Health Legal Report – August 2016

Welcome to the August 2016 edition of the Health Legal Report.

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We also set out some of the Bills we are tracking throughout Australia, as well as some useful information links.

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Health Privacy in a Big Data World

By Claudia Hirst, Legal Counsel and Giovanni Marino, Senior Solicitor

Introduction

The consultation draft of the 'Guide to Big Data and the Australian Privacy Principles' (**Guide**) was released by the Office of the Australian Information Commissioner (**OAIC)** in May**.** The consultation period closed in July and we can expect a finalised Guide in the coming months. It is therefore timely to consider some of the key concepts in the big data and privacy conversation and how they apply to health services.

Message – Design, Management, and Improvement

Privacy is evolving quickly as big data capacity grows. The OAIC recommends that organisations adopt a design and systemic risk management approach. Tools to assist with this approach are:

- A privacy management plan
- Privacy Impact Assessments
- Privacy notices which are appropriate for purpose
- Security risk assessments
- Continuous quality improvement.

What is Big Data?

Big data is the collection, creation and fast analysis of large amounts of personal data. In the health sphere, it has developed as a result of the move from paper based to electronic health records coupled with the expansion in data analytics technology. In simple terms data analytics technology uses algorithms to rapidly sort, collate, compare and analyse vast amounts of data.

The Guide refers to Gartner's 'three V's' definition of the term 'big data':

> … high-volume, high-velocity and/or high-variety information assets

How is it Relevant to Health Services?

Uses of big data range from large scale research on the cause of diseases to the development of patient centred applications which feedback intelligence to patients allowing them to self-monitor progress and report it through mobile apps.

Smaller organisations or service providers may not be in the business of analysing big data. However, such organisations are still the repositories of large amounts of 'liquid' patient data. One way for smaller organisations to leverage the information pool is through partnerships with larger or multiple organisations.

The challenge for health services in this environment is to contribute to and benefit from big data analytics while still protecting genuinely sensitive and identifiable information.

Legislation and the Guide

The *Privacy Act 1988* (Cth) (**Act**) and its Principles (**APPs**) apply to private health care organisations, community health centres, and other private health providers. Similar principles apply to public health services under State and Territory health records legislation.

Big data activities challenge how the key requirements for collection and handling of personal information under privacy principles work in practice. The Guide provides a structure for working through this challenge and will also be useful to entities not bound by the APP's.

Following are some of the key messages from the Guide in its current draft form.

Privacy by design

The Guide recommends Privacy by Design (**PbD**). Privacy by Design means building privacy into the architecture of systems and business practices rather than "bolting it on afterwards" – it means embedding privacy into organisational governance.

> Embedding 'privacy by design' will lead to a trickledown effect where privacy is considered automatically by the entity, resulting in better overall privacy practice and compliance.

Important features of PbD are:

- A privacy officer
- Strategic documents which acknowledge systemic privacy management
- A privacy management plan
- A risk management and mitigation approach to privacy.

Privacy Impact Assessments

Privacy Impact Assessments (**PIAs**) are an essential tool for implementing PbD.

A PIA systematically assesses the impact of a project or function on individual privacy and recommends design that manages that risk by eliminating or minimising it. A PIA will consider system functionality as well as communication with clients and patients.

> Undertaking PIAs for big data activities will help entities describe their aims and the key privacy impacts for the activity.

The OAIC *Guide to undertaking privacy impact assessments* can be found at www.oaic.gov.au.

Four elements are crucial in assessing and managing the privacy impact of business practices:

- privacy notices
- de-identification
- consent
- security.

Privacy Notices

APP 5 requires an organisation to take reasonable steps to notify individuals of the details of the collection and uses of the information – this is usually achieved through a privacy notice.

Research shows that many people do not read privacy notices. Therefore, the PIA should carefully consider the design of the privacy notice. The privacy notice should be in an easy-to-read, user centric format, tailored to its purpose.

> Privacy notices have a big job to do. They need to communicate information handling practices clearly and simply, but also comprehensively and with enough specificity to be meaningful.

The Guide recommends innovative approaches to privacy notices:

- 'just in time' or video privacy notices that appear on screen when an individual is about to input their personal information
- multi-layered privacy notices, for example, using brief notices supplemented by longer notices.

Consent

APP 6 requires that health information held by an organisation only be used or disclosed for its primary purpose. However, it may be used or disclosed for a directly related secondary purpose in specified circumstances, including where:

- the individual has consented; or
- the individual would reasonably expect the organisation to use the information for the secondary purpose, and that purpose is related (or directly related in the case of health information) to the primary purpose for which the information was collected.

The privacy notice may be a key document in establishing express or implied consent.

