Tasmania and the hierarchy of persons responsible, called the "order of priority" in Western Australia, is similar to, but not identical with, the hierarchy in New South Wales. This matter is dealt with in 12. 8. 4 below.

However, the first question that arises when a person cannot give a valid consent to their own treatment is, do they have an advance health directive? If so the next question is whether that advance health directive, on a sensible reading of it, contains a treatment decision relevant to the treatment proposed for that person. If so, the treatment provided to that person must be decided according to that treatment decision.[244] If the person needs treatment urgently, it may not be practical to check on whether the person has an advance health directive.[245]

However, this new regime does not replace the parens patriae jurisdiction of the Supreme Court of WA as the *Guardianship and Administration Act 1990 (WA)* makes clear.[246]

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[241] *Guardianship and Administration Act 2000 (Qld)* s 42.

[242] Ibid. s 43. The health care principle is set out in the *Guardianship and Administration Act 2000 (Qld)*, Schedule 1, s 12. It is outlined at above at 12. 7. 5.

[243] Parts 9C and 9D of the *Guardianship and Administration Act 1990 (WA)*.

[244] Ibid. s 110ZJ(1).

[245] This and other matters are taken up in 12. 8. 3. 1 below.

[246] *Guardianship and Administration Act 1990 (WA)* s 3A. This was an issue before s 3A was added to the *Act*. See *BCB* [2002] WAGAB 1, [46] and *Re BCB, Application for Guardianship Order* [2002] SR (NSW) 338. As to the parens patriae jurisdiction of the Supreme Court of WA see, *Minister for Health V AS* [2004] WASC 286.

12. 8. 1. Medical and dental treatment defined

The term "treatment" is defined as medical or surgical treatment, including both a life sustaining measure and palliative care. Treatment is also defined to mean dental treatment or other health care.[247] A treatment decision is defined to mean a decision to give or to refuse consent to the commencement or continuation of any treatment.[248]

It is suggested that this definition of treatment is consistent with the broad view of what is included in medical treatment taken by WASAT and its predecessor, the Guardianship and Administration Board. In the *BTO Case*, a Full Board of the Guardianship and Administration Board stated that it considered that the concept of treatment included not only medical or surgical procedures designed actively to treat a person's illness or condition, but also the provision of care in the form of oversight of a person's condition and medical advice as to by what measures it may best be managed, the prescription of courses of medication and the like. [249]

In the *BTO Case*, the Full Board then went on to include decisions about the provision and withdrawal artificial hydration and nutrition in medical treatment in the following terms:

> Medical care, flowing from such oversight and medical advice, may also involve advice concerning the appropriateness of withdrawal of particular measures of treatment or care or the effect of not providing certain forms of treatment or care that may be available, including those by which a person is non-naturally hydrated or nourished, as well as the act of withdrawing such forms of medical treatment or care.[250]

Those matters are now covered by the term "palliative care" in the definition of treatment, as other aspects of palliative care also are.

The Full Board's broad view of the concept of treatment led it to suggest that whether certain actions or acts were "treatments" depended on the circumstances of each case and must be decided on a case by case basis.[251] In this regard the Full Board considered whether the use of physical and chemical restraints in a nursing home could constitute treatment under the section. The Full Board took the view that whether or not a particular form of physical or chemical restraint would fall within the definition of treatment would depend

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[247] *Guardianship and Administration Act 1990 (WA)* s 3.
[248] Ibid. s 3(1).
[249] *BTO* [2004] WAGAB 2 [39]. WASAT continued in that view, see *ADP* [2005] WASAT 131 [24] and *AB* [2005] WASAT 303 [50].
[250] *BTO* [2004] WAGAB 2 [39].
[251] Ibid. [36].

on the reasons for its use, the purposes to which it might be put and who prescribed its use.[252]

In *ADP*, WASAT saw the use of olanzapine in the circumstances of that case as both a chemical restraint and a treatment and appointed a guardian with authority to give consent to both treatment and the use of chemical and physical restraint.[253]

In *SJ and MET*, WASAT had to deal with a situation in which it was proposed that treatment to achieve "massive weight loss either through wiring her jaws or stomach stapling and feeding a liquid diet under medical supervision" on a woman with an intellectual impairment and behavioural problems. There were doubts about whether this treatment should be carried out on her and a "palliative care program" was suggested as an alternative treatment.[254] WASAT made a distinction between those actions relating to the proposed treatment that were physical and chemical restraints and those that were treatment. Its reasons for decision state:

> While we accept that restraint of [MET] to facilitate her treatment may be in her best interests, given the evidence before us, we do not see it forming part of the treatment provided. The use of a 24 hour guard, the suggested use of restraints on the hands of the represented person, and medication to manage her behaviour used in the past are or would be attempts to control the voluntary movements of the represented person, albeit for the purposes of delivering health care which she needs and are therefore in our view restraints. It is not appropriate that such restraints be seen as an incident of treatment itself. In the case of the guard placed on the room of the represented person we conclude that this is clearly a restraint on her movement and not part of treatment.
>
> The distinction between treatment and restraint to facilitate the delivery of that treatment is an important safeguard for [MET]. There is an obligation on the guardians, and those treating [her], to use the least restrictive possible means by which treatment may be delivered to her. Strategies to facilitate treatment may include the use of behaviour management programs, while she remains in hospital, or …the use of medication to manage her distress and agitation.[255]

WASAT appointed MET's parents as her joint, limited guardians in order for the treatment restraining her and restricting her diet to be carried out.[256]

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[252] *BCB* [2002] WAGAB 1, *Re BCB; Application for a Guardianship Order* [2002] SR (WA) 338.
[253] *ADP* [2005] WASAT 131.
[254] *SJ and MET* [2006] WASAT 210 [16].
[255] Ibid. [36] and [37].
[256] Ibid. [39] and [40].

While WASAT considered that psychiatric treatment was treatment for the purposes of the *Guardianship and Administration Act 1990 (WA)*, it was aware of the policy concerns about the appropriate relationship between that *Act* and the *Mental Health Act 1996 (WA)*.[257] WASAT was also aware that it is sometimes difficult to determine whether the medications being administered to an incapable person constitute an attempt to modify their behaviour or whether they are treatments for a psychiatric condition.[258]

In relation to contraceptive treatment, the Full Board noted that an earlier Full Board:

> had no hesitation in saying the definition of treatment in the *Act* was "broad enough to encompass" the proposed administration of contraception to a female person who did not have the capacity herself to consent to it.[259]

It may be implied from the *Guardianship and Administration Act 1990 (WA)* that sterilsation of a person is treatment for the purposes of the *Act*, but that a "person responsible" may not consent to that treatment.[260] Sterilisation is dealt with under Part 5, Division 3 of the *Act*. It is also dealt with in Chapter 15.

12. 8. 2. The test for incapacity to consent to medical or dental treatment

If a patient, that is a person who needs treatment, is unable to make reasonable judgments relating to any treatment proposed for them, their "person responsible" may make the treatment decision for them, subject to certain exceptions as to the nature of the treatment and other matters discussed below.

12. 8. 3. The types of treatment

The *Guardianship and Administration Act 1990* (WA) does not differentiate between major and minor medical treatment for the purposes of substitute consent by a person responsible as the NSW legislation does. However, it provides specifically for urgently needed treatment and sterilisation treatment.

12. 8. 3. 1. Urgent treatment.

Urgent treatment includes both medical and dental treatment as well as any other treatment as defined in s 3 of the *Act*. It also includes those treatments described as medical treatments in 12.8. 1 above that is urgently needed by a patient to:

1. save their life;
2. prevent serious damage to their health; or

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[257] *MW* [2005] WASAT 205 [55]. See also *AB* [2005] WASAT 303 [54]-[55].
[258] Ibid. [56].
[259] *BTO* [2004] WAGAB 2 [37] referring to *Re MC; Review of Guardianship Order* (unreported Full Board, 7 May 2004 (Mrs P Eldred, Deputy President, Dr A McCutcheon and Ms F Child, Members)) 7.
[260] *Guardianship and Administration Act 1990* (WA) s 110ZD (7).

3. prevent them from suffering or continuing to suffer significant pain or distress.[261]

However, urgent treatment does not include sterilisation of the patient.[262]

If a patient, unable to make reasonable judgments about that treatment, needs urgent treatment and:

1. it is not practicable for the health professional[263] who proposes to provide the treatment to determine whether the patient has an advance care directive containing a treatment decision inconsistent with providing the treatment, and

2. it is not possible for them to obtain a treatment decision from the patient's tribunal appointed guardian, enduring guardian or person responsible,

the health professional may provide the treatment without first obtaining consent to do so from a substitute decision-maker.[264] There are specific provisions relating to the provision of urgent treatment after an apparent attempted suicide by a patient.[265]

12. 8. 3. 2. Sterilisation

The term "sterilisation" is not defined in the *Guardianship and Administration Act 1990 (WA)*. However, that *Act* excludes sterilisation from the definition of urgent treatment, states that persons responsible cannot consent to sterilsation and contains specific provisions about the sterilisation of people under guardianship.[266] In relation to a person under guardianship, a guardian may consent to sterilsation only if a Full Tribunal of WASAT has first given its consent to the proposed procedure for sterilisation.[267] This matter is taken up in more detail in Chapter 15. 6. 4.

