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Mr Peter Hennessy
Executive Director
NSW Law Reform Commission
GPO Box 5199
SYDNEY NSW 2001

Dear Mr Hennessy

Minors' consent to medical treatment: submission by Shopfront Youth Legal Centre

The Shopfront Youth Legal Centre is a free legal service for homeless and disadvantaged young people aged 25 and under. It was established in 1993 and is a joint project of Mission Australia, the Salvation Army and the law firm Freehills.

We commend the Commission on producing such a detailed and well-researched Issues Paper. We welcome the opportunity to provide a submission. We have chosen not to comment on all issues raised, but to concentrate on those that are within our expertise and most relevant to our client group.

The Shopfront Youth Legal Centre's perspective

The Shopfront Youth Legal Centre has over ten years' experience in dealing with marginalised young people. A high percentage of our clients are affected by mental illness, intellectual disability, alcohol and other drug abuse, or a history of abuse and neglect.

Our three senior solicitors all have extensive experience as children's lawyers, and one is an accredited specialist in children's law. Our main area of expertise is in criminal law, but we also practise in the areas of family law, care and protection, administrative and civil law.

We are often called upon to advise young people (and to educate youth workers and other professionals) about legal issues relating to medical treatment and related services such as counselling and health education. We also regularly have to grapple with issues of capacity, for example, when assessing a child's capacity to instruct us in legal proceedings.

We believe that most children, at least from early adolescence, have the capacity to exercise sound judgment about matters affecting their lives. In our view,

children should be encouraged to participate in decision-making and to be accorded autonomy commensurate with their capacity.

On the other hand, we recognise that children are vulnerable and that adolescence is often a turbulent time. In many cases young people need guidance and protection, so as to reduce the risk they will make decisions detrimental to their welfare.

In many cases, protection and guidance is adequately provided by a child's parents or other family members. However, we are painfully aware that parents cannot always be relied upon to make decisions in their children's best interests. A small minority of parents are abusive; others may lack the capacity to make decisions for their children due to mental illness or disability. Some parents may find that their capacity to exercise sound judgment is impaired by extreme stress (which may be the case if their child has a serious medical problem or disability).

The balance between a young person's autonomy and need for protection is a difficult one to strike. We hope that, in this submission, we can offer some useful suggestions as to how this balancing exercise may best be conducted.

Chapter 1: Introduction

Medicare

We support the comments made in the Issues Paper about Medicare. Without access to their own Medicare cards, young people's ability to make their own decisions about medical treatment is compromised.

Although we recognise that the Medicare system is governed by federal jurisdiction, we suggest that measures could be taken at State level to improve the situation. One such measure is lobbying the Federal government to change their policy (which is, admittedly, unlikely to be successful under current circumstances). Another is the provision of more State government funding for youth health centres where young people may receive treatment without providing their Medicare cards.

Definitions (issues 1.1 and 1.2)

The proposed definition of "treatment" at first seems fairly straightforward, but contains some ambiguities. Would it include medical advice or health information? Would it include services provided by counsellors and educators employed at youth health services under the ultimate supervision of a medical practitioner?

On the one hand we would wish the definition of "medical treatment" to remain narrow, so that young people of any age can access counselling, health information, and the like, without having to obtain parental consent.

On the other hand, if there is no legislative framework offering counsellors, educators and allied professionals a defence to potential legal action, they may be reluctant to provide services to children and young adolescents without parental consent.

On balance we support the view that "treatment" should not include advice, information, education and counselling.

Chapter 2: Young people's capacity to make medical decisions – the current law

Co-existing rights to consent (issue 2.4)

Co-existing rights to consent pose a difficulty, especially if a parent, by giving consent, is effectively able to override the child's refusal.

We refer to our comments below on refusal of treatment.

Legal regime for resolving disputes over consent (Issue 2.5)

We believe it would be desirable if all children (whether under or over 16) were subject to the same legal regime for resolving disputes over medical consent. At the very least, we see the need for a more cohesive legal regime for children under 16.

Refusal of treatment (issue 2.6)

It is our view that, if a person is considered competent to consent to treatment, they should be equally competent to refuse treatment.

We do not agree with the proposition at paragraph 3.41 of the Issues Paper that:

“If the primary motivation in recognising young people's right to consent to medical treatment is to allow them better access to health care, that same concern does not apply to allow them a right to refuse treatment and in fact argues against such a right.”