If an organisation plans to use or disclose personal information for a 'secondary purpose' this should be included in the privacy notice.

A privacy notice may set out a range of likely secondary uses of personal information, including big data activities. This will inform individuals of what to expect.

The Guide recommends that organisations consider how they might allow individuals to choose which uses and disclosures they agree to and which they do not – for example, by using a multi-tiered approach.

Many uses of big data are as yet unknown. One way to address this is to allow for recontact of individuals whose information is collected. Another option is to utilise de-identified data.

Research

Organisations involved in conducting research relevant to public health or public safety, or in the management, funding or monitoring of a health service, will be aware of the *Guidelines approved under Section 95A of the Privacy Act 1988* (the **Guidelines**). The Guidelines provide a framework to ensure the protection of an individual's health information that is collected, used or disclosed in the conduct of research or health service management activities. The Guidelines require that it must be impracticable to seek consent from the individual involved for the organisation to collect, use or disclose health information, and also that de-identified information will not achieve the purpose of the research or health service management activity.

A PIA may overlay and complement the requirements in the Guidelines to ensure that a research or health service management activity protects an individual's privacy.

De-identified Personal Information

De-identified information can be used, analysed and shared without compromising a person's privacy. The Guide recommends that entities consider first whether de-identified personal information could be utilised for the proposed purpose.

De-identification is no longer as simple as removal of names and file numbers and address details. As capacity for data analytics grows, the potential for re-identification also grows. Matching of data sets between providers may result in re-identification of data that was de-identified in the individual data set.

> Big data analytics can lead to the creation of personal information

The Guide recommends that the PIA examine:

- the proposed de-identification techniques used
- how the de-identified data will be handled (for example, whether the data will be disclosed to third parties)
- the risk of re-identification.

The intended outcome will be the adoption of strategies to achieve effective de-identification, recognition of potential re-identification risks and management of those risks.

Security of Personal Information

Overseas disclosure will occur if an organisation engages overseas cloud service providers to manage data.

Before disclosing information overseas, APP 8.1 requires an organisation to take reasonable steps to ensure that the overseas recipient does not breach the APPs.

Big data activities often hold larger amounts of data and for longer periods of time.

APP 11 requires organisations to take reasonable steps to protect personal information from misuse, interference and loss, as well as unauthorised access, modification or disclosure.

> …'honey pots' containing vast amounts of valuable data may increase the risk that an entity's information systems may be hacked.

The Guide recommends that an information security risk assessment be part of a PIA.

A security risk assessment will identify 'reasonable steps' to protect personal information. These may include:

- providing access on a 'need to know' basis
- maintaining an audit log of ICT system activities to detect and investigate
- privacy incidents
- encryption and intrusion prevention and detection systems
- destroying or de-identifying the personal information when it is no longer needed
- having a response plan in the event of a data breach.

If you have any questions arising out of this article, please contact ***Giovanni Marino*** *on* ***(03) 9865 1339*** *or email* ***giovanni.marino@healthlegal.com.au****.*

Responding to Elder Abuse

By Claudia Hirst, Legal Counsel and Anne Howard, Solicitor

Background

The Australian Law Reform Commission (the **ALRC**) is currently conducting an inquiry into elder abuse (the **Inquiry**). The Inquiry is tasked with identifying a" best practice legal framework" for the prevention, mitigation and response to elder abuse.

For the purposes of the Inquiry, the following definition of 'elder abuse' is used:

> ...a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect (The World Health Organisation in the *Toronto Declaration on the Global Prevention of Elder Abuse*).

In June the ALRC released an Issues Paper inviting submissions by 18 August. The submissions will inform a discussion paper to be released for comment in November 2016. This will be followed by a final report in May 2017.

Key Issues

The Inquiry provides an opportunity for aged care providers and health services to have input to systems and legal changes that may reduce the risk of elder abuse. The Inquiry also provides an opportunity for services to consider existing practices, staff training and models of care with the goal of recognising and reducing the risks of elder abuse or neglect.

The Issues Paper raises squarely the question of whether a more interventionist legal framework is required to prevent elder abuse. In this context, the Issues Paper flags for consideration mandatory reporting and civil penalties for breach of duty as an alternate decision maker. In addition, it considers whether current sanctions are sufficient.

The paper highlights the importance of supported decision-making and decision-making based upon a person's values and rights rather than the traditional best interest test. This approach is in line with the

Victorian Government's position paper "*Simplifying Medical Treatment Decision Making and Advance Care Planning*" which proposes to legally recognise advance directives and supported decision-making.

More information on the position paper is here:

https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/simplifying-medical-treatment-decision-making

We will keep you informed as the position paper passes through the legislative process.

