

# *Guardianship and Health Decisions in China and Australia: A Comparative Analysis*

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## **Abstract**

This article compares the Australian and Chinese adult guardianship systems, and considers whether there is potential for drawing on some (or many) aspects of the

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Australian model for the Chinese legal framework. Australia has a well-developed guardianship framework that provides mechanisms for making healthcare decisions when an adult is no longer able to do so. This framework has evolved over many years and, in some cases, individuals can decide about medical treatment in advance of the situation arising, or who should be the decision-maker if he or she later loses capacity. The current Chinese legal framework, on the other hand, is a fragmented one and comprises laws that were not designed to deal with how healthcare decisions can be made for a person without capacity. This article outlines the legal framework in both jurisdictions and considers whether, having regard to the fact that these two countries have different values and cultures, there are features of the Australian guardianship system that could inform the development of Chinese law.

Now is a time of dramatic demographic change in both Australia and China. The populations of both countries are ageing, with the number of individuals in the above 80 age bracket predicted to increase by 179 percent in China and 154 percent in Australia by 2030.<sup>1</sup> China's population is ageing more rapidly than Australia's, with its median age increasing by 22 percent between 2012 and 2030, whilst Australia's is increasing by only 7 percent.<sup>2</sup> As the populations in both countries age, there will be an increased incidence of older persons suffering from cognitive decline due to dementia and other conditions. Affected older persons may no longer be able to make some, possibly many, decisions for themselves. Accordingly, both countries need to consider establishing frameworks to facilitate decisions being made on behalf of this potentially vulnerable cohort.

International developments will likely influence the development of such frameworks. With the ratification of the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD)<sup>3</sup> by Australia and China<sup>4</sup> and the emergence of the internationally recognized Yokohama Declaration on adult guardianship,<sup>5</sup> there has been a global shift in policy. Adults with decision-making impairments are no longer predominantly viewed as vulnerable and in need of protection, but instead are recognized as individuals entitled to human rights, equality, and citizenship.

1. United Nations Population Division, 'World Population Prospects: 2015 Revision' (UN Department of Economic and Social Affairs 2015) <<https://esa.un.org/unpd/wpp/DataQuery/>> accessed 3 May 2017. Note that the United Nations estimates appear conservative and vary. Euromonitor International predicts an increase in the above 80 age segment by 289% in China and 122% in Australia respectively: 'Australia in 2030' (Passport Global Market Information Database (GMID), Euromonitor International 13 August 2012) <[www.euromonitor.com/australia-in-2030-the-future-demographic/report](http://www.euromonitor.com/australia-in-2030-the-future-demographic/report)> accessed 20 January 2017; 'China in 2030' (Passport GMID, Euromonitor International 22 May 2012) <[www.euromonitor.com/china-in-2030-the-future-demographic/report](http://www.euromonitor.com/china-in-2030-the-future-demographic/report)> accessed 20 January 2017.
2. United Nations Population Division (n 1).
3. Convention on the Rights of Persons with Disabilities, UN General Assembly Resolution A/RES/61/106 [2006] 189 UNTS 137 (entered into force 3 May 2008); Optional Protocol to the Convention on the Rights of Persons with Disabilities, UN General Assembly Resolution A/RES/61/106, Annex II [2006] (entered into force 3 May 2008).
4. Australia ratified the CRPD on 17 July 2008 and the Optional Protocol on 21 August 2009. China ratified the Convention on 1 August 2008. There are 160 signatories and 173 parties to the Convention, and 92 signatories and 92 parties to the Optional Protocol.
5. This declaration was adopted by the First World Congress on Adult Guardianship Law, 'Yokohama Declaration' (International Guardianship Network, 4 October 2010) <[www.international-guardianship.com/yokohama-declaration.htm](http://www.international-guardianship.com/yokohama-declaration.htm)> accessed 3 May 2017. Since 2010, there has been a Second World Congress in 2012 in Australia, a Third World Congress in 2014 in the US, and a Fourth World Congress in 2016 in Germany: 'Previous Congresses' (International Guardianship Network) <[www.international-guardianship.com/previous-congresses.htm](http://www.international-guardianship.com/previous-congresses.htm)> accessed 27 April 2017.