A young person may be discouraged from seeking medical advice if he or she is not confident of the right to refuse treatment. For example, a pregnant young woman may refrain from seeing a doctor if she believes she may be forced to have a termination.

There may be some situations in which children (and their parents) should be deemed incompetent to refuse treatment. A child should not be denied life-saving treatment because of his or her parents' religious beliefs, no matter how conscientiously-held. It is a more difficult matter if a mature, competent child has conscientiously-held beliefs which are inconsistent with certain types of treatment (eg organ donation).

In relation to the case study in paragraph 2.51, we believe that the level of understanding and maturity required by the court was unreasonably high. A large proportion of adults would fail to meet the competence test if this sort of threshold were imposed. However, that is not to say we believe the child should have been entitled to refuse treatment. In such cases - where treatment is necessary to save a child's life or prevent a serious disability - we would support an overriding best-interests test so that a court may order a child to undergo treatment.

Chapter 3: Young people's capacity to make medical decisions - models for reform

Young people making decisions about medical care (Issue 3.1)

In general, we believe that young people should be empowered to make decisions about their own medical care as soon as they are competent to do so. Even where a young person is not competent to consent to treatment, he or she should be consulted and informed about the treatment as much as possible.

However, some types of treatment (often described as "special") potentially have a serious and long-term impact. There is a strong argument for requiring authorisation by a court or tribunal before carrying out such treatment on a child.

Comments on Model One (Issues 3.2 to 3.7)

We agree that the law should assess a young person's competence to consent to medical treatment in terms of the individual young person's understanding of the nature and possible consequences of the proposed treatment. The child's ability to reason and weigh up various alternatives may be a factor influencing the practitioner's assessment of whether the child is competent.

It would be helpful to prescribe guidelines by which the treating medical practitioner can assess the individual patient's degree of understanding. These guidelines would need to be prepared in consultation with experienced child development specialists. Although it would be very difficult to spell out in legislation the precise level of understanding that a young person must demonstrate in order to be competent, it would be desirable for legislation to include a list of factors to be taken into account.

We do not believe that Model One places too much emphasis on the young person's right to autonomy, nor does it place too much discretion in the medical practitioner's hands. If a young person is competent to consent to medical treatment, and the nature and consequences of the treatment are adequately explained, the risk of the child making a detrimental decision is lessened.

By way of analogy, as legal practitioners in criminal matters we are required to act on the instructions of the child. There is always a possibility that a child's instructions may conflict with their best interests, and the consequences of a "wrong" decision can be serious. In practice, however, we have observed that most of our child clients make decisions in their own best interests, as long as they are given competent legal advice about their options. In a medical context, we believe that most children would also make decisions in their own best interests if the options were adequately explained to them.

We would imagine that most medical practitioners are relatively experienced in assessing competence; they would often be required to assess the competence of adults with mental illnesses, intellectual disabilities or dementia.

If safeguards were thought desirable to check the exercise of the medical practitioner's discretion, this could be considered. A requirement for a second medical opinion may pose difficulties, especially in rural and regional areas where doctors are scarce.

There is some merit in the idea of a safeguard that gives an "interested person" the right to challenge a medical practitioner's decision about competence. However, in practice, this would be difficult to achieve because it would require "interested

persons” to be made aware of a medical practitioner’s decision before treatment is carried out. We believe that such a requirement may be likely to discourage young people from seeking medical assistance, especially in areas such as sexual health.

As previously mentioned, we believe there are some categories of treatment that should not be undertaken unless the treatment is in the child’s best interests. In these cases it may be necessary to have the treatment authorised by a court or tribunal. We believe that the types of treatment defined as “special” in the *Children and Young Persons (Care and Protection) Act* and in the *Guardianship Act* should come within this category (with the exception of termination of pregnancy, and administration of addictive drugs such as methadone in appropriate cases).

Comments on Model Two (Issue 3.8)

We agree that a fixed-age test, as proposed in Model Two, would be easier to implement and would place less responsibility on medical practitioners for assessing children’s capacity. However, there is a risk that some children who are not competent may make detrimental decisions, and that mature younger children are denied access to treatment because the law does not deem them competent to consent.

A rebuttable presumption that a child is competent to consent to treatment at a certain age (for example, 14) may provide useful guidance to practitioners without being too restrictive.

Comments on Model Three (Issue 3.9)

We believe that there is merit in Model Three; however, we do not believe that parental consent should be able to override a competent child’s objection or refusal. If a child objects to or refuses medical treatment, any dispute should be resolved by an independent body such as the Guardianship Tribunal.