12. 8. 3. 3. Treatment that is not urgent medical or dental treatment

If the proposed medical, dental or other treatment is not urgent or does not involve sterilisation of a person under guardianship, and the patient is unable to make reasonable judgments about that treatment, the treating doctor, dentist or

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[261] *Guardianship and Administration Act 1990 (WA)* s 110ZH.
[262] Ibid.
[263] While the relevant health professional will usually be a doctor, the term "health professional" is very widely defined and includes, chiropractors, dentists, dental therapists or dental hygienists, dental prosthetists , medical radiation technologist, midwifes, nurses, occupational therapists, optometrists, osteopaths, pharmaceutical chemists, physiotherapists, podiatrists, psychologists and any other person who practises a discipline or profession in the health area that involves the application of a body of learning. See *Civil Liability Act 2002 (WA)* s 5PA.
[264] *Guardianship and Administration Act 1990 (WA)* s 110ZI (2).
[265] Ibid. s 110ZIA.
[266] Ibid. ss 110ZH, 110ZD(7) and 56-63.
[267] Ibid. ss 56A and 58(1). The term "Full Tribunal" is defined in s 3 of the *Act*.

other health professional must deal with the question of consent as set out in 12. 8. 4.[268]

12. 8. 4. Who is the substitute decision-maker for medical and dental treatment?

As already noted at 12.8, the first question that arises when a person cannot give a valid consent to their own treatment is, do they have an advance health directive? If so the next question is whether that advance health directive, on a sensible reading of it, contains a treatment decision relevant to the treatment proposed for that person. If so, the treatment provided to that person must be decided according to that treatment decision.[269]

If there is no relevant advance health directive, and the treatment is not urgent as described above at 12. 8. 3. 1, the person who may consent to the proposed treatment as the substitute decision-maker is the first in order of priority of the following:

1. an enduring guardian of the person needing the treatment who is authorised to make treatment decisions about the treatment, is reasonably available and is willing to make a decision to consent or to refuse consent to the treatment ;

2. a guardian of the person needing the treatment, appointed by WASAT, and who is authorised to make treatment decisions about the treatment, is reasonably available and is willing to make a decision to consent or to refuse consent to the treatment;

3. the person's spouse or de facto partner who is of full legal capacity, has reached 18 years and is living with the person, who is also reasonably available and is willing to make a decision to consent or to refuse consent to the treatment;

4. the person's nearest relative who maintains a close personal relationship with the person, has frequent personal contact with them and a genuine interest in their welfare, who is of full legal capacity, who has reached 18 years of age and who is also reasonably available and is willing to make a decision to consent or to refuse consent to the treatment and who is first in the following order of priority of relatives,
    (a) their spouse or de facto partner who is not living at home with them,
    (b) the person's child,
    (c) the person's parent,
    (d) a sibling of the person;

[268] Ibid. s 110ZJ.
[269] Ibid. s 110ZJ(1).

5. the person's primary provider of care and support, but who is not remunerated for providing that support and who also maintains a close personal relationship with the person, has frequent personal contact with them and a genuine interest in their welfare, who is of full legal capacity, who has reached 18 years of age and who is also reasonably available and is willing to make a decision to consent or to refuse consent to the treatment; and

6. finally, a person who maintains a close personal relationship with the person, has frequent personal contact with them and a genuine interest in their welfare, who is of full legal capacity, who has reached 18 years of age and who is also reasonably available and is willing to make a decision to consent or to refuse consent to the treatment.[270]

Because of the reasonable availability requirement in particular, it is possible that different people will be the person responsible for an incapable person on different occasions when that person needs treatment.[271] It is the obligation of every person when acting as person responsible and making a treatment to act according to their opinion of the best interests of the person needing the treatment.[272]

12. 9. Australian Capital Territory

The Australian Capital Territory's comprehensive regime for substitute decision-making in relation to the medical and dental treatment of those unable to give a valid consent to their own treatment came into operation 2 February 2009.[273]

12. 9. 1. Medical and dental treatment defined

In the Australian Capital Territory medical treatment is defined to include dental treatment and to include any medical procedure or treatment as well a series of procedures or a course of treatment.[274] It does not include prescribed medical procedures.[275] Consent to the carrying out of these procedures cannot be given under the substitute consent regime. This matter will be returned to in 12. 9. 3. 2.

12. 9. 2. The test for incapacity to consent to treatment

A person cannot give a valid consent to their own medical (or dental) treatment if they have impaired decision making ability for giving consent to medical

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[270] Ibid. s 110ZD. For a consideration of "close personal relationship" see, *Public Advocate and F* [2007] WASAT 14 and *DMS* [2008] WASAT 14.
[271] For a case in which WASAT considered there was not need to appoint a guardian because there were persons around capable of acting as "persons responsible" for the person the subject of the application see, *CGH and NVF* [2010] WASAT 76 [33].
[272] Ibid. s 110ZD(7).
[273] See, *Guardianship and Administration of Property Amendment Act 2008 (ACT).*
[274] *Guardianship and Management of Property Act 1991 (ACT)* s 32A.
[275] Ibid.

treatment.[276] Such impaired ability is defined as: a person's decision-making ability that is impaired because of a physical, mental, psychological or intellectual condition or state, whether or not the condition or state is a diagnosable illness.[277]

12. 9. 3. What treatments need substitute consent when a person cannot give a valid consent to their own treatment?

In the Australian Capital Territory substitute consent must be obtained for all treatments under the new legislative regime unless the treatment can be given in accordance with the *Medical Treatment Act 2006 (ACT),* is urgent or is a prescribed medical procedure. The latter two forms of treatment will be returned to below at 12. 9. 3. 1 and 12. 9. 3. 2 respectively. The *Medical Treatment Act 2006 (ACT)* is discussed further in 12. 9. 5. 1 and in Chapter 13 at 13. 4. 4 and 13. 5. 4.

12. 9. 3. 1. Urgent medical treatment.

Urgent medical treatment is not defined in the *Guardianship and Management of Property Act* 1991 (ACT), but the substitute consent regime contained in it is stated not to affect "any common law right of a health professional to provide urgent medical treatment without consent.[278] The ACT Public Advocate suggests that treatment that is necessary to preserve the life of the patient or to prevent "serious morbidity" would be urgent medical treatment.[279] In New South Wales, as well as Victoria and Tasmania, the statutory definition of urgent treatment is treatment that is necessary, as a matter of urgency to save the incapable person's life, or prevent serious damage to their health, or to prevent them from suffering or continuing to suffer significant pain or distress.[280] It is suggested that this broader definition could be adopted into the Australian Capital Territory and exercised in accordance with the experience of the ethical practices developed in those States as an appropriate way for doctors to decide whether treatment is urgent or not. It is also suggested that consideration be given to the concept of necessity.[281]

12. 9. 3. 2. Prescribed treatments

The *Guardianship and Management of Property Act 1991 (ACT)* has prescribed a number of medical treatments and provided the process for obtaining consent to the carrying out of those treatments. The prescribed medical treatments are:

1. abortion

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[276] Ibid.
[277] Ibid. s 5.
[278] Ibid. s 32N.
[279] See Office of Public Advocate website, www.publicadvocate.act.gov.au.
[280] *Guardianship Act 1989 (NSW)* s 37(1). The same test exists in Victoria see, *Guardianship and Administration Act* 1986 (Vic) s 42A(1) and in Tasmania see, *Guardianship and Administration Act 1995 (Tas)* s 4.
[281] *In re F* (1990) 2 AC 11, 76. See also *Northridge v Central Sydney Area Health Service* [2000] NSWSC 1241 [19]-[20]

2. reproductive sterilisation
3. hysterectomy
4. medical procedures concerned with contraception
5. removal of non-regenerative tissue for transplantation to the body of another living person
6. treatment for mental illness, electroconvulsive therapy or psychiatric surgery.[282]

However, treatment for mental illness, including electroconvulsive therapy and psychiatric surgery, is dealt with under the *Mental Health (Treatment and Care) Act 1994 (ACT).*[283]

The process requires that first the Australian Capital Territory Civil and Administrative Tribunal (ACAT) appoints a guardian for the person unable to give a valid consent to their own treatment and then make a declaration that the person the subject of the guardianship order is "not competent to give a consent required for a prescribed medical procedure".[284]

The ACAT appointed guardian then applies to ACAT for an order consenting to the prescribed medical procedure proposed for the person under their guardianship. The guardian, the person under guardianship and any other person whom ACAT considers should have notice the hearing of an application are given notice of, and may attend, the hearing. After hearing the evidence, ACAT considers whether or not it should consent to a prescribed medical procedure for the person under guardianship if it is satisfied that:

1. the procedure is otherwise lawful; and
2. the person is not competent to give consent and is not likely to become competent in the foreseeable future; and
3. the procedure would be in the person's best interests.[285]

12. 9. 4. Who is the substitute decision-maker for medical (and dental) treatment?

In most cases since 2 February 2009 the automatic substitute decision-maker for an adult person unable to give a valid consent to their own medical or dental treatment is, in order of precedence:

1. the person's guardian appointed by the ACAT with authority to give consent to medical treatment,

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[282] *Guardianship and Management of Property Act 1991 (ACT)*, Dictionary. At the time of writing no other medical procedure had been prescribed in the Act or the *Guardianship and Management of Property Regulation* 1991 (ACT).
[283] Ibid. s 70(1) note.
[284] Ibid. ss 7 and 69.
[285] Ibid. s 70. Other aspects of the procedure that has to be followed, the matters the Tribunal has to take into account when determining whether the proposed procedure is in the person's best interests and the special requirements about non-regenerative tissue are set out in s 70.