Below we highlight some of the specific issues raised by the ALRC Issues Paper that are particularly relevant to health services and aged care providers.

Aged Care Providers

The Inquiry is interested in evidence or case studies of elder abuse in aged care, including residential, home and flexible care settings.

The Issues Paper dentifies areas where safeguards against, and responses to, elder abuse may be improved. These include:

- The role of aged care assessment programs, the National Aged Care Advocacy Program and the community visitors scheme, in detecting and responding to instances of elder abuse
- The use of substitute decision making, through powers of attorney and guardianship and advance care directives

- Registration of advance care directives and regulation of substitute decision makers
- The place of uniform laws for substitute decision making
- Compulsory training for attorneys
- The role of criminal offences for dishonestly using or obtaining a power of attorney
- Regulation of the use of restrictive practices, including physical and chemical restraint
- The potential role of individual remedies for breaches of the Charter of care recipients' rights and responsibilities
- The current reporting regime for allegations of assault, complaints procedures and sanctions for elder abuse.

Health Services

The Issues Paper recognises that health services and health professionals are often at the "front line" in identifying and responding to instances of suspected elder abuse.

The Inquiry has identified three focus areas to be examined for improvement opportunities in relation to health services. They are:

- The role of health professionals in detecting whether an older person is at risk of, or a victim of, elder abuse
- The value of health-justice partnerships in detecting and responding to elder abuse and whether there are any other health service models that should be developed to fulfil this function
- Whether there should be any changes made to confidentiality and privacy laws to allow health services to be more effective in detecting and responding to elder abuse.

The Issues Paper highlights the need for health services to provide appropriate training to health professionals to enable them to be confident in identifying and responding to at-risk adults. The paper recommends that the "*WHO Clinical and Policy Guidelines on Responding to Intimate Partner Violence and Sexual Violence Against Women*" (**WHO Guidelines**) be used as a base for targeting capability training.

The WHO guidelines are found here:

http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

The paper encourages organisations to require reporting of suspected abuse and to review their privacy obligations with the aim of removing barriers to reporting. The paper recommends the introduction of health service wide elder abuse policies.

One example is established at St Vincent's Hospital in Melbourne. This model includes:

- the establishment of a coordination and response group to review data relating to suspected cases of abuse
- supporting staff to identify pathways for intervention based on preferences of the patient
- notification of all suspected, confirmed or witnessed cases of elder abuse to the coordination and response group
- a training framework focused on addressing the different roles and responsibilities of staff.

The Victorian Royal Commission into Family Violence suggested that this framework be adapted for use in other hospitals and aged care facilities.

Best practice going forward

Health and aged care services should review policies for identifying people at risk of elder abuse including staff training, recognition of substitute care givers and management of families in conflict. Policies should include clear recognition of advance care plans and powers of attorney. In keeping with the current focus on advance directives, health and aged care services should develop a clear framework for the recognition of advance care plans based on individual value statements and incorporating supported decision-making. This will underpin further developments in this area in individual jurisdictions in 2017.

If you have any questions arising out of this article, please contact ***Anne Howard*** *on* ***(03) 9865 1311*** *or email* ***anne.howard@healthlegal.com.au****.*

Compliance Report

Access to Medicinal Cannabis Act 2016 No.20 (Vic)

By Astrid Keir-Stanley, Compliance Associate

Introduction

The *Access to Medicinal Cannabis Act 2016 No.20* (Vic) (**the Act**) passed its third reading in the Upper House of Parliament on 24 March 2016 and received Royal Assent on 26 April 2016.

Though some operational parts of the Act commenced on 8 June 2016, the majority is yet to be proclaimed, and is due to commence early 2017.

The Act introduces a new legal framework to provide for the medicinal use of cannabis products for the supply to, and treatment of Victorians with specified conditions via the use of '*practitioner medicinal cannabis* authorisations'.

In accordance with section 46 of the Act, the *'practitioner medicinal cannabis authorisation-eligible patient' and the 'practitioner medicinal cannabis authorisation - exceptional circumstances'* essentially authorises each practitioner specified in it to issue a patient medicinal cannabis authorisation to the specified patient for the specified approved medicinal cannabis product. It also authorises each practitioner to supply that product to that patient by issuing the patient medicinal cannabis authorisation. Organisations should be aware that medical practitioners will need to apply to the Health Secretary for a *'practitioner medicinal cannabis authorisation'*.

More specifically, section 48 of the Act provides that a specialist medical practitioner may apply to the Health Secretary for a '*practitioner medicinal cannabis authorisation-eligible patient'* where the practitioner is satisfied that:

- the patient is an **eligible patient** (being a patient under 18 years of age who experiences severe seizures resulting from epilepsy where other treatment options have not proved effective or have generated intolerable side effects and who meets other prescribed criteria); and it is appropriate in all the circumstances that the patient should be treated with an approved medicinal cannabis product, and the prescribed additional criteria (if any) are met.