We do not believe that Model Three is too complicated to be workable in practice. Certainly it is no more complicated than Model One.

Comments on Model Four (Issue 3.10)

We believe that there is merit in Model Four, which would differentiate between different types of medical treatment when deciding who may consent to that treatment.

We support the suggestion that children (at least from the onset of puberty) should be able to consent in their own right to treatment in the areas of sexual health (eg. contraception, sexually transmissible diseases), mental health and alcohol and other drug abuse. The public interest in ensuring that young people have access to confidential health services in these areas is paramount.

However, we would qualify this by saying that some treatments such as electroconvulsive therapy, administration of psychiatric medication, sterilisation, long-term contraception and any major surgery should be treated differently. Either the test for competence should be more rigorous, or consent to treatment should be subject to an overriding best interests test. In the case of procedures that are irreversible or likely to have a significant long-term impact (eg. sterilisation, psychosurgery) we suggest that a child should not be competent to consent but that any such treatment ought to be authorised by a court or tribunal before proceeding.

Comments on Model Five (Issue 3.11)

We do not support Model Five, in which it is proposed that some groups of young people (those who are homeless, married or in de facto relationships, or are parents) automatically be presumed competent to consent to medical treatment.

We would be the first to acknowledge the practical difficulties in obtaining parental consent to treatment for these groups of young people, and the undesirability of involving parents in these decisions where the child is living independently.

However, our experience is that many homeless young people are in fact less mature and less competent to make decisions than their peers who live in stable homes. The prevalence of mental illness, intellectual disability and serious emotional disturbance (usually the result of abuse or neglect) among homeless young people is alarmingly high. Although many homeless young people are “streetwise” and may appear mature beyond their years, their emotional and cognitive development is often delayed, and their judgment may be affected by stress or trauma.

We believe that competence should be assessed according to the individual child, not according to their housing, marital or parental status. For homeless or independent young people who are not competent to consent to treatment, there is a glaring need for an alternative to parental consent.

We have worked with many young people who are estranged from their parents and whose parents no longer play a meaningful role in their lives. However, the parents still have parental responsibility at law, as care proceedings have either not been commenced or have not resulted in an order re-allocating parental responsibility.

In our experience, DOCS will rarely intervene once a child is approaching 16; if they do intervene at this age, they are unlikely to commence care proceedings in the Children’s Court. In cases where a parent/child relationship is tenuous, but has not broken down altogether, DOCS intervention is more likely to be in the form of supervision rather than an order re-allocating parental responsibility.

While many homeless young people are competent to consent to medical treatment, a significant number are not – for example, those who have an intellectual disability or are in the acute phase of a mental illness. For children who do not have a meaningful relationship with their parents, but do not have anyone else formally exercising parental responsibility, there needs to be a meaningful consent obtained.

A possible option would be to extend the application of the *Guardianship Act* – and expand the jurisdiction of the Guardianship Tribunal - to cover children below 16. We believe a “person responsible” should be able to consent to minor medical treatment on a child’s behalf. A “person responsible” may be a relative, a caseworker at a youth refuge, or another responsible adult who the young person knows and trusts.

With respect to major treatment, we believe the most appropriate procedure is the appointment of a guardian to make decisions on the child’s behalf. Special treatment should only be carried out with authorisation from the Tribunal.

Chapter 4: Making decisions about medical care for young people who are not competent to decide for themselves

Provision for settling disputes between parents over their children's medical care (Issue 4.1)

We believe that current provisions are adequate but not ideal. The Family Court (or another court exercising family law jurisdiction, such as the Federal Magistrates' Court) may often be an appropriate forum for the settling of such disputes. However, we believe it would be desirable to provide an alternative forum, and clear guidelines, for the resolution of such disputes.

Involvement of other family members or caregivers (issue 4.3)

We believe there is place for the involvement of other family members or caregivers, especially where a child lives with extended family members or in alternative accommodation such as a youth refuge, but where no order has been made re-allocating parental responsibility.

Under the *Guardianship Act*, a "person responsible" (who may be a relative or carer, but not necessarily a legal guardian) may consent to certain types of treatment on behalf of a person over 16 who lacks capacity to consent. We see merit in extending these provisions to children under 16, in cases of minor medical treatment.