2. the person's enduring attorney with authority to give consent to medical treatment appointed either under the *Powers of Attorney Act 2006 (ACT)* or a law of a State or the Northern Territory that substantially corresponds with that *Act*,
3. a health attorney for the person.[286]

The term health attorney is further defined in a "priority order" to mean a capable adult who is:

1. the person's domestic partner who is in a close and continuing partnership with the person, [287]
2. the person's carer,[288]
3. a close relative or friend of the incapable person.[289]

Treating doctors and dentists are given a discretion to seek consent from the health attorney they believe is best able to represent the views of the now incapable person.[290] However, they must consider the health attorneys in priority order but may take into account any circumstance they believe, on reasonable grounds, is relevant, particularly how readily available a particular health attorney is. They need not consider a health attorney if they believe, on reasonable grounds, that that health attorney is not a suitable person to consent to medical treatment for the now incapable person. But they must make a record of the reasons for their belief.[291]

Another approach to the problem of unavailable or unsuitable health attorneys or where the person does not have a health attorney, is for the treating doctor to apply to the ACAT to appoint the Public Advocate as an emergency guardian for 10 days with authority to give consent to medical treatment on behalf of the now incapable person.[292]

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[286] Ibid. ss 32A and 32B.

[287] Ibid. The *Legislation Act 2001 (ACT)* s 169 describes the term "domestic partner" as a reference to someone who lives with the person in a domestic partnership, and includes a reference to a spouse or civil partner of the person. As to who is a "civil partner", see the *Civil Partnerships Act 2008 (ACT)*.

[288] *Guardianship and Management of Property Act 1991 (ACT)*ss 32A, 32B(1)(b) and 23C. Consistent with the approach in NSW, a carer is a person who gives, or arranges for the giving of, care and support to the incapable person in a domestic context but does not receive remuneration or reward, but may receive the care's pension, for giving, or arranging for the giving of, the care and support. However, if the protected person lives in a hospital, nursing home, group home, boarding-house, hostel or similar place, a person giving, or arranging for the giving of, care and assistance to the protected person at that place is not, only because of that fact, a carer for the protected person.

[289] The term "close relative or friend " is defined in s 32A to mean the same as it means in NSW namely, a relative or someone else in a close personal relationship with the person who has frequent contact with the person and a personal interest in the person's welfare but does not receive remuneration or reward for the contact.

[290] *Guardianship and Management of Property Act 1991 (ACT)* s 32D(2).

[291] Ibid. s 32F(2) and (3).

[292] Ibid. s 67.

12. 9. 4. 1. Information that must be given to the health attorney requested to consent to treatment

If a doctor or dentist asks a health attorney to consent to medical treatment for a person, they must give the health attorney information about the following matters:

1. the reasons why the person has impaired capacity for giving consent to treatment,
2. their condition,
3. the treatment for which consent is sought,
4. any alternative treatment that is available,
5. the nature and likely effect of the treatment for which consent is sought and any alternative treatment,
6. the nature and degree of any significant risks involved with the treatment for which consent is sought and any alternative treatment,
7. the likely effect of not providing the treatment,
8. the decision-making principles,[293] and
9. any other matter that the doctor or dentist believes, on reasonable grounds, is relevant to the provision of consent for the treatment.[294]

12. 9. 5. Objections to treatment

12. 9. 5. 1. Objections by the incapable person

Objection to the proposed treatment by the incapable person is not addressed by the legislation. If the objection is in the form of a common law advance directive that is relevant to the person's current situation, it should be followed. If the now incapable person has made a health direction under the *Medical Treatment (Health Directions) Act 2006* that is relevant to their current situation, it should be followed the extent possible under that *Act*. If their objection to the proposed treatment is known, but is not one of these, it must, nevertheless, be given effect to under the principles to be followed by (substitute) decision-makers under the *Guardianship and Management of Property Act 1991 (ACT)* unless, making the decision in accordance with those wishes is likely to significantly adversely affect the now incapable person's interests.[295]

12. 9. 5. 2. Objections by health attorneys

Such objections may delay but not necessarily preclude the treatment from being given. If a doctor or dentist requests a health attorney to give consent to treatment and the health attorney refuses to give the consent, the doctor or dentist must refer the matter to the Public Advocate. If the Public Advocate considers the refusal reasonable, she must take no further action. Otherwise she must apply to the ACAT to be appointed as the guardian for the incapable person.[296]

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[293] Ibid. s 4.
[294] Ibid. s 32G.
[295] Ibid. s 4(2)(a) and (b).
[296] Ibid. s 32H.

12. 9. 5. 2. Objections in the form of disagreements between health attorneys
If a doctor or dentist seeks substitute consent to treatment from the health attorney they believe is best able to represent the views of the incapable person, but they become aware that one or more of the other health attorneys for the person objects to the giving of consent, the doctor or dentist must refer the matter to the Public Advocate. The Public Advocate may then either:

1. try to help the available health attorneys reach agreement about consent, or
2. apply to the ACAT to be appointed as guardian for the incapable person, or
3. do both.[297].

As already noted a doctor or dentist is not required to seek the views of other health attorneys for an incapable person before obtaining the consent of the health attorney that they believe, on reasonable grounds, is best able to represent the views of the incapable person.[298] Consequently, while they may avoid becoming aware of the objections of other health attorneys, they must refer the matter to the Public Guardian

12. 10. Northern Territory

The Northern Territory does not have a comprehensive scheme for substitute decision-making in relation to the medical and dental treatment of those unable to give a valid consent to their own treatment set out in legislation. There are some legislative provisions that apply to some very limited situations. Consequently, the common law, insofar as it exists, applies to those situations not covered by the legislation.

12. 10. 1. The limited legislative provisions

12. 10. 1. 1. Emergency Medical Operations Act 1973 (NT)
The *Emergency Medical Operations Act 1973 (NT)* deals only with surgical operations and the administration of anaesthesia and blood transfusions.[299] It provides that where a doctor is of the opinion that an adult (or a child) is in danger of dying or suffering a serious, permanent disability and the performance of the surgical operation or blood transfusion is desirable in order to prevent the death of the person or the disability occurring, then the doctor may perform the operation. However, the doctor must be of the opinion that the person is, by reason of their medical condition, unable to give their consent to the operation and that it is not practicable to delay the operation until the consent of the patient or their next of kin or the person having authority to give substitute consent can be sought.[300]

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[297] Ibid. s 32I.
[298] Ibid. s 32I(4).
[299] *Emergency Medical Operations Act 1973 (NT)*, s 2.
[300] Ibid. s 3(1), (2), (3) and (5). Section 2 of the *Emergency Medical Operations Act 1973 (NT)* defines "next of kin" as the spouse, de facto partner or blood relative of the incapable person.

Where an operation is carried out in these circumstances the operation is deemed to have been carried out with the consent of the person authorized by law to give consent.[301] The doctors carrying out the operation are protected against liability arising from the lack of consent but not from liability arising from performance of the operation.[302]

12. 10. 1. 2. Adult Guardianship Act 1988 (NT)
Section 21 of the Adult *Guardianship Act* 1988 (NT) deals with medical and dental procedures, terms which are not defined in the *Act*. However, it applies only to those adults the subject of either full guardianship orders or conditional orders in which the guardian has the power "to consent to health care that is in the best interests of the represented person".[303] The section does not apply to any medical or dental procedure which is carried out in an emergency and appears necessary to save the life of the person.[304] That matter is dealt with under emergency treatment below 12. 10. 2.

It is unlawful for a doctor or dentist to carry out a "major medical procedure" on a person under guardianship without the consent of the Magistrates Court.[305] A "major medical procedure" is defined to mean:

1. a medical or dental procedure that is generally accepted by the medical or dental profession as being of a major nature, but which does not remove an immediate threat to the person's health;[306]
2. a medical procedure relating to contraception or the termination of pregnancy.[307]

The Court is required to commence to hear the application within 14 days of receiving it.[308] The Court is required to ascertain the wishes of the person, presumably about the proposed procedure, as far as that is reasonably possible, a requirement that is already implied by section 4 of the *Act*.[309] Even when the guardian has been given the power to determine health care matters, which at least implies that the person under guardianship is incompetent of decision-making in this regard, the Court is required to inquire into whether the person understands the nature of the proposed procedure and is capable of giving or refusing consent. If the person is capable of giving consent, the Court must

[301] Ibid. s 3(6).
[302] Ibid. s 4.
[303] *Adult Guardianship Act* 1988 (NT) s 21(1).
[304] Ibid.
[305] *Adult Guardianship Act* 1988 (NT) s 21(2).
[306] Ibid. s 21(4)(a). Treatment that removes an immediate treat to a person's health is emergency treatment and can be carried out under the *Emergency Medical Operations Act* 1973 (NT), if applicable, or the common law.
[307] Ibid. s 21(4)(b).
[308] Ibid. s 21(5).
[309] Ibid. ss 21(6) and 4(c).

give effect to the person's wishes.[310] That requirement is consistent with the provision that the wishes of the person under guardianship are to be given effect to wherever possible. However the requirement is made subject to the power of the Court where satisfied that the procedure was in the best interests of the person, to give its consent to the proposed procedure even if the Court finds the person understands the procedure and is capable of giving and refusing consent to it and refuses consent to it.[311]

12. 10. 1. 3. The Natural Death Act 1988 (NT) and advance directives
The *Natural Death Act 1988 (NT)* is also dealt with in Chapters 13. 1, 13. 4, 13. 4. 2 and 13. 5. 2. and Chapter 14. 4. 4. It provides that capable adults who desire not to be subjected medical or surgical measures that prolong or are intended to prolong life in the event of them suffering from a terminal illness may make a direction in a formal manner.[312] However, the *Act* specifically states that it does not affect the rights of a capable person to refuse medical or surgical treatment.[313]

12. 10. 2. Emergency treatment.
Where there is an urgent need for medical or dental treatment, the common law as set out in 12. 2 above applies. In New South Wales, as well as Victoria and Tasmania, the statutory definition of urgent treatment is treatment that is necessary, as a matter of urgency to save the incapable person's life, or prevent serious damage to their health, or to prevent them from suffering or continuing to suffer significant pain or distress.[314] This broad definition could be adopted by judicial decision in the Northern Territory and exercised in accordance with the experience of the ethical practices developed in those States that have them in their legislation.