In addition, section 50 provides that a registered medical practitioner may apply to the Health Secretary for a '*practitioner medicinal cannabis authorisation - exceptional circumstances'* in respect of a patient who is *not* an eligible patient; where the practitioner is satisfied that:

- the patient is not an eligible patient but exceptional circumstances exist to justify the patient being treated with an approved medicinal cannabis product; and the prescribed additional criteria (if any) are met.

Organisations should be aware that the Act also authorises:

- a pharmacist to sell or supply an approved medicinal cannabis product to a patient in accordance with a patient medicinal cannabis authorisation, or a person acting on the patient's behalf, and to transport the product for that purpose
- a registered medical practitioner to sell or supply a medicinal cannabis product to a person who is participating in research or in a trial in accordance with a practitioner medicinal cannabis authorisation—research purposes, and to transport the product for that purpose.

If you have any questions arising out of this article, please contact ***Astrid Keir-Stanley*** *on* ***(03) 9865 1329*** *or email* ***astrid.keir-stanley@healthlegal.com.au****.*

Useful information links

At Health Legal we regularly access a broad range of information to ensure we keep up to date on what is happening in our areas of interest, both here in Australia and overseas.

In each publication we will share some of our regularly accessed sources of information, which we believe our clients will find useful. The links we would like to share this time are:

- http://networkedsociety.unimelb.edu.au/
  A useful source of events and information about connected technologies and their application.
- https://www.digitalhealth.gov.au/
  The Australian Government Digital Health Agency (formerly NEHTA).
- https://icdppc.org/
  The International Conference of Data Protection and Privacy Commissioners. A useful source of information and current events in privacy nationally and internationally.
- http://advancecareplanning.org.au/news-events/2016-advance-care-planning-national-conference-melbourne-victoria-15-16-nov
  Details of the forthcoming Advance Care Planning Conference in Melbourne in November
- https://aabhl.org/page/upcoming_conferences.html
  Details of the upcoming Australian Association of Bioethics and Health Law Conference

Awards

In acknowledgement of our success in the legislative compliance field we are pleased to announce that Health Legal was recently recognised as one of the most promising Compliance Solution providers of 2016 by APAC CIO Outlook magazine.

To view the article, visit http://www.healthlegal.com.au/current-news/

Precedents/Standard Form Agreements and Policies

Due to client demand, we have developed a range of standard form Agreements and Policies which are commonly used by health, aged care and community service providers. The documents have been prepared in a template form so they can be completed by your staff and include service contracts for the provision of pathology and radiology services, requests for tenders, leases and supply of goods contracts.

For further information about these precedents please contact ***Natalie Franks*** *on* ***(03) 9865 1324*** *or* ***natalie.franks@healthlegal.com.au***.

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Case Report – Informed Decision Making

Central Queensland Hospital and Health Service v Q [2016] QSC 89 – Court Orders required for termination of the pregnancy of a child

By Claudia Hirst, Legal Counsel

Introduction

This decision concerns the application by Central Queensland Hospital and Health Service (**CQHHS**) with the agreement of the 12 year old young woman and her parents to terminate a 9 week pregnancy of the young woman, Q. The Supreme Court of Queensland, after hearing from Q, her mother, an obstetrician and neuropsychiatrist made orders that Q be permitted to undergo a termination and that the hospital be permitted to perform the termination. The orders included both termination by the administration of drugs and surgical termination if required.

Facts

Medical and psychiatric evidence; wishes of child and her parents

Q is a young woman who, following the separation of her parents, has experienced difficulty adjusting with episodes of self-harm and attempted suicide. She presented to the applicant health service, on referral from her General Practitioner, expressing a firm wish that she have a termination. Q, in her own opinion, felt she was not ready for a pregnancy. Evidence before the Court given by her mother, father, expert counsellors and psychiatrists confirmed that, given her history and her age, the pregnancy placed her at risk of further self-harm and suicidal thoughts. In addition, evidence from a consultant obstetrician confirmed that the physical risks of the pregnancy, some of which were life threatening, outweighed the risk associated with a termination. On the evidence of risk, Justice McMeekin concluded as follows:

> In summary, the evidence is all one way. While termination of the pregnancy carries with it some risk those risks are far outweighed by the alternative.

The need for intervention by the Court.

The application was brought in the *parens patriae* jurisdiction of the Supreme Court of Queensland, which provides for the protection of the interests of those people unable to protect their own interests. The dominant factor in exercising the jurisdiction is to decide in the best interests of the protected person, in this case a child. The exercise of this jurisdiction would not have been necessary had Q been able to give informed consent to the procedure (except for the potential for criminal liability in the Queensland jurisdiction).