For more serious forms of treatment falling short of special treatment, we believe it should be possible for the Guardianship Tribunal to appoint a relative or carer as a guardian for the purpose of making decisions about the child's treatment.

Treatment requiring authorisation by a court or tribunal (issue 4.4)

We believe that some types of treatments should not be carried out without the authorisation of a court or tribunal, even if the child is competent to consent and/or the child's parents have given consent.

We believe it would be desirable to spell out a list of such treatments in legislation, but to make the list non-exhaustive. This would allow room for the common law to keep pace with new and different forms of treatment.

As mentioned above in our comments on Model One (Issues 3.2 to 3.7), most types of treatment defined as "special" in the *Children and Young Persons (Care and Protection) Act* and in the *Guardianship Act* should require court or tribunal authorisation.

We believe that some treatments, such as termination of pregnancy, or administration of certain types of drugs (eg methadone, psychiatric medications) should not require court or tribunal authorisation if the child is competent and has given consent. However, we believe it is inappropriate for a parent to be empowered to consent to these treatments on a child's behalf.

We believe it is desirable that some forms of treatment (for example, gender reassignment) should not be carried out until the child is competent to consent *and* a court or tribunal has authorised the treatment.

Consent to special medical treatment (Issue 4.5)

As mentioned in our comments on Issue 2.5, we believe it would be desirable to have a single regime applying to children of all ages. There seems little

justification for maintaining the different rules that currently apply to children under 16 and to those aged 16 or over.

Jurisdiction of courts and tribunals (Issue 4.7)

We are attracted to the arguments in the Issues Paper in favour of vesting exclusive jurisdiction in the Guardianship Tribunal. To us they are more compelling than those in favour of vesting exclusive jurisdiction in the Family Court. Some of the arguments advanced in favour of the Family Court also apply to the Guardianship Tribunal – for example, the non-adversarial nature of proceedings and the capacity to develop a body of law over time. Procedures for resolving disputes over consent in the Family Court (or the Supreme Court) are likely to be complex, expensive and time-consuming. The Guardianship Tribunal provides a much more accessible forum.

Even if the jurisdiction of the Guardianship Tribunal is expanded, it would probably be desirable to retain the existing jurisdiction of the Family Court. In some cases, for example where the issue of a child's medical treatment arises in the context of a broader family law dispute, the Family Court may be the most appropriate forum.

Criteria for decision-making (Issue 4.8)

We believe it would be desirable for criteria to be set out in legislation, and that it may be appropriate to apply different criteria according to different types of treatment. However, such criteria should not be prescriptive and should not unduly interfere with the court or tribunal's discretion. The best interests of the child should always be the paramount consideration.

Responsibility for decision-making: parents versus authorisation by an external body (Issue 4.9)

As we have previously mentioned, we believe that some types of treatment (generally those defined by legislation as "special") should require authorisation by a court or tribunal. The court or tribunal should be required to consider the parents' views but such views should not be determinative.

Although it is true that, in general, parents know their children better than anyone, parents are not always equipped to make decisions in the best interests of their children. It is also true that parents are expected to cope with the consequences of the medical decision and should have some say in the process. However, the main person who has to live with the consequences is the child, and there should be some independent safeguard to ensure that the decision is in the best interests of the child.

As to time delays, we believe that it should still be possible to carry out emergency treatment without the need for consent.

Limits on ability of mature young people to make medical decisions (Issue 4.10)

As mentioned above, we believe that some types of treatment potentially have such serious and long-term consequences that they should be authorised by a court or tribunal, even if the child is competent to consent. The child's views should of course be taken into account, and in the case of a mature young person should be given considerable weight.

Chapter 5: Treating young people without consent

Refusal of emergency care (Issue 5.1)

We do not believe a parent or a child should be able to refuse emergency treatment, where a medical practitioner believes that the treatment is necessary to preserve the person's life or to prevent significant long-term harm.

However, we can envisage a situation where a child has a life-threatening illness and is continually being "saved" by emergency treatment, but does not have any reasonable prospect of recovering from the illness or of having any appreciable quality of life. In such a case it may be appropriate for the child or a parent to apply for a court or tribunal order authorising them to refuse consent to any such emergency treatment in the future.

Medical examinations (Issue 5.4)

In some situations it may be appropriate for a child to undergo a medical examination against his or her will and without parental consent. The obvious example is in cases of suspected child abuse. The interests of public health may necessitate an examination if it is thought that a child is infected with a serious contagious disease.