Another approach that has some currency in the Northern Territory is to carry out treatment that is urgent and necessary to save life or prevent serious damage to health on a person incapable of giving a valid consent to their own treatment under the extended principle of necessity referred to at the commencement of this chapter at 12. 2. 1.[315]

12. 10. 3. Medical and dental treatment that is neither urgent nor covered by the legislation
There is no legislation in the Northern Territory setting out who can give substitute consent to medical or dental treatment proposed for an incapable

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[310] Ibid. s 21(7).
[311] Ibid. s 21(8).
[312] Natural Death Act 1988 (NT) s 4.
[313] Ibid. s 5(1).
[314] *Guardianship Act* 1989 (NSW) s 37(1). The same test exists in Victoria see, *Guardianship and Administration Act* 1986 (Vic) s 42A(1) and in Tasmania see, *Guardianship and Administration Act* 1995 (Tas) s 4.
[315] See also, *In re F* [1990] 2 AC 1, 71-79,; *R v Bournemouth Community Area and Mental Health NHS Trust, Ex parte L* [1998] 2 FLR 550, 557-558 and *Northridge v Central Sydney Area Health Service* [2000] NSWSC 1241.

adult if that treatment is not urgent or not a surgical procedure or not a major medical procedure to be given to an adult under guardianship. In these circumstances, treating doctors should follow the best practice approaches developed in medical and dental practice in the Northern Territory and elsewhere and attempt to discover what the incapable person's view of the treatment was likely to be, based on their previous use of medical and dental services, if they had access to them, and the opinions they expressed about particular treatments or treatments in general when they had capacity. If that information can be provided, it should be considered along with the best interests of the person. The views of relatives, especially those who have responsibilities under customary law for the well-being of the incapable person, should also be considered, but not so as to override the views or the best interests of the incapable person.

12. 11. Common ground in the legislation and case law of the States

The greatest amount of common ground between the States in relation to substitute consent to medical treatment is found in relation to the test for incapacity to consent to medical or dental treatment and the definitions of medical and dental treatment. By contrast, in relation to objections to treatment, there is a marked contrast between the approach in New South Wales and the approach in Queensland

12. 11. 1. The test for incapacity to consent to medical or dental treatment

This test is the same in New South Wales, Tasmania and Victoria. In those States a person is incapable of giving a valid consent to their own medical or dental treatment if:

1. they are incapable of understanding;
   (a) the general nature of the treatment, or
   (b) the effect of the treatment, or
2. they are incapable of indicating whether or not they consent to the carrying out of the treatment.[316]

The Queensland definition is very similar and there are decided cases giving examples of the test for capacity in action in that State. [317] The approaches taken in both South Australia and Western Australia are different, but the effect of the tests in those States is similar to the tests on the other States. [318] The Australian Capital Territory test is impaired decision-making ability for the giving of consent to medical treatment.[319]

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[316] *Guardianship Act 1989 (NSW)* s 33(2), *Guardianship and Administration Act 1995 (Tas)* s 36 and *Guardianship and Administration Act 1986 (Vic)* s 36(2).
[317] *Guardianship and Administration Act 2000 (Qld)* Schedule 4. For examples the test for capacity in action see, *Re IM* [2003] QGAAT 16, *Re L* [2005] QGAAT 13 and *Re MHE* [2006] QGAAT 9.
[318] *Guardianship and Administration Act 1993 (SA)* s 3 and *Guardianship and Administration Act 1990 (WA)* ss 119(1), (2) and (4) and 43(1)(b).
[319] *Guardianship and Management of Property Act 1991 (ACT)* ss 5 and 32A.

The three part common law test developed by Thorpe J in England which has been adopted in New South Wales is an effective way to assess whether or not a person has capacity to consent to their own treatment. For a person to be capable of giving a valid consent to their own treatment, they must be able to:

1. take in (and comprehend) and retain the treatment information,
2. believe that information, and
3. weigh that information, balancing risks and needs. (weigh it in the balance and arrive at a choice) [320]

12. 11. 2. Definitions of medical and dental treatment

In New South Wales and Tasmania, medical and dental treatment are defined together. They are medical treatment, including 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 as well as dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a registered practitioner. They can also include any other act declared in the regulations to be "treatment" as just defined.[321]

In Victoria medical treatment is defined in the same way as in New South Wales and Tasmania while dental treatment is defined as dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a registered practitioner.[322] In South Australia medical and dental treatment are defined in ways that are very similar to the definitions in the States already mentioned.[323]

In Queensland the role of the substitute decision-maker is broader than elsewhere in Australia. They make decisions relating to "matters relating to health care". Health care is described as, care or treatment of, or a service or a procedure for an adult:

1. to diagnose, maintain, or treat the adult's physical or mental condition, and
2. carried out by, or under the direction or supervision of, a health provider.[324]

Health care also includes withholding or withdrawal of a life-sustaining measure if the commencement or continuation of the measure would be inconsistent with good medical practice.[325] While this definition is very similar

[320] *In re C* [1994] 1 All ER 819, 822 and 824.
[321] *Guardianship Act* 1989 (NSW) s 33(1) and *Guardianship and Administration Act* 1995 (Tas) s 3.
[322] *Guardianship and Administration Act* 1986 (Vic) s 3.
[323] *Guardianship and Administration Act* 1993 (SA) s 3.
[324] *Guardianship and Administration Act* 2000 (Qld) Schedule 2, s 5(1).
[325] Ibid. ss 5(2) and 5A.

to the definition of medical and dental treatment in the other States, it applies to the health care provided by a much wider range of health care professional than just doctors and dentists.[326]

In 2005, the then Queensland Guardianship and Administration Tribunal relied on the England and Wales Court of Appeal's broad view of the definition of medical treatment in the *Mental Health Act 1983 (UK)* to support its view that seclusion could be a medical treatment.[327] Giving the judgment of the Court of Appeal, Hale LJ noted that the House of Lords had held in *Reid v Secretary of State for Scotland* that medical treatment could include treatment which alleviated or prevented a deterioration of the symptoms of the disorder, even if the treatment would have no effect on the disorder itself and that similarly, in *B v Croydon Health Authority*, in the context of the force-feeding an anorexic woman, the Court of Appeal held that doing so was treatment for the mental disorder even if the treatment addressed only the symptoms of anorexia or was ancillary to trying to address the underlying disorder.[328] She then went on to point out that:

> [S]ome psychotic patients deteriorate when over stimulated and when interaction with others becomes too intense. Seclusion can reduce their psychotic symptoms by reducing social stimulation. Some patients with persecutory delusions report feeling safer in seclusion…. It can also be said that, in a wider sense, seclusion aimed at addressing the risks to others presented by the behaviour of a patient in the manic phase of a bipolar affective disorder when the behaviour is itself the result of that disorder is treatment 'for' the disorder in the same way that force-feeding the anorexic patient was treatment for her disorder. While her behaviour was purely self destructive, the consequences of allowing Mr S to persist in behaviour which was damaging to others would also have been damaging to him.
>
> We take the view, therefore, that seclusion is certainly capable of being medical treatment…[329]

The Court of Appeal's decision was overturned by the House of Lords after the Queensland Tribunal had given its decision.[330] While Hale LJ's statement just quoted was not disapproved of by the House of Lords, it is respectfully suggested that, outside Queensland at least, seclusion may not be within the definition of medical treatment. As Lord Steyn pointed out in the House of Lords, the case concerned the use of seclusion in hospitals where mentally

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[326] Ibid. Schedule 4.
[327] *Munjaz v Mersey Care National Health Service Trust* [2003] EWCA Civ 10.
[328] *Reid v Secretary of State for Scotland* [1999] 2 AC 512 and *B v Croydon Health Authority* [1995] Fam 133.
[329] *Munjaz v Mersey Care National Health Service Trust* [2003] EWCA Civ 10, [42]-[45].
[330] *Regina (Munjaz) v Mersey Care National Health Service Trust* [2005] UKHL 58, [2006] 2 AC 148.

disordered patients were detained.[331] Lord Bingham was of the opinion the description of medical treatment in the *Mental Health Act 1983 (UK)* was wide enough "to cover the nursing and caring for a patient in seclusion, even though seclusion cannot properly form part of a treatment programme".[332] Lord Hope stated that seclusion was not part of a patient's treatment. Its aim was to contain severely disturbed behaviour and the decision to resort to it was made by a nurse or a doctor and it is supervised by medical staff in the hospital. For that reason it fell well within the scope of the phrase "the medical treatment of patients suffering from mental disorder".[333]

Lord Scott reaffirmed the concerns of the other law lords when he stated:

> It is accepted that the only legitimate purpose of placing an inmate in seclusion is the protection of others. Seclusion cannot be used as a punishment nor can it constitute medical treatment, at least in the narrow sense of that expression.[334]

Whether or not it is legitimate to use seclusion in a mental health facility is not the issue here. However, what is clear from the speeches (judgments) of all of the law lords in the case is that they did not consider seclusion to be medical treatment.