Issues considered

Q's capacity for informed consent

Justice McMeekin considered whether Q was able to give consent to the medical procedure. In considering Q's capacity, a psychiatric report was tendered which stated that:

> She had little or no idea about the process of pregnancy and had no idea of the realistic emotional and physical demands that would be part of caring for and raising a child.

His Honour added that, while he believed Q had a good understanding of the risks of the procedures to be performed, there was real doubt about Q's ability to understand the long term consequences of a

decision not to terminate. Following the observations of Wilson J in *State of Queensland v B*, Justice McMeekin concluded that

> …very few 12 year olds could have the maturity to comprehend the impact a decision like this might have on them in the longer term.

Informed consent by Q's parents.

Q's parents were willing to consent to the termination. This was not considered sufficient to authorise the proposed termination. Again, following *State of Queensland v B*, Justice McMeekin agreed with Justice Wilson's reasoning that the consent of a parent was not sufficient to authorise the termination of a pregnancy. The reasoning in the *State of Queensland v B* was that the termination had similar characteristics to the sterilisation procedure considered in *Marion's case.* In particular, there was a risk of making a wrong decision with grave consequences. In that case Justice Wilson reached the conclusion on this basis:

> The Court in its role as parens patriae must act in the best interests of the child B, whereas her parents may ultimately make a decision which favours other and possibly conflicting interests of the family as a whole.

Having concluded that the Court was the appropriate decision maker in relation to the proposed termination, His Honour was required to determine whether the proposed procedures were lawful in Queensland.

Decision

The lawfulfulness of the termination

The Criminal Code Act 1899 (QLD) deals with abortion at sections 224 and 225. It is an offence for a person, by administering medication, or by surgery, to procure a miscarriage. Section 282 allows for justification of a surgical procedure or other medical treatment where it is reasonably required in the circumstances for the patient's benefit or the preservation of a mother's life. In interpreting the Statute, His Honour referred to the test set out by the Supreme Court of Victoria, known as the 'Menhennit rules', and adopted in the 1983 Queensland case of *K v T* [1983] 1 Qd R 396. These rules are no longer applicable to Victorian abortion law, which does not prohibit abortion up to 24 weeks of pregnancy.

In the Queensland context, Justice McMeekin referred to the need to have an honest belief that that the procedure is necessary to preserve the physical or mental health of the woman and that the procedure is not out of proportion to the danger to be averted. He found this test was satisfied on the facts in respect of both the administration of medication and surgical intervention if required.

Orders made

Justice McMeekin made orders that the termination procedures were lawful; that Q was permitted to undergo the procedures; and permitting the Hospital to perform the termination of Q's pregnancy by the administration of medication or, if that was unsuccessful, by a surgical procedure.

Conclusion

This case demonstrates the operation of the *parens patriae* jurisdiction in the State Supreme Courts. An application to a court in this jurisdiction (or in some cases to the Family Court) is required where a person lacks capacity and it is not clear that an alternative decision maker, including a parent or guardian, can lawfully make the proposed decision.

Relevant medical decision makers should be aware of the circumstances in which parents and guardians may not have the legal power to consent to, or to refuse certain medical decisions.

*If you have any questions arising out of this article, please contact **Claudia Hirst** on **(03) 9865 1340** or email **Claudia.hirst@healthlegal.com.au**.*

Case Report – Informed Decision Making

Application of a Local Health District; Re a Patient Fay [2016] NSWSC 624 – termination of pregnancy where a patient was found to lack capacity

By Giovanni Marino, Senior Solicitor

Introduction

The New South Wales Supreme Court recently considered whether a patient, a pregnant 19 year old woman with an intellectual disability, had capacity to refuse the treatment proposed by medical practitioners.

Facts

The patient, 'Fay', was a 19 year old woman with an intellectual disability, and who identified as Aboriginal. Fay was approximately 22 weeks pregnant at the time of the hearing and was a single mother of a 4 year old son.

Fay had been admitted to intensive care at a hospital in country New South Wales (the **Hospital**) on 6 April 2016 with placental haematoma and progressive renal failure.

Fay's treating doctors believed she was at significant risk of permanent cerebral damage and possibly death if pregnancy continued, and recommended that her pregnancy be terminated to allow for more effective control of her blood pressure. Up until this stage the foetus had been progressing relatively normally, however it was accepted that if intervention occurred the foetus would not survive at birth.