Clearly a forced medical examination is distressing for a child, and it is always preferable to attempt to obtain the child's (or, where the child lacks sufficient understanding, the parents') consent before proceeding.

Educational institutions (Issue 5.6)

We support the development of more uniform guidelines with respect to consent to minor medical treatment in schools and other institutions which care for children and young people.

In the case of "older" young people (from the age of about 10 upwards) we support the principle that the school should obtain the child's consent before providing minor medical treatment.

Chapter 6: Young people with mental illness or intellectual disability

Voluntary admission to psychiatric hospital (Issues 6.1 and 6.2)

We do not believe the objection of one parent alone should be sufficient to bar a child's voluntary admission to hospital. We agree that a number of factors should be considered, including the nature of the child's mental illness, the child's level of understanding and the views of the parent(s).

Because of bed shortages in psychiatric wards, it is unlikely that a hospital will admit someone as a voluntary patient unless there are sound medical grounds for their admission.

In theory, we believe that children should be able to consent to voluntary admission to a psychiatric hospital in the same manner as other types of medical treatment. However, in reality the situation may be complicated by a child's poor state of mental health, and the child may lack capacity to consent.

Psychosurgery & ECT (Issue 6.3)

We believe the provisions concerning children's consent should be the same for ECT as for psychosurgery. A child should be presumed incapable of consenting to ECT, and such treatment should only be carried out with the authority of a court or tribunal.

Chapter 7: Treating young people with special needs

Groups of young people requiring special consideration (Issue 7.1)

The Issues Paper has correctly identified various groups of young people with special needs. Their special needs arise from the prevalence of health problems among these groups, and also from the fact that young people in these groups may face practical difficulties in obtaining parental consent because they do not live in "traditional" nuclear families.

To this list we would possibly add "children and young people at risk of homelessness" – that is, children who may be forced to leave home at any time (or who may have already spent periods out of home) because of a dysfunctional family situation. These children, as well as homeless children, will usually find it difficult to get parental consent for medical treatment.

Children and young people in out-of-home care (Issue 7.2)

We support a change to the legislative provisions with governing consent to treatment for children in out-of-home care. As pointed out in the Issues Paper, it is unfair that a child as old as 17 could have their objection to treatment overridden by the consent of an authorised carer. The provisions should be amended so that children in care have the same rights as other children, while still being afforded protection from exploitation and abuse.

Homeless young people (Issue 7.5)

We are acutely aware of the health problems experienced by homeless young people, and support the comments made in the Issues Paper.

For suggestions on how consent issues for homeless young people may be resolved, please refer to our comments in response to Issues 3.11 and 4.3.

Children in juvenile detention centres (Issue 7.6)

This is a small but extremely vulnerable group of young people.

A recent survey conducted by the Department of Juvenile Justice, Corrections Health and the University of Sydney shows that detainees experience a multiplicity of physical and mental health problems. Another significant finding is that at least 10% of detainees had an intellectual disability, and many others functioned in the borderline range. Over 80% of detainees reported symptoms consistent with a clinical mental disorder.

Given the prevalence of intellectual disability and mental illness among detainees, issues of consent need to be carefully examined. We agree that the existing law is not sufficiently clear as to the obtaining of consent before examining and treating young people in detention centres.

Children whose parents are not competent to consent to treatment (Issue 7.7)

There is no reason why parents aged under 18 should not be competent to consent to treatment on behalf of their children. However, some parents – whether under or over 18 – will lack the capacity to consent.

We support a procedure for the appointment of a guardian or person responsible to make medical decisions on behalf of a child whose parents lack the capacity to consent.

Chapter 9: Disclosure of and access to young people's health information

Confidentiality

We believe that a young person seeking medical treatment is generally entitled to expect confidentiality. If a young person is competent to consent to (or refuse) treatment, his or her medical information should be treated with the same confidentiality as that of an adult (subject to the reporting provisions under the *Children and Young Persons (Care and Protection) Act*).

It is often said that, in order to properly exercise parental responsibility and to make decisions in the best interests of their children, parents need to be fully informed about matters affecting their children. As a general proposition, we agree with this. However, it needs to be qualified by a recognition that parental responsibility and control over children dwindle as the child matures, and that children may be discouraged from seeking medical assistance if they are not accorded some privacy.