In Western Australia treatment is defined widely to mean any medical, surgical, dental or related treatment or care that may lawfully be provided to a patient with the patient's consent or the consent of any person authorised by law to consent on their behalf.[335]

In the Australian Capital Territory dental treatment is included in the definition of medical treatment.[336]

The broad view of what is included in medical and dental treatment, leaves open the question of whether or not particular treatments or aspects of treatment including oversight of the person's condition, medical advice about how that that condition could best be managed and the prescription of courses of medication are included. A group of Western Australian decisions show why those aspects of treatment are included in the definition.[337] The Victorian case *Gardner; re BWV* touches upon the criteria for determining whether or not an action or activity is medical treatment and explains why the provision of

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[331] Ibid. [39].
[332] Ibid. [19].
[333] Ibid. [67].
[334] Ibid. [103].
[335] *Guardianship and Administration Act 1990 (WA)* s 3(1).
[336] *Guardianship and Management of Property Act 1991 (ACT)* s 32A.
[337] *BTO* [2004] WAGAB 2 [39]. See also, *ADP* [2005 WASAT 131 [24] and *AB* [2005] WASAT 303 [50]. See 12. 7. 2

nutrition and hydration through artificial means is medical treatment.[338] The Western Australian case *BTO* includes the withdrawal of nutrition and hydration through artificial means in medical treatment.[339] Psychiatric treatment and contraceptive treatment have both been held to be included in medical treatment in Western Australia.[340]

Some Western Australian cases address the question of whether the giving of medications or the use of physical means to stop a person moving or walking is medical treatment or chemical or physical restraint.[341]

12. 11. 3. Objections

In New South Wales the cases involving proposals to treat Jehovah's Witnesses with blood products, and a case involving a Christian Scientist, show how the objection to treatment of the incapable person is dealt with.[342] This approach contrasts with the approach taken in Queensland where the legislative provision has been interpreted by the predecessor of QCAT, the Queensland Guardianship and Administration Tribunal.[343]

12. 12. The medical approach to substitute consent to medical and dental treatment

12. 12. 1. What may affect capacity?

12. 12. 1. 1. General medical conditions

A number of medical conditions may render a person unable to understand either the general nature or the effect of a particular treatment. Any chronic or acute perturbation of mental state may affect such understanding. Delirium, an impairment in attention and cognition caused by an underlying physical illness such as chest or urinary tract infection or drug toxicity, is frequently seen in the acute medical setting and it often impairs a person's capacity to consent to medical treatment. Because delirium is a transient disorder it is important that the person's capacity to consent to their own treatment is reassessed after the resolution of the delirium, if the proposed treatment can wait until that occurs.

Although executive impairment (i.e. impairment in frontal lobe functions) causing deficits in reasoning is generally associated with dementia, recent

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[338] [2003] VSC 173, 7 VR 487 [75] – [78] and also [90] – [91].
[339] *BTO* [2004] WAGAB 2 [39]. See 12. 7. 2.
[340] *MW* [2005] WASAT 205 [55]. See also *AB* [2005] WASAT 303 [54]-[55]. *BTO* [2004] WAGAB 2 [37] referring to *Re MC; Review of Guardianship Order* (unreported Full Board, 7 May 2004 (Mrs P Eldred, Deputy President, Dr A McCutcheon and Ms F Child, Members)) 7. See 12. 7. 2.
[341] *BCB* [2002] WAGAB 1, *Re BCB; Application for a Guardianship Order* [2002] SR (WA) 338.*SJ and MET* [2006] WASAT 210. See 12. 7. 2.
[342] *Re BB* (unreported, Guardianship Tribunal Matter No. 2000/3642, 18 July 2004); *Re FF* (unreported, Guardianship Tribunal Matter No. 2001/1482, 27 March 2001); *Re RD* (unreported, Guardianship Board, C/5887, Matter No. 94/1858, 22 June 1994); *Re DD* (unreported, Guardianship Tribunal Matter No. 1999/3501, 18 August 1999), 9; *Re AF* (unreported, Guardianship Tribunal Matter No. 2004/1867, 6 April 2004). See also *Re JJ* (unreported, Guardianship Tribunal Matter No. 1999/3642, 20 October 1999) and *Re IL* (unreported, Guardianship Board, C/8433 Matter No. 94/2383, 19 July 1994). See 12. 3. 1. 10 and 12. 12. 1.
[343] *Re CJ* [2006] QGAAT 11. See 12. 3. 1. 10.

studies have suggested that patients with chronic diseases, such as hypertension, chronic obstructive pulmonary disease, and diabetes, may also have executive deficits independent of any co-occurring dementia or psychiatric condition.[344]

A range of medical conditions may also affect a person's ability to indicate whether or not they consent to the carrying out of treatment. A person may be unable to communicate whether or not they consent to the proposed treatment because they are unconscious, sedated, intubated, suffering the effects of a stroke or are otherwise either temporarily or permanently unable to communicate. It is important to appreciate that those suffering from strokes or other paralysing conditions may be able to communicate by means other than oral communication and where possible the consent process should be facilitated. For example, Stein and Wagner found that using a process of enhancing informed consent with a patient-selected "helper" during the informed consent process for persons with aphasia can improve the quality of the informed consent, while reserving final decision-making authority for the patient. [345]

12. 12. 1. 2. Psychiatric conditions

Psychiatric disorders such as depression, schizophrenia, bipolar affective disorder (manic-depressive disorder) and schizoaffective disorder (a hybrid of schizophrenia and mood disorder) may be associated with cognitive dysfunction, poor insight or psychotic symptoms which interfere with medical decision-making capacity.[346]

In the case of schizophrenia, the strongest correlate or indicator of capacity, particularly understanding and appreciation of disclosed information, is performance on cognitive testing.[347] Specific psychotic symptoms may also impact on a person's capacity but only if they relate to the decision at hand. In the previously mentioned case of *Re C*, a man with paranoid schizophrenia was held to meet the test for capacity to make a decision about whether or not to consent to the amputation of one of his legs because of gangrene, because his symptoms did not interfere with the decision at hand.[348]

Depression may affect capacity by virtue of either a passive or an active wish to die, or anergia (lack of energy) and amotivation (lack of motivation) with

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[344] Schillerstrom JE, Horton MS, Royall DR. (2005) "The impact of medical illness on executive function", *Psychosomatics* (2005) 46(6):508-16.

[345] Stein J, Brady Wagner LC "Is informed consent a 'yes or no' response? Enhancing the shared decision-making process for persons with aphasia". *Top Stroke Rehabil*. (2006)13(4):42-6

[346] Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, Szmukler G, Hotopf M "Reliability of mental capacity assessments in psychiatric in-patients." *Br J Psychiatry*. 2005 Oct;187:372-8.

[347] Palmer BW Jeste DV "Relationship of individual cognitive abilities to specific components of decisional capacity among middle-aged and older patients with schizophrenia." *Schizophr Bull*. 2006 Jan;32(1):98-106

[348] *In re C* [1994] 1 All ER 819

regards to decision making. Low self esteem or apathy may render depressed patients at particular risk of "going along with" treatment suggestions regardless of their own views. [349] Some people with depression have psychotic symptoms such as delusions regarding their bodies. Severe Obsessive Compulsive Disorder may cause an indecisiveness that paralyses decision-making.

12. 12. 1. 3. Dementia

Misunderstanding and faulty assumptions about the relationship between dementia and medical incapacity have led to poor practice in many health settings. Commonly, a diagnosis of dementia is equated with loss of capacity. A diagnosis of dementia does not preclude capacity to give consent to medical treatment. There are different causes of and different stages of dementia each with different effects on cognition. Furthermore, some decisions are simpler than others.

Notwithstanding this caution, there is increasing evidence to suggest that even patients with early dementia may have impairment of capacity to give medical consent. However, this depends on the type of dementia and associated cognitive deficits, and the complexity of the decision to be made. Moye and others found that some patients with mild-to-moderate dementia develop a clinically relevant impairment of their consent capacity within a year, particularly those who had initial problems with naming, logical memory and flexibility. [350] Similarly, in a two-year longitudinal study comparing healthy older adult subjects and mild Alzheimer's Disease patients, Huthwaite and others found that even at baseline, mild Alzheimer's Disease patients performed equivalently compared with controls on simple standards of evidencing a choice and making the reasonable choice, but significantly below controls on complex standards of appreciation, reasoning, and understanding. While the mild Alzheimer's Disease group did not show significant decline from baseline on any capacity standard at one year follow-up, at two-year follow-up the mild Alzheimer's Disease group showed significant declines from baseline on the complex consent abilities of appreciation, reasoning, and understanding. [351]

In the early stages of the disease the difficulties in understanding a treatment situation and choices probably relate to deficits in conceptualization and memory (e.g. semantic memory and verbal recall), while in the middle stages, declining capacity to identify the consequences of a treatment choice probably relates to executive dysfunction (loss of decision making and reasoning). In the advanced stages of the disease, receptive and expressive language deficits

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[349] BMA, op cit, (footnote 346) p 161

[350] Moye J, Karel MJ, Gurrera RJ, Azar AR et al "Neuropsychological predictors of decision-making capacity over 9 months in mild-to-moderate dementia", *J Gen Intern Med* 2006 21(1):78-83.

[351] Huthwaite JS, Martin RC, Griffith HR, Anderson B, Harrell LE, Marson DC. "Declining medical decision-making capacity in mild Alzheimer's Disease: a two-year longitudinal study", Behav Sci Law. 2006;24(4):453-63..

(aphasia and severe dysnomia) hamper ability to communicate simple treatment choices. [352]

These studies suggest the value of early assessment and regular monitoring of medical consent capacity even in patients with mild Alzheimer's Disease to ensure that it is adequate for each specific situation in which consent to treatment is sought.[353]

12. 12. 1. 4. Intellectual disability

Intellectual disability is low general intellectual functioning as measured by IQ score associated with difficulties in adaptive behaviour (or handicap) manifesting before the age of 18. [354] There are many causes of intellectual disability including abnormalities of chromosomes or genes (e.g. Down syndrome, Fragile X syndrome), nutritional problems, problems with the pregnancy or birth, prematurity, exposure to infection (e.g. rubella) or drugs during pregnancy and developmental abnormalities such as autism. As with dementia, the extent to which intellectual disability hinders capacity to give medical and dental consent depends on the nature and severity of the intellectual disability and the complexity of the consent situation. This may vary within the same individual. For example, a person with an intellectual disability may be able to understand the nature and the effect of some treatments, because those matters are easy to understand or the treatment and its effect are familiar to the person. They may also be able to communicate clearly that they consent to or refuse to consent to the treatment. In relation to other treatments they may not be able to understand the treatment or its effects or they may not be able to come to a decision about it. In those situations, they will not be able to give a valid consent to the treatment.