Fay wanted to continue with the pregnancy, and Fay's mother supported this decision. Fay did, however, sign a consent form on 12 May 2016 in the following terms:

> If I have a severe complication like an eclamptic seizure (fit), a cerebral haemorrhage (bleeding in the brain), a stroke, bleeding of the liver or my doctor considers that I am likely to die, then I consent to delivering of the baby even if that means the baby will not survive.

Despite the signed consent, the doctors wanted to intervene immediately (providing termination of the pregnancy) rather than waiting for one of the above events to occur.

Tribunal findings

The Hospital sought an Application for Special Treatment from the New South Wales Civil and Administrative Tribunal (**NCAT**) on 10 May 2016. A telephone conference was conducted on 11 May 2016 by three members of NCAT, Fay and her mother, the treating obstetrician, the nephrologist, and a hospital administrator. During that meeting the nephrologist informed NCAT that Fay's condition was at a high risk of deteriorating over the next seven days, and would increase over time.

NCAT had the following conversation with Fay during the telephone conference:

> Member: Do you understand the medical treatment that is being proposed?
>
> Fay: They want to take away my baby.
>
> Member: Do you want that?
>
> Fay: No.

Upon being asked further questions by NCAT, Fay handed the telephone back and started crying, after which point the telephone conference was terminated.

On 12 May 2016 NCAT dismissed the Hospital's application, on the basis that NCAT considered Fay

had the requisite capacity to refuse the proposed treatment.

The Hospital appealed NCAT's decision to the New South Wales Supreme Court.

Consideration by the New South Wales Supreme Court

The Hospital challenged NCAT's findings and sought to invoke the *parens patriae* jurisdiction of the Court, seeking orders which would allow the Hospital to proceed with the proposed treatment. The Court invoked its *parens patriae* jurisdiction, and leave was granted by the Court to conduct a rehearing and receive fresh evidence. The rehearing was conducted by Fay's bedside on 14 May 2016.

The Court noted that its *parens patriae* jurisdiction was essentially protective in nature and predominantly concerned with the welfare of the person involved (in this case, Fay).

The Court found that while the jurisdiction was broad, it was generally to be exercised only in exceptional cases and with considerable caution, and in the case of an adult, "care should always be taken to ensure that there is no interference unlawfully in the free will of a capable individual."

The Court further found, however, that "[g]enerally whenever there is a conflict between a capable adult's exercise of the right of self-determination and the State's interest in the preservation of life the right of the individual must prevail" (relying on *Hunter and New England Area Health Service v A by his tutor T* (2009)).

The Court further noted there was a rebuttable presumption that an adult had the capacity to consent to or refuse treatment, and found that:

> If a person is unable to comprehend and/or retain information which is material to the relevant decision, in particular the consequences of the decision, or the person is unable to use and weigh the information as part of the process of making the decision, then generally the person will be seen as incapable of exercising their right of self-determination.

The Court also considered the influence of third parties in decision making, and referred to *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 in which the Court expressed the view that:

- a person was entitled to receive advice and assistance from others in reaching a decision especially from family members
- even strong opinions that are designed to persuade a person to make a particular decision will not be objectionable "so long as it did not overbear the independence of the patient's decision"
- a patient who is very tired, in pain or depressed will be less able to resist having their will overborne than one who is rested, and free from pain and cheerful, and the relationship of the 'persuader' to the patient may be of crucial importance; and
- the influence of parents on their children or of one spouse on the other can be much stronger than would be the case in other relationships.

Evidence was heard from a number of medical experts at the hearing. The Court found the medical evidence to be uncontroversial. The expert evidence indicated that Fay was in serious need of medical intervention to enable the control of her blood pressure so as to avoid serious consequences to her life. A psychiatric report concluded that Fay did not understand her medical condition and the treatment options available to her, and that Fay was largely if not wholly dependent on her mother (who would often answer for her).

The Court also placed significant weight on evidence provided by Fay's solicitor, Ms McMullen, as to her conversation with Fay regarding the proposed treatment. Ms McMullen's evidence was that she was simply unable to obtain instructions from Fay during this conversation due to Fay's lack of understanding. At the end of this exchange, Fay began to cry and ask for her mother. The Court found that this exchange betrayed "a real lack of understanding on Fay's part as to the very difficult decision-making process which sadly confronted her" and also confirmed the 'dominant' position of her mother.

The Court was satisfied that Fay "did not adequately understand nor was capable of balancing or making an informed decision such as to permit her to refuse the treatment recommended".

At the bed-side rehearing, the Court found that Fay was "uncommunicative", and either unable or unwilling to engage in dialogue about the various recommendations made to her.

The Court noted that Fay was "clearly distressed and made even more distressed by these proceedings", but there was also a "serious limitation" in her capacity to understand what had been put to her.

On the evidence presented, the Court found there was "more than ample" material to rebut the presumption of capacity that would normally be present.

