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Parliament House
QLD 4000

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Queensland Parliamentary Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying

Thank you for the opportunity to provide input into the Queensland's Parliamentary inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 78,000 medical practitioners and students around Australia, including Queensland.

In addition to assisting members in claims and complaints under our insurance policies, Avant has a medico-legal advisory service (MLAS) that provides support and advice to members when they encounter medico-legal issues. Our members have contacted us for advice about issues relating to end-of-life and palliative care and voluntary assisted dying. We have also assisted our members in various matters in which end-of-life and palliative care issues have been raised.

In this submission we have answered select questions from the end-of-life and palliative care and voluntary assisted dying sections.

Please contact me on the details below if you require any further information or clarification of the matters raised in this submission.

Yours sincerely



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Avant submission to the Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying

End of life and palliative care

Question 21: How can the delivery of palliative care and end-of-life care services in Queensland be improved?

Education and training - We believe that the delivery of palliative care and end-of-life services would be improved in Queensland with better education and training related to decision-making in these areas. It is Avant's experience that practitioners are often uncertain about the law and their obligations when treating patients at the end of life. Doctors and patients require a greater understanding of the law specific to the end-of-life decision making and how this integrates with practice.

Better education and training regarding end-of -life law can help:

1. Doctors support their patients and their families where legal issues arise. For example, a person trying to create an advance care directive (ACD)¹;
2. Build confidence in doctors when delivering end-of -life care and lessen disputes about treatment decisions which arise out of different understandings of the law; and
3. Reduce legal claims and complaints which are emotionally stressful and resource-intensive for all parties involved.

Doctors are often challenged by the implications of an ACD. Some practitioners can feel very uncomfortable about proceeding on the basis of a refusal of treatment. On the other hand, some practitioners express concern about providing increasing pain relief and sedation in the terminal phases of illnesses because of the concern that they may be subject to prosecution or, at the very least, have their decision-making scrutinised in other forums. The doctrine of double effect is often not well understood.

Further, the calls we have received from our members include issues such as who is the appropriate substitute decision-maker when a patient lacks capacity and there are several family members present, and how to proceed in the face of an ACD where it conflicts with their clinical judgment or the wishes of family members.

Practitioners worry about getting it wrong and this can impact on the way they practise and their decision-making, potentially to the detriment of the patient and their families. Comprehensive education and training in this specific area would help give doctors the confidence they need to guide their patients and their families through this inherently stressful time. If doctors, patients and families feel assured that they are getting the right information it will help alleviate some of the pain and suffering and anxiety associated with decision-making. This will enhance the delivery of these care services for Queenslanders.

We know that education and training in this area exists – such as the Palliative Care Education & Training Collaborative.² As an Australian Government funded and endorsed program, we would urge the Queensland government to promote this program in the education of doctors and other health care practitioners across the state. Continual

¹ In Queensland, statutory ACDs are called "Advance Health Directives" under the *Powers of Attorney Act 1998*.

² QUT Institute of Health and Biomedical Innovation <https://palliativecareeducation.com.au/my/>

Professional Development hours could be attributed to this training (or similar training) to encourage practitioners to complete it.

National consistency in legal framework - As a national organisation we support national consistency of approach in legislation and national consistency of terminology in these areas. Each state and territory in Australia has a different legal framework for end-of-life decision-making. As a result there are different terms for similar concepts.

In the context of advance care planning, although ACDs are used in all states and territories, the terminology, format, documentation requirements, the application of ACDs in practice and even the hierarchy of substitute decision-makers, differ markedly from state to state.³

In Queensland, statutory ACDs are called “Advance Health Directives” under the *Powers of Attorney Act 1998*. They have particular technical requirements. This Act specifically states that the common law on ACDs is not affected.⁴ However, the *Guardianship and Administration Act 2000* lists the only ways that a decision about a health matter for an adult with impaired capacity may be made and does not include common law directives. The *Guardianship and Administration Act* also states that where inconsistencies exist between it and the *Powers of Attorney Act*, that the *Guardianship and Administration Act* will prevail.⁵ This ambiguity may lead to patients not having their wishes met and also creates a legal risk for doctors.