Not surprisingly, performance of intellectually disabled people decreases with increasingly rigorous definitions of understanding nature and effect. Cea and Fisher found that most adults with mild intellectual disability and almost half with moderate disability were able to make and justify treatment choices and fully or partially understand treatment information while 50% with mild and 18% with moderate intellectual disability were able to appreciate partially the relevance of treatment choices to their situation and weigh the treatment risks against the benefits.[355] Looking at the comparative difficulty of different elements of the capacity task for 20 subjects with learning disability, Wong and others found that the risks of saying “no” were the most difficult to understand

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[352] Marson DC,Chatterjee A, Ingram KK, Harrell LE, “Toward a neurologic model of competency: Cognitive predictors of capacity to consent in Alzheimer's disease using three different legal standards”, *Neurology* 1996; 46(3):666-72

[353] D.Moye J, Karel MJ, Gurrera RJ, Azar AR, “Neuropsychological predictors of decision-making capacity over 9 months in mild-to-moderate dementia”, *J Gen Intern Med* 2006 21(1):78-83.

[354] http://www.aihw.gov.au/publications/welfare/dpida/dpida-c00.html

[355] Cea CD, Fisher C.B. “Health care decision-making by adults with mental retardation.” *Mental Retardation* 2003; 41(2): 78-87.

followed by the risks of the procedure, the voluntariness of the consent, the purpose of the procedure and the procedure itself.[356]

As mentioned previously with regards to people with communication difficulties (and indeed this applies also to people with mental illness), steps can be taken to facilitate decision-making with people with intellectual disability. For example, the decision-making task can be simplified by presenting the information about the decision in an uninterrupted form and then as constituent elements, and by limiting the verbal demands of the response by including recognition and non-verbal demonstration.[357]

12. 12. 1. 5. Acquired brain injury

Acquired brain injury is damage to the brain after birth. It usually affects cognitive, physical, emotional, or independent functioning and can result from traumatic brain injury (i.e. accidents, falls, assaults etc) and non-traumatic injury (i.e. poisoning, infection, brain tumours).

Again, the impact on capacity depends on the nature and severity of the person's deficit and the decision to be made. However, the nature of acquired brain injury is such that, unlike dementia which is a degenerative cognition, or intellectual disability which is usually a stable condition, there is potential for recovery in acquired brain injury. For example, in a six month longitudinal study of change in medical decision-making capacity in 24 subjects with moderate to severe traumatic brain injury, Marson and others found that patients showed substantial recovery of reasoning and partial recovery of appreciation and understanding consent abilities.[358]

12.12. 2. The medical assessment of capacity

12. 12. 2. 1. General assessment of capacity: myths and faulty assumptions

The assessment of capacity in clinical settings is often characterised by inconsistency, inaccuracy and subjective impressions.[359] Ganzini and others identified ten common myths clinicians hold about decision-making capacity[360]:

1. decision-making capacity and competency are the same;
2. lack of decision-making capacity can be presumed when patients go against medical advice;

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[356] Wong J.G. Clare ICH, Holland A.J., Watson P.C., Gunn M. "The capacity of people with a "mental disability" to make a health care decision." *Psychological Medicine* 2000, 30(2); 295-306.
[357] Ibid.,
[358] Marson D.C., Dreer L.E., Krzywanski S., Huthwaite J.S., Devivo M.J., Novack TA. (2005) "Impairment and partial recovery of medical decision-making capacity in traumatic brain injury: a 6 month longitudinal study" *Arch Phys Med Rehabi* 2005 86(5) :889-95.
[359] Sullivan K. "Neuropsychological assessment of mental capacity." *Neuropsychology Review* 2004; 14(3):131-142.
[360] Ganzini L, Volicer L, Nelson WA, Fox E, Derse AR, "Ten myths about decision-making capacity." *J Am Med Dir Assoc* 2005 6(3 Suppl):S100-4.

3. there is no need to assess decision-making capacity unless patients go against medical advice;
4. decision-making capacity is an "all or nothing" phenomenon;
5. cognitive impairment equals lack of decision-making capacity;
6. lack of decision-making capacity is a permanent condition;
7. patients who have not been given relevant and consistent information about their treatment lack decision-making capacity;
8. all patients with certain psychiatric disorders lack decision-making capacity;
9. patients who are involuntarily committed lack decision-making capacity; and
10. only mental health experts can assess decision-making capacity.

A "functional" approach to capacity assessment which takes into account the individual's relevant abilities and the demands of the particular decision-making task is far preferable to the commonly used "status" approach which relies on the patient's diagnosis, age or legal status to make assumptions about capacity.[361] The functional approach invalidates the faulty assumption that all patients with dementia, schizophrenia or intellectual disability lack decision-making capacity.

Obtaining a valid consent from a patient is more than just signing a form or reading out a consent form and asking a patient if they understand what was read out to them. Even when they give some thought to the issue of capacity, health care professionals often make inaccurate and inconsistent determinations about a person's capacity to give a valid consent to their own treatment. [362] Practices that have been identified as problematic include capacity assessment based on bedside cognitive assessment at best or subjective impressions about capacity at worst. In a study of subjective estimates of cognitive impairment in older surgical patients, Davis and others have demonstrated that guessing at a patient's cognitive function commonly leads to error, resulting in procedures being undertaken without a valid consent having been obtained. Although staff found it easier to recognize extremes of cognitive functioning, when a patient's degree of cognitive impairment was intermediate, estimates were only slightly better than that expected by chance, resulting in patients undergoing procedures without their capacity to consent being properly assessed.[363]

The assumption that a patient with dementia still has capacity is often based on their acquiescence to treatment, while conversely, refusal of treatment is often equated with incapacity. A study of Massachusetts nursing homes showed that informed consent was not considered an issue and decision making capacity

[361] Wong J.G. Clare ICH, Holland A.J., Watson P.C., Gunn M. "The capacity of people with a 'mental disability' to make a health care decision." *Psychological Medicine* 2000, 30(2); 295-306.
[362] Sullivan K Mental Capacity. Powers of Attorney and advance health directives (2005) Collier B, Coyne, Sullivan K. Leichardt :The Federation Press
[363] Davis DHJ. "Subjective estimates of cognitive impairment in older surgical patients. Implications for giving informed consent" *Journal of the American Geriatrics Society* (2005), 53(10) 1842 -1843.

was not being tested. The usual practice was for capacity to be presumed until a patient failed to acquiesce to treatment, and only at that point would the issue of capacity be fully addressed. [364]

12.12. 3. General screening tools

There is widespread agreement among doctors that while general screening tools such as the Mini Mental State Examination or the Abbreviated Mental Test provide a guide to the severity of cognitive impairment or dementia, and thus a context for the capacity assessment, they are inadequate to assess capacity to consent to medical treatment. Neither of them deals with the specific requirements for a valid consent. Nor does either of them test the crucial frontal lobe functions of judgment and reasoning upon which the task of medical decision-making relies. A patient may have intact language, memory, praxis (ability to perform coordinated movements or motor activities) and perceptual skills but still have impairment of capacity due to executive dysfunction. Ideally, a two-stage capacity assessment involving an assessment of global functioning first followed by an assessment of the specific medical decision making task is advised. [365]

12. 12. 4. Specific scales

The development of clinical assessment tools has been driven by the legal developments in this area, particularly in the Unites States. According to Appelbaum and Grisso [366], the article that awakened modern interest in legal standards of competence to consent to treatment was by Roth and others, who despaired in attempting to identify a single operative legal standard and referred to this as the 'search for the holy grail'.[367] Over the last 30 years experts in the field have sought to develop clinically applicable tools incorporating various identified legal standards for defining capacity.

Some of the earlier instruments focused on assessing comprehension of presented information. Fitten and others used three written "vignettes" of increasingly complex hypothetical treatment situations followed by a structured interview to assess understanding of treatment decision-making in elderly nursing home patients.[368] Similarly, the Hopkins Competency Assessment Test is a brief instrument for evaluating competency to give consent to medical treatment or to write advance directives based on the patient's comprehension of a short essay outlining a doctor's assessment of medical decision making

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[364] Gurian, Baker, Jacobson, Lagerbom and Watts (1990)

[365] Sullivan K In Mental Capacity. Powers of Attorney and advance health directives Collier B, Coyne, Sullivan K. (2005) Leichardt :The Federation Press

[366] Grisso T, Appelbaum PS (1995) "Comparison of standards for assessing patients' capacities to make treatment decisions" *Am J Psychiatry*. 152, 1033-1037.

[367] Roth LH, Meisel A, Lidz CW. "Tests of competency to consent to treatment" *American Journal of Psychiatry* (1977) 134: 279-284.

[368] Fitten LJ, Lusky R, Hamann C. "Assessing treatment decision making in elderly nursing home patients" *Journal of the American Geriatrics Society* (1990) 38: 1097-1104.

capacity and the rights of patients to make durable powers of attorney regarding future medical care. [369]

12. 12. 4. 1. The four-abilities model

In a more inclusive approach, Grisso and others identified all four of the commonly applied legal standards in the USA courts for determining decision-making competence (the 'four-abilities model') vis: [370, 371, 372,373]

1. Ability to communicate a choice
2. Ability to understand relevant information
3. Ability to appreciate the situation and its likely consequences
4. Ability to manipulate information rationally (or reason about it) in a manner that allows one to make comparison and weigh options.