Even where a young person is not competent to consent to medical treatment, and consent is instead given by a parent or other responsible person, we believe that children should still have some entitlement to confidentiality. In many cases, especially with younger children, it will of course be important for parents to receive information about the medical treatment that is being administered. However, there are some types of information which should be kept confidential, especially if the treatment relates to mental health, drug use or sexual health. A parent who has consented on behalf of a child may be informed in general terms about the nature and progress of the treatment, without having to be made aware of the precise content of the communication between the child and the medical practitioner.

In many cases it would be detrimental to the parent/child relationship, and to the progress of the medical treatment, if some degree of confidentiality is not accorded to the child. In abusive or dysfunctional families the disclosure of information to parents may have a significant adverse effect on the child's welfare. Even in the most loving and harmonious families, young people (especially during adolescence) are not always comfortable discussing sensitive or personal issues with their parents.

In relation to the reporting of children at risk under the *Children and Young Persons (Care and Protection) Act*, we see little utility in extending the mandatory reporting provisions to young people aged 16 and 17. Although we support the principle that children aged 16 and over should be entitled to the same

protection as under-16s, many professionals believe reporting is futile because the Department of Community Services rarely intervenes once a child reaches 16. However, a person who believes a young person aged 16 or 17 is at risk *may* make a report to DOCS, and will be subject to the same legal protection as a mandatory reporter in the case of a child under 16.

Access to health information

We believe that, regardless of capacity to consent, children should be allowed access to their medical records upon request. This may be subject to a proviso that a medical practitioner is not required to release information if he or she is of the view that it would pose a serious threat to the patient's life or health (as is currently the case with adults' access to their medical records).

We believe that it would rarely be in a patient's best interests to refuse access to their medical records. The view that a patient may be unduly confused or distressed by reading his or her medical records is, in our view, outdated and paternalistic. If there is a risk of distress to the patient, this can be overcome by ensuring that someone (either the medical practitioner or an independent person) is available to explain the information to the patient and to provide support if necessary.

In our view, parents should be able to obtain access to their child's medical records only if they have consented to the treatment on behalf of the child. If someone else has consented to medical treatment on the child's behalf (eg. a court or tribunal) we suggest that parents should be required to obtain the court or tribunal's authorisation before having access to their child's medical records (unless, of course, the child is now competent to consent to parental access to records and has given that consent).

In general, we do not believe that parents and children should have co-existing rights of access to health records. If a child has consented to treatment on his or her own behalf, we see no justification for medical records to be disclosed to parents without the consent of the child. In our view, the only situation in which co-existing rights may be appropriate is where a parent has consented to medical treatment on behalf of a child, but the child is now competent to seek access to his or her records.

We believe that a parent who has consented to treatment on a child's behalf should generally be entitled to request access to the child's medical records. If the child is above a certain age (we suggest 10 or 12) we believe the child should be notified and should have a right to object. If the child objects, there should be some independent adjudication as to whether the release of the records is justified and is in the best interests of the child. In some cases partial release of records to parents may be appropriate (for example, by removing or blacking out sensitive material).

We believe that the current law regulating access to medical records could benefit from consolidation, if this is constitutionally possible. We cannot see the justification for such significant discrepancies between the regime applying to public hospitals, private hospitals and other private health providers.

Chapter 10: Consolidation or codification

As the Issues Paper clearly demonstrates, the law with regard to minors' consent to medical treatment is extremely complex. It is piecemeal and riddled with inconsistencies. As well as causing unnecessary confusion, there is a risk of injustice arising from this imperfect patchwork of legislation and common law.

We see a need for the law in this area to be consolidated, preferably into one easily accessible piece of legislation. Even if it is not possible or desirable to consolidate the law into one Act, we believe that much could be done to iron out the inconsistencies between different statutes.

We do not support codification because we believe this would be too restrictive and inflexible. It is necessary to leave some room for the common law to keep pace with developments that may not be foreseen at the time a code is drafted. Advances in medical research and technology may lead to the introduction of new types of treatments which are not specifically contemplated by legislation. There is also the possibility that some types of treatment, previously considered very invasive and/or potentially harmful can now be administered without significant trauma or side effects (for example, "keyhole" surgery is less invasive than traditional surgical methods; new types of anti-psychotic medications do not have the same debilitating side-effects as their predecessors).

Conclusion

We would be happy to expand on any of the matters in our submission, or to participate in any relevant consultations.

If you wish to receive further comments, please do not hesitate to contact us on 9360 1847 or by email at jane.sanders@freehills.com, jane.irwin@freehills.com or suzie.miller@freehills.com.

Yours faithfully

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