A lack of consistency between states and territories impacts upon the ability of doctors to provide appropriate care at the end of life. These issues combined increases a doctor’s medico-legal risk, including to criminal and civil claims and disciplinary or coronial proceedings. The intricacies and varied legal requirements across states and territories surrounding ACDs and substitute decision-making cause confusion and have significant implications for doctors and patients.

In 2012, the Senate Community Affairs References Committee’s report, *Palliative Care in Australia*, found that differences in state and territory legislation and complexities with advance care planning were hampering greater take-up. The Senate Committee recommended that “national model legislation for advanced care planning be developed, and that all governments pursue harmonisation of legislation as a high priority”.⁶

Avant supports the development and use of consistent terminology and legal elements across Australia as a matter of priority. We believe that the legislation around Australia that impacts on end-of-life choices should be harmonised.⁷

The legislative framework should be clear in its application and should facilitate appropriate end-of-life decision-making. The National Framework for Advance Care Directives released in 2011⁸ and the Australian Commission on Safety and Quality in Health Care’s National

³ See Carter R, Detering K, Silvester W and Sutton E “Advance care planning in Australia: what does the law say” *Australian Health Review* 2016, 40, 405-414. See also QUT End of Life Law in Australia <https://end-of-life.qut.edu.au/>

⁴ S39 *Powers of Attorney Act 1998*

⁵ S8(2) *Guardianship and Administration Act*

⁶ Senate Community Affairs References Committee. *Palliative Care in Australia*. 2012. See also Deeble Institute “Improving end-of-life care in Australia” Issues brief no. 19, 14 December 2016

⁷ Avant Position Paper: *Advance care planning and end-of-life decisions making* 26 November 2015

⁸ The Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers’ Advisory Council. *A National Framework for Advance Care Directives*. September 2011: 1-76

Consensus Statement: Essential elements for safe and high-quality end-of-life care are a useful start towards a nationally consistent approach to end of life care. Avant is supportive of this.

When a person lacks capacity, doctors do not ordinarily need the consent of the person's substitute decision-maker, before deciding to withhold or withdraw treatment which the doctor considers to be futile. Queensland is the only jurisdiction in Australia where doctors do require consent from a substitute decision maker to withhold or withdraw life sustaining treatment when they consider the treatment to be futile.⁹ If the substitute decision maker does not give that consent a doctor can seek it using another mechanism (for example, applying to QCAT for the Tribunal's consent or to Queensland's Supreme Court for it to evoke its *parens patriae* jurisdiction).¹⁰ However, that will take up valuable time and resources.

Providing treatment that is futile is inconsistent with sound medical practice and contradicts a doctor's medical and ethical standards. This requirement also has the potential for doctors to provide treatment that is not in the patient's best interests, which in itself is contrary to principles of guardianship. Given this inconsistency, and that this requirement only exists in Queensland, it is likely to be a knowledge gap for doctors. End -of-life services would be improved if this area of the law was consistent with other jurisdictions in Australia. This way, patients are receiving care that is beneficial, doctors are not exposed to legal claims or complaints for misunderstanding this unique requirement and doctors are providing care which is scientifically sound and ethical.

Question 22: What are the particular challenges of delivering palliative and end of life care in regional, rural and remote Queensland?

Providing and attracting the right number of appropriately qualified doctors, and supporting palliative care multidisciplinary teams, is crucial for the delivery of optimal palliative and end of life care. Palliative care specialist support is vital for ensuring that care for people who are near to the end of life receive optimal care. In addition, without the appropriate type and levels of support, the medico-legal risk of our members increases as they become more vulnerable to claims and complaints by patients.

Disparities in service provision and access are evident in regional, rural and remote areas of Queensland where there are fewer specialised palliative care doctors practising than in the major cities. These communities are often reliant on a small number of general practitioners to deliver a wide range of services. We are concerned that the lack of palliative care specialists in regional, rural and remote areas is a barrier to delivering the best care possible towards the end of life. As the population ages and treatment options become more technically complex and varied, the challenges faced by general practitioners in these areas will only become more difficult unless the government intervenes with appropriate resourcing. Although in some areas there is a need for the provision of support for the appointment of palliative care specialists, where this does not exist general practitioners need to be supported by having specialist resources available for them for consultative

⁹ Willmott, Lindy, White, Benjamin P., Parker, Malcolm, & Cartwright, Colleen (2011) The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment : Part 2 (Queensland). *Journal of Law and Medicine*, 18(3), pp. 523-544.