Using three instruments to measure these abilities they found that different groups of patients were identified as impaired depending on the measure used. The proportion of patients identified as impaired increased when compound standards were used, i.e. when impairment was defined as poor performance on any of two or three measures.

What emerged from this work was the MacArthur Competence Assessment Tool-Treatment. This instrument assesses patients' competence to make treatment decisions by examining their capacities in four areas - understanding information relevant to their condition and the recommended treatment, reasoning about the potential risks and benefits of their choices, appreciating the nature of their situation and the consequences of their choices, and expressing a choice. A high degree of ease of use and inter-rater reliability (i.e. agreement between different raters) in both hospitalized, medically ill patients and patients with psychiatric disorders has been identified with this tool. [374]

12. 12. 4. 2. Aid to Capacity Evaluation

In the attempt to create the "gold standard" of capacity assessment tools, a plethora of other instruments have been developed, most of which are based on the assessment of a composite of legal standards. The 'Aid to Capacity Evaluation' is a face to face semi-structured interview which has a high

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[369] Janofsky JS, McCarthy RJ, Folstein MF "The Hopkins Competency Assessment Test: A brief method for evaluating patients capacity to give informed consent" *Hospital and Community Psychiatry* (1992) 43(2): 132-136.

[370] Grisso T, Appelbaum PS (1995) "Comparison of standards for assessing patients' capacities to make treatment decisions" *Am J Psychiatry*. 152, 1033-1037.

[371]Grisso T, and Applebaum PS "The MacArthur Treatment Competence Study. I: Mental illness and competence to consent to treatment" *Law Hum Behav*. 1995 19(2):105-26.

[372] Grisso T, and Applebaum PS "The MacArthur Treatment Competence Study. II: Measures of abilities related to competence to consent to treatment" *Law Hum Behav*. (1995) 19(2):127-48.

[373] Grisso T, and Applebaum PS (1995) "The MacArthur Treatment Competence Study. III: Abilities of patients to consent to psychiatric and medical treatments" *Law Hum Behav*. (1995) 19(2):149-74.

[374] Grisso T, Appelbaum PS, Hill-Fotouhi C. « The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions" *Psychiatr Serv*. 1997 Nov;48(11):1415-9.

probablility of identifying those incapable of giving consent.[375] The Aid to Capacity Evaluation categorises patients into 'definitely incapable', 'probably incapable', 'probably capable' and 'definitely capable'. The clinical standards of the Aid to Capacity Evaluation include:

1. able to understand medical problem
2. able to understand proposed treatment
3. able to understand alternative to proposed treatment
4. able to understand option of refusing proposed treatment
5. able to appreciate reasonably forseeable consequences of accepting proposed treatment
6. able to appreciate reasonably forseeable consequences of refusing proposed treatment
7. is the person's decision affecting by a) depression or b) delusion/psychosis

12. 12. 4. 3. Capacity to Consent to Treatment Instrument

The Capacity to Consent to Treatment Instrument is a psychometric measure that tests capacity to consent to medical treatment using a series of four core capacity standards: S1 (evidencing/communicating choice), S3 (appreciating consequences), S4 (providing rational reasons), and S5 (understanding treatment situation), and one experimental standard [S2] (making the reasonable treatment choice) [376].

12. 12. 4. 4. Health Care Capacity Decisional Aid

The Health Care Capacity Decisional Aid rates patient responses to a capacity assessment interview on a likert-like scale (from definitely able to definitely unable) in the following domains[377]:

1. Ability to understand relevant information or health problem
2. Ability to understand the various choices (one to four)
3. Ability to appreciate consequences

12. 12. 4. 5. Stewart and Biegler's specific questions

In a very practical way, Stewart and Biegler have suggested specific questions clinicians might ask patients to test comprehension, appreciation and reasoning, namely:

1. Understanding/comprehension : Ask patient to recall and paraphrase information related to proposed treatment including risks and befits

[375] Etchells E, Darzins P, Silberfeld M, Singer PA, McKenny J, Naglie G, Katz M, Guyatt GH, Molloy DW, Strang D. "Assessment of patient capacity to consent to treatment" *J Gen Intern Med*. (1999) 14 (1):27-34

[376] Marson DC, Ingram KK, Cody HA, Harrell LE. "Assessing the competency of patients with Alzheimer's disease under different legal standards" *Arch Neurol* 1995; 52: 949–954

[377] Darzins, P, Molloy DW, Strang D. (Ed) *Who can decide? The six step capacity assessment process* (2000) Memory Australia Press, Adelaide, 58-71.

of treatment, alternative treatment and no treatment at all. (Retest later to check for stability.)

2. Believing /appreciating : Tell me what you really believe is wrong with your health now? Do you believe that you need some kind of treatment? What is the treatment likely to do for you? Why do you think it will have that effect? What do you believe will happen if you are not treated? Why do you think the doctor has recommended this treatment for you?
3. Weighing/reasoning: Tell me how you reached the decision to accept/reject treatment? What things were important to you in reaching the decision? How do you balance those things? [378]
4. Choice: Have you decided whether to go along with your doctor's suggestion for treatment?

While the MacArthur Competence Assessment Tool-Treatment has been found to have the most empirical support, none of these tools or question sets provides the "gold standard" for capacity assessment. Although superior to a clinician's subjective rating of capacity, all instruments have limitations, ranging from lack of inter-rater reliability and lack of supporting psychometric data to lack of generalisability across contexts or ecological validity i.e. the difficulty extrapolating understanding of a hypothetical situation to the specific decision to be made. [379, 380] Given these limitations, the best use of such instruments is to standardize or structure capacity assessments so that the same questions are asked of all patients. This is particularly useful in research settings, but it is also useful for clinicians when making assessments as it ensures that they assess all the elements of decision-making and base their conclusions on comprehensive assessments rather than on subjective impressions.

12. 12. 5. The effect of the type of decision on capacity assessment

Two issues need to be taken into account in the assessment of medical decision-making. These are the risk of the procedure and complexity of the decision-making required. The assessment of capacity should be made with reference to the type of decision to be made. There is a spectrum or hierarchy of decisions from simple (e.g. having a blood test) to complex (e.g. carotid artery surgery) and accordingly, people may be capable of making simple decisions but not more complex ones. Freedom is maximized when a person is allowed to make the decisions they are capable of making.[381]

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[378] Stewart C, Biegler P A "Primer on the law of competence to refuse medical treatment" *Australian Law Journal* (2004) 78: 325-342.

[379] Sullivan K In Mental Capacity. Powers of Attorney and advance health directives Collier B, Coyne, Sullivan K. Leichardt :The Federation Press, p128.

[380] Dunn LB,Nowrangi MA, Palmer BW, Jeste DV, Saks ER "Assessing decisional capacity for clinical research or treatment: a review of instruments" *Am J Psychiatry*. 2006 Aug;163(8):1323-34

[381] Darzins, P, Molloy DW, Strang D. (Ed) op. cit.(footnote 377), p 6.

Further, when the risks are high, it is important that the criterion of competence is applied assiduously.[382] As stated previously, the courts have acknowledged that the more serious the decision, the greater the capacity required.[383] This is known as a "risk related standard" according to which the level of capacity to refuse a treatment may differ from that needed to consent to it. Frequently, the benefits of treatment are high and the risks low while the risks of refusal are high and the benefits low, suggesting that the level of capacity to refuse might be higher.[384] This notion of "asymmetry" means that just because patient is competent to consent to treatment, it doesn't necessarily follow that he is also competent to refuse it. Consent to medical treatment requires a relatively lower level of capacity than the refusal of that same treatment.[385] This is extremely relevant to the area of end-of life decisions, which will be discussed in a later chapter.

12. 12. 6. Information, education and facilitation

One of the crucial elements of the health care capacity assessment is the presentation of the information about the health problems, treatments and choices available to the patient i.e. "the education step".[386] To be capable of making a decision people must be adequately informed. People can easily be mistaken to be incapable if education or information is not provided to them or it is given in such a way that it is incomprehensible. In order to maximize patient autonomy, barriers to communication (e.g. hearing and visual impairment, literacy or language differences) must be addressed if possible and communication facilitated by establishing rapport, tailoring and personalising information, giving sufficient time for assimilation of information and using visual aids which are readable.[387] Similarly, in patients with dementia, interventions aimed at maximising their understanding and reasoning by supporting naming, memory, and flexibility may help to optimise capacity.[388]

Such efforts can be fruitful even in patients who might otherwise be deemed incapable. For example, Palmer and Jeste found that an interactive dialogue between patient and investigator with repeated presentation of information is

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[382] Parker M, Cartright M, In: Mental capacity in medical practice and advance care planning : clinical ethical and legal issues In Collier B, Coyne C, Sullivan Mental Capacity Federation Press: Annandale 2005 p74.

[383] *Re T* [1993] Fam 95, 113; *Re MB* [1997] EWCA Civ 1361 and *Re B* [2002] EWHC 429 (Fam) [31].

[384] Parker M, Cartright M, In: Mental capacity in medical practice and advance care planning : clinical ethical and legal issues In Collier B, Coyne C, Sullivan Mental Capacity Federation Press: Annandale 2005 p74.

[385] Hertogh CMPM Autonomy, competence and advance directives. In: Jones GGM, Miesen BML. (eds) Caregiving in dementia. Research and applications. (Vol 3) New York London, Brunner Routledge, 2004, p391-403.a

[386] Darzins, P, Molloy DW, Strang D. (Ed) op. cit.(footnote 379) p64-67.

[387] Parker M., and Cartright C: Mental capacity in medical practice and advance care planning : clinical ethical and legal issues In Collier B, Coyne C, Sullivan Mental Capacity Federation Press: Annandale 2005 p74.