The Court also found that the influence of Fay's mother was a "most significant factor". The Court noted that:

- Fay's mother was vehemently opposed to any form of intervention except in "dire circumstances"
- at all times in the hearing she purported to speak on behalf of Fay, indicating that Fay had strongly held views opposing intervention, and that Fay understood all of the relevant risks that might manifest (but the Court was not satisfied that Fay held or could have come to such a view)
- the manner and tone in which Fay's mother gave her evidence, gave the Court "grave concerns" that she did not really understood the significance of the likely risks that might confront her daughter.

As an example, the Court referred to the mother's concern that Fay's son would be disappointed (if pregnancy was terminated) as Fay had promised the son that she would be bringing a little brother home from the Hospital. The Court noted that this showed little insight into the possible consequence that Fay might suffer a stroke during pregnancy, and how that might impact on Fay's ability to parent.

While not criticising the mother, the Court's view was that her mother had "run her life for a very long time because Fay was simply incapable of doing it herself", and that Fay's mother did not herself fully appreciate the significance of the risks faced by Fay.

On the basis of the above evidence, the Court allowed the proposed intervention. Given the seriousness of the repercussions for Fay if treatment were delayed, the Court made its decision at the time of the bed-side hearing.

The Court then went on to consider NCAT's initial dismissal of the application. The Court held that the manner in which NCAT conducted the investigation was "wholly unsatisfactory". The Court noted that on an "extraordinarily limited and ambiguous exchange" and contrary to the medical evidence presented, NCAT concluded that Fay had capacity to refuse treatment. Furthermore, NCAT failed to provide reasons for their decision which constituted an error of law.

Conclusion

This case supports the principle that an adult who is not capable of comprehending the nature and consequences of a medical treatment decision will be incapable of refusing or consenting to that medical treatment. The case also demonstrates that the refusal of a person responsible or 'next of kin' may be ineffective if the Court considers that the decision is contrary to the patient's best interests.

The case highlights the importance of a person's medical decision making not being overborne (for example, by a family member).

If you have any questions arising out of this article, please contact ***Giovanni Marino*** *on* ***(03) 9865 1339*** *or email* ***giovanni.marino@healthlegal.com.au****.*

Managing Contested Bequests

By Jeremy Smith, Compliance Officer and Alon Januszewicz, Associate Legal Counsel

Introduction

It is not uncommon for patients and community members to leave bequests to health services, community health organisations and research institutes. In many cases, the family of the deceased will be supportive of their relative's wishes to leave money to the service. However, in some instances, family members will object to the bequest being made and will make a claim against the executor, or even against the beneficiary health service.

In broad terms, there are 2 ways in which a will may be legally challenged by disappointed beneficiaries (generally relatives of the deceased):

- **By claiming that the will was not validly made:** The will may be challenged on the basis that it was not validly made because the deceased person did not have testamentary capacity. 'Testamentary capacity' requires (amongst other matters) that the deceased understood the nature and the effect of the will. There are also formal requirements which must be satisfied for the will to be valid. If the will is found to be invalid, the laws of intestacy, which govern the distribution of the estate where there is no will or no valid will, will apply and the family will receive the proceeds of the estate.
- **By making a claim for further provision from the estate**: If the will is valid, certain 'eligible persons' are able to make an application for a family provision order from the estate under Part IV of the *Administration and Probate Act 1958* (Vic) within 6 months of the grant of probate.

Family provision claim

In order to make a family provision order, the Court must be satisfied that:

- the applicant is an *eligible person*
- there was a relationship of dependency as specified in the Act
- at the time of death, the deceased had a moral duty to ensure the provision of proper maintenance and support of the applicant, and the dispositions in the will fail to fulfil this duty adequately.

Eligible persons

In Victoria, only 'eligible persons' may make a claim for further provision from the estate. This follows a recent amendment to the Act so that only persons who, at the time of the deceased's death, were in a defined relationship with the deceased (i.e. spouse or domestic partner or a child) are able to make a claim. This requirement prevents claims being made by, for example, distant relatives with no meaningful connection with the deceased.

Issues considered the Court

Before the claim is heard by the Court, the parties will be required to attend a mediation to attempt to settle the claim. Generally, the executor (who is responsible for carrying out the wishes of the deceased) and the person making the claim will attend the mediation. However, if the health service has been named as a party in the proceedings, it will also be required to attend the mediation and should be legally represented.

If the claim is not resolved by mediation and proceeds to trial, the Court must take into account the deceased's will, any evidence regarding the deceased's reasons for making the dispositions in

the will, and any evidence relating to the deceased's intentions regarding the provision of maintenance and support for the applicant. Furthermore, there is a non-exhaustive list of matters the Court may take into account such as any mental, physical or intellectual disability of an applicant or any other beneficiary of the estate.