¹⁰ *Guardianship and Administration Act 2000* (Qld) s 115, 240; *Guardianship and Administration Act Powers of Attorney Act 1998* (Qld) s 109

support to help them deliver this specialised area of care. Finally, we have also been made aware of gaps in service provision in the private health care sector and in aged care services. In the context of all of these workforce issues, we acknowledge the work of Palliative Care Australia in providing Palliative Care Service Guidelines for planning the workforce and system capabilities needed to deliver palliative care services across Australia.¹¹

Voluntary Assisted Dying

Question 25: Should voluntary assisted dying (VAD) be allowed in Queensland? Why/why not?

As a membership organisation, Avant recognises that our members hold a range of views on VAD. Because of this, we do not take a position on the substantive issue of whether or not VAD should or should not be permitted at law.

Question 28: If there is to be a VAD scheme, what features should it have?

A VAD scheme must incorporate sufficient protections for those doctors who choose to participate, and those who choose not to participate, similar to the structure recently implemented in relation to the abortion laws.

The scheme needs to provide a clear framework within which patients and doctors can operate.

As a matter of general principle, legislation which forms part of the scheme should balance the need for clear and unambiguous wording with the need to leave sufficient scope for the exercise of clinical judgment, consideration of the patient's individual circumstances and changing standards of medical practice over time.

If legislation is too prescriptive, compliance will be difficult and may leave limited room for clinical judgment and increase medico-legal risk. Legislation that is too flexible may be open to interpretation and retrospective criticism.

On balance, given the nature of the substantive issues, we recommend that the legislation outline the processes to be followed and doctors' obligations at a high level. Comprehensive guidelines should govern areas where clinical judgment or where further detail is required.

We recommend this because guidelines are able to be updated more easily than legislation, to take into account developing clinical practice. Compliance with guidelines can be mandated in the legislation if necessary to give them legislative force. Issues that could be dealt with in guidelines, with input from appropriately qualified practitioners, include: definitions; specific issues for the consent discussion; location of treatment; monitoring the use of medication; and what happens in circumstances where the medication is not effective.

¹¹ Palliative Care Australia, *Palliative Care Service Guidelines*, January 2018, http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-Service-Delivery-2018_web2.pdf

The following protections should be included in the legislation:

1. That a doctor should not face any criminal, civil, administrative or disciplinary action for refusing to participate, or for choosing to participate.
2. That a doctor is immune from criminal and civil liability, and disciplinary action for providing treatment that causes death if they have acted in accordance with the requirements of the legislation in good faith and without negligence.
3. That this immunity be extended to a doctor being present when the patient takes the medication.

Question 37: Should medical practitioners be allowed to hold a conscientious objection against VAD? If so, why? If not, why not?

Yes, medical practitioners should be allowed to hold a conscientious objection against VAD. No doctor should be compelled to participate. The “voluntary” nature of this scheme should apply equally to both patients and doctors.

A doctor has no legal or ethical obligation to provide interventions that the doctor considers to be not clinically indicated and not in the best interests of the patient.

While this is a clearly established ethical and legal position, because the legalisation of assisted dying is contentious, we recommend that any legislation include a provision that makes it clear that no one can be compelled to participate.

We recommend that the provision should not be framed as “conscientious objection” and that it should be framed as:

1. Participation is voluntary
2. A person is not required or compelled to comply with a patient’s request
3. A person should not face any criminal, civil, administrative, or disciplinary action for refusing to participate.

Question 38: If practitioners hold a conscientious objection to VAD, should they be legally required to refer a patient to a practitioner that they know does not hold a conscientious objection or to a service provider that offer such a service? If so, why? If not, why not?

Any legislation should not include a prescriptive requirement for referral in the case of conscientious objection. We recommend that issues relating to referral not be included in the legislation, but that it continue to be dealt with within the framework of the Code of Conduct. The Medical Board of Australia’s Code of Conduct outlines the expected standard of practice where doctors’ religious or moral views have the potential to impact on patient access to care.¹²

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¹² Medical Board of Australia Good medical practice code of conduct for doctors in Australia clauses 2.4.6 and 2.4.7