[388] D.Moye J, Karel MJ, Gurrera RJ, Azar AR "Neuropsychological predictors of decision-making capacity over 9 months in mild-to-moderate dementia" *J Gen Intern Med*. 2006 21(1):78-83.

likely to aid understanding of disclosed information among patients with schizophrenia [389]

12. 13. Medical approach to blood transfusions and substitute consent to medical treatment

Whether and how to treat now incapable people who for religious, cultural or ethical reasons either have refused to be or are known to oppose being given either certain medical treatments or any medical treatments are extremely difficult matters for treating doctors and other health professionals. This is because of the well established common law right of capable people to refuse medical treatment, for any reason or no reason, and for their stated views, particularly those set out in advance directives, to be complied with if they lose capacity.

Doctors and other health professionals are faced with this difficulty most often with Jehovah's Witnesses and blood transfusions. However, it must be appreciated that while blood transfusions do save lives and assist in the recovery process in a number of situations, the giving of blood does involve risks and blood transfusions do not bring about miracle cures.

12. 13. 1. The medical approach to transfusion refusal

The right of competent adults to refuse blood transfusion is well respected. Fortunately, blood is not always needed and patients in relatively good health can tolerate a fair degree of aneamia. Transfusions carry risks, for example, transmission of viruses, prior disease and transfusion–associated immunosuppression. They also have benefits. There are alternatives to blood transfusions and the concept of "bloodless medicine" has been developed to deal with these very circumstances.

Bloodless medicine involves blood conservation approaches (i.e. in phlebotomy or taking blood) and the use of adjunctive (i.e. extra, or alternative) such as antifibrinolytics (stops clots breaking up), procoagulants (reduces haemeorrhage) or erythropoietin (increases red blood cell blood production) and blood substitutes. [390] Much has been written about pharmacological and surgical options to treat patients who refuse blood and studies have compared outcomes of open heart surgery and major, intermediate and minor gynaecological procedures in Jehovah's Witnesses compared with patients who accept the transfusion of blood products and found them comparable. [391,392]

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[389] Palmer BW Jeste DV "Relationship of individual cognitive abilities to specific components of decisional capacity among middle-aged and older patients with schizophrenia" *Schizophr Bull.* 2006 32(1):98-106

[390] Rogers DM. Crookston KP "The approach to the patient who refuses blood transfusion" *Transfusion* (2006) 46: 1471-1477

[391] Stamou SC, White T, Barnett S, Boyce SW, Corso PJ, Lefrak EA. "Comparisons of Cardiac Surgery Outcomes in Jehovah's Versus Non-Jehovah's Witnesses" *Am J Cardiol.* 2006; 98(9):1223-5.

[392] Massiah N, Abdelmagied A, Samuels D, Evans F, Okolo S, Yoong W. "An audit of gynaecological procedures in Jehovah's Witnesses in an inner city hospital" *J Obstet Gynaecol.* 2006 26(2):149-51

Rogers and Crookston have suggested the following guidelines on how to deal with the patient who refuses transfusion:

1. Seek to understand the patient and develop good rapport, explore treatment possibilities, decide together on the course of action to be taken and also make contingency plans in advance
2. Respect confidentiality
3. Document carefully
4. Access available resources to support the decision-making process including other professionals who have had experience in similar situations, ethics committees, risk management groups, or transfusion medicine specialists. [393]

In 2009, the decision of the Supreme Court of New South Wales in *Hunter and New England Area Health Service v A* made it clear that if an adult when capable had made an advance directive in an appointment of enduring guardianship directing the enduring guardian to refuse medical treatment, the person's treating doctors, and by implication the enduring guardian, are bound by that advance directive.[394] Nevertheless, considerable difficulties arise in cases involving Jehovah's Witnesses where the Witness the subject of the application has not got a current "blood card" – a form of advance directive carried by many Jehovah's Witnesses setting out that they do not wish to receive blood products and what substitute non-blood products they are willing to receive. The New South Wales Guardianship Tribunal has the power to give direct consent to proposed medical treatments. This is different from appointing a guardian to give such consent. It has said in relation to dealing with applications, usually by treating doctors, to consent to giving blood transfusions to Jehovah's Witnesses that:

> [W]hilst it (the Tribunal) has an obligation to have regards to the views of the patient and to take (those views) very seriously indeed, it was not bound by those views and could make a decision in relation to treatment which was contrary to the views of the patient if the Tribunal believed there were strong reasons for doing so.[395]

In the matter in which the Tribunal made that statement, the Tribunal refused to consent to a blood transfusion for a 19 year old woman who had toxic shock syndrome with multi-organ failure even though it was satisfied, from a medical treatment perspective, that the proposed blood transfusion was the most

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[393] Rogers DM. Crookston KP "The approach to the patient who refuses blood transfusion" *Transfusion* (2006) 46: 1471-1477

[394] [2009] NSWSC 761.

[395] *Re DD* (unreported, Guardianship Tribunal Matter No. 1999/3501, 18 August 1999), 9. The Tribunal might well take a different view in cases where either the patient has a current and relevant "blood card" or other advance directive, or where the patient's views have been clearly stated and proved to the Tribunal's comfortable satisfaction.

appropriate form of treatment for promoting and maintaining her health and well-being. The Tribunal took a number of things into account. The young woman had recently professed commitment to the key tenets of her religion including the obligation to abstain from blood transfusions, although she did not have a current blood card. Her parents, who were her persons responsible, wanted everything possible done for her medically and gave their consent to all proposed treatments except for blood transfusion. The Tribunal also considered the consequences of her having a blood transfusion. While it was unlikely that she would not be rejected by her church if she had a blood transfusion consented to on her behalf by others, this fact could lie heavily on her conscience and affect both her recovery and later health. Another factor was that the giving of a blood transfusion would not necessarily restore her health.[396] She was not given the blood transfusion for which consent was sought, but she recovered without it – probably as a result of the high quality of the other medical care provided to her.

There have been other applications in which the Tribunal has followed the approach set out in this case, but in which the Tribunal has given consent to the proposed blood transfusion. In a 2004 case, the Tribunal decided to consent to an application for a blood transfusion to be given to AF, who was the only member of his family who was a Jehovah's Witness. The Tribunal accepted that he had signed an advance directive in the form of a "no transfusion card" or "blood card" in 2003 and may have signed others as well. However, there was no current card signed by him. Also, there was evidence that recently, when he had been asked, he had indicated that he wanted a blood transfusion. In addition, there was conflicting evidence about how closely he adhered to other tenets of the Jehovah's Witnesses and, evidence that he had already been given transfusion in the emergency setting.[397] Stewart has criticised the Tribunal's decision.[398]

There have been other cases in which the Guardianship Tribunal has either consented to or refused consent to blood transfusions.[399] Some of these are discussed earlier in this chapter under objections to medical treatment in New South Wales at 12. 4. 10. The question of advance directives and blood transfusions is discussed again in Chapter 13. 6. 4. 4.

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[396] Ibid. 10.

[397] *Re AF* (unreported, NSW Guardianship Tribunal, matter no 2004/1867, 6 April 2004).

[398] Stewart, C "Advance directives: Disputes and dilemmas" in Freckelton, I and Petersen, K, op cit (footnote 159) pp 49-50. For a case in which the former Guardianship and Administration Board of Victoria did not, in an emergency situation, pursue the likelihood that a person refusing a blood transfusion may have been a Jehovah's Witness and may have had an advance directive in the form of a "blood card" see, *Qumsieh v Guardianship and Administration Board* (1998) 14 VAR 46. See also Stewart's discussion of that case, and related matters, in Stewart, C, "Qumsieh's Case, Civil Liability and the Right to Refuse Medical Treatment", (2000) 8 *JLM* 56.

[399] For a case in which the Tribunal refused consent to a blood transfusion see, *Re FF* (unreported, Guardianship Tribunal Matter No. 2001/1482, 27 March 2001). For cases in which the Tribunal gave consent to blood transfusions see, *Re JJ* (unreported, Guardianship Tribunal Matter No. 1999/5085, 20 October 1999), *Re IL* (unreported, Guardianship Tribunal Matter No. 1994/2383, 18 July 1994) and *NKQ* [2008] NSWGT 21 .

12. 14. Conclusion

Capacity reflects an interaction between the decision-maker and the demands of the decision-making task.[400] The legal definition of capacity to give consent to treatment is a broad one and usually encompasses an understanding of the nature and effect of the particular treatment and an ability to indicate consent. However, understanding the nature and effect of a treatment requires more than just parroting a description of treatment. The commonly adopted English common law test, Thorpe J's test, which is supported by current scientific literature in this area, suggests that capacity to give treatment consent is more complex and involves an ability to retain information about the treatment and appreciate or manipulate it, weighing up risks and alternatives.[401]

This higher order, medical conceptualization of capacity has been developed to ensure that false positive assessments of capacity do not occur and that we protect people from making decisions of which they are incapable. This of course creates a tension between the principles of beneficence and autonomy, the latter being the fundamental principle upon which much of the law is based. Setting too high a threshold for capacity will tend to offend against the principle of self-determination, while setting the standard too low potentially places people at risk of self harm.[402]

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[400] Wong J.G. Clare ICH, Holland A.J., Watson P.C., Gunn M. "The capacity of people with a "mental disability" to make a health care decision" *Psychological Medicine* 2000, 30(2); 295-306.

[401] *In re C* [1994] 1 All ER 819, 822 and 824; *Re MB* [1997] EWCA Civ 1361; *Re B* [EWHC 429 (Fam) [33]; *Re NK* (unreported Guardianship Tribunal NSW, C/28379, Matter Nos 2004/1672 and 2004/1673, 3 June 2004).

[402] Parker M., and Cartright C: Mental capacity in medical practice and advance care planning : clinical ethical and legal issues In Collier B, Coyne C, Sullivan Mental Capacity Federation Press: Annandale 2005 p67