Costs of the proceedings

The general rule in family provision proceedings (as in any civil litigation) is that the losing party is ordered to pay the costs of the winning party. However, where a trustee or beneficiary is forced to defend proceedings, their reasonable legal costs will generally be borne by the estate. It is important to consider the costs implications involved in resisting a claim by a disappointed beneficiary.

Conclusion

There are legal and reputational risks in opposing a valid claim made by a family member and in our experience, health services left a bequest do not wish to stand in the way of such claims. Therefore, if a bequest is challenged, it is helpful to seek early advice about the legitimacy of the claim. It is often the case that claims on the estate can be resolved even before legal proceedings are issued.

*If you have any questions arising out of this article, please contact **Alon Januszewicz** on **(03) 9865 1312** or email **alon.januszewicz@healthlegal.com.au**.*

Staff News

Chris Chosich will be joining Health Legal as a solicitor on his admission in October. Chris will continue to work with the compliance team and will take on advice and contract work from October. Congratulations, Chris.

We also congratulate Teresa Pollock who has been promoted to Chief Operating Officer of Law Compliance and Alon Januszewicz who has been promoted to the role of Associate Legal Counsel.

Our compliance team continues to grow and this month we welcomed **Lissa Board** as Compliance Administration Officer. Lissa will provide administrative support to the team and will assist in the delivery of our expanding range of legislative compliance products to our clients across the country.

Compliance Alert Service

In response to client demand we have developed a compliance alert service which complements our existing legislative compliance products and services.

Updates to the Compliance Register and Self-Assessment Questions are delivered on a quarterly in arrears basis so that you are updated on legislative changes which have occurred in previous 3 month period.

We have now launched an alert service which provides you with pro-active advanced warning of the commencement of new significant Acts and Regulations. "Significant" Acts and Regulations means those which will have a significant operational impact on your organisation. As part of this alert, we will provide you with a summary of the legislation and provide you with a link to the relevant Act/Regulation.

This alert service will allow you to prepare for new legislation before the Acts and Regulations have commenced.

LAW COMPLIANCE

If you would like to add this service to your current subscription (or if you have any questions), please contact ***Teresa Pollock*** *on* ***(03) 9865 1337*** *or* ***teresa.pollock@lawcompliance.com.au***.

Legislative Changes being tracked

The following significant Bills are being tracked by our compliance team to ensure that our subscribing alert clients are notified once they are passed by Parliament:

- Fair Work Amendment (Protecting Australian Workers) Bill 2016 (Cth)
- Fair Work Amendment (Remaining 2014 Measures) Bill 2015 (Cth)
- Marriage Amendment (Marriage Equality) Bill 2016 (Cth)
- National Cancer Screening Register Bill 2016 (Cth)
- Privacy Amendment (Notification of Serious Data Breaches) Bill 2015 (Cth)
- Superannuation Legislation Amendment (Choice of Fund) Bill 2016 (Cth)
- Freedom of Information Amendment (Office of the Victorian Information Commissioner) Bill 2016 (Vic)
- Public Administration Amendment (Public Sector Communication Standards) Bill 2016 (Vic)
- Tobacco Amendment Bill 2016 (Vic)
- Crimes and Anti-Discrimination Legislation Amendment (Vilification) Bill 2016 (NSW)
- Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2016 (NSW)
- Gene Technology (Western Australia) Bill 2014 (WA)
- Health Care (Privacy and Confidentiality) Amendment Bill 2016 (SA)
- Retirement Villages Bill 2016 (SA)
- Voluntary Euthanasia Bill 2016 (SA)
- Residential Tenancies (Miscellaneous) Amendment Bill 2016 (SA)
- Building Bill 2016 (TAS)
- Building (Consequential Amendments) Bill 2016 (TAS)
- Care and Consent to Medical Treatment Bill 2016 (TAS)
- Fire and Emergency Services (Domestic Smoke Alarms) Amendment Bill 2016 (QLD)
- Fire and Emergency Services (Smoke Alarms) Amendment Bill 2015 (QLD)
- Health and Other Legislation Amendment Bill 2016 (QLD)
- Public Health (Medicinal Cannabis) Bill 2016 (QLD)
- Revenue and Other Legislation Amendment Bill 2016 (QLD)
- Medical Services Amendment Bill 2015 (NT)

If you would like details of these new Bills please contact ***Teresa Pollock*** *on* ***(03) 9865 1337*** *or* ***teresa.pollock@lawcompliance.com.au****.*

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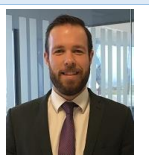

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