Australia possesses a reasonably developed adult guardianship system within its eight states and territories.<sup>6</sup> Further, over recent years, some of these jurisdictions have reviewed their operation, and others have amended their legislation. For example, the law reform commissions in Queensland and Victoria completed reviews on the adult guardianship system in 2010 and 2013 respectively,<sup>7</sup> and Western Australia completed a review through the Department of Attorney General in November 2015.<sup>8</sup> South Australia,<sup>9</sup> the Northern Territory,<sup>10</sup> and the Australian Capital Territory<sup>11</sup> have amended their legislation. The New South Wales Law Reform Commission is currently reviewing the *Guardianship Act 1987* (NSW).<sup>12</sup> New medical treatment decision-making legislation was passed by the Victorian Parliament in 2016, to take effect in March 2018, which will result in further changes to its guardianship system.<sup>13</sup> The principal drivers for law reform have included changing demographics and social attitudes, and the ratification of the CRDP with its shift to empowering those with decision-making impairments.<sup>14</sup> Significant propositions for law reform have included transitioning from a paternalistic ‘best interests’ model towards a substituted judgement or supported decision-making framework,<sup>15</sup> adopting a context-specific capacity assessment process,<sup>16</sup> and optimizing the autonomy and community participation of the individual.<sup>17</sup>

China’s adult guardianship system is still emerging. Like Australia, the significant drivers of reform include economic pressure caused by demographic change, developing concepts of patient-centric welfare, shifting away from paternalism, and changing family structures.<sup>18</sup>

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6. Guardianship and Management of Property Act 1991 (ACT); Guardianship Act 1987 (NSW); Guardianship of Adults Act 2016 (NT); Guardianship and Administration Act 2000 (Qld); Guardianship and Administration Act 1993 (SA); Guardianship and Administration Act 1995 (Tas); Guardianship and Administration Act 1986 (Vic); Guardianship and Administration Act 1990 (WA).
  7. Queensland Law Reform Commission, *A Review of Queensland’s Adult Guardianship Laws* (Report No 67, 2010); Victorian Law Reform Commission, *Guardianship Final Report* (Report No 24, 2012).
  8. Western Australia Department of Attorney-General, *Statutory Review of the Guardianship and Administration Act 1990* (July 2015) <[www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/3913697cc31f70b26648cd4748257f100012c4df/\\$file/tp-3697.pdf](http://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/3913697cc31f70b26648cd4748257f100012c4df/$file/tp-3697.pdf)> accessed 20 January 2017.
  9. SA Health, ‘Advance Care Directives Act 2013’ (*Government of South Australia*, 2013) <[www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/legislation/advance+care+directives+act+2013](http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/legislation/advance+care+directives+act+2013)> accessed 20 January 2017.
  10. The Guardianship of Adults Act 2016 (NT) replaced the Adult Guardianship Act 1988 (NT) from 28 July 2016.
  11. See e.g., the Guardianship and Management of Property Act 1991 (ACT) and Public Trustee and Guardian Act 1985 (ACT).
  12. New South Wales Law Reform Commission, ‘Review of the Guardianship Act 1987’ (New South Wales Government, 2017) <[www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc\\_current\\_projects/Guardianship/Guardianship.aspx](http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Guardianship.aspx)> accessed 20 January 2017.
  13. *Medical Treatment Planning and Decisions Act 2016* (Vic).
  14. Queensland Law Reform Commission (n 7) [4.124]-[4.127], [4.138]-[4.148], [5.166]-[5.180]; Victorian Law Reform Commission (n 7) xxi-xxiii.
  15. Queensland Law Reform Commission (n 7) [5.166]-[5.180]; Victorian Law Reform Commission (n 7) xxii.
  16. Queensland Law Reform Commission (n 7) at [4.124]-[4.127]; Victorian Law Reform Commission (n 7) [7.160].
  17. Queensland Law Reform Commission (n 7) at [4.124]-[4.148]; Victorian Law Reform Commission (n 7) xxiv.
  18. Xinyan Ma and Guoqiang Li, ‘On Adult Deficiency of Capacity for Conduct and Perfection of Adult Guardianship System: With Consideration to System Arrangement of Civil Code’ (2005) 2(7) *US-China Law Review* 27, 28-32.

The purpose of this article is to examine whether there are any aspects of the Australian guardianship system, in the specific context of decisions about medical treatment, which might lend themselves to adoption or adaptation in China. Over Australia's decades of experience, lessons have been learnt, and the regulatory framework is now evolving to reflect greater emphasis on human rights and supporting adults in the decision-making process. It is widely acknowledged that differences in socio-cultural contexts preclude the simple transplantation of foreign laws, and circumspection is required.<sup>19</sup> Nevertheless, since the 1980s, the progressive opening of the Chinese economy and international integration have shifted Chinese attitudes towards a critical acceptance of foreign experiences as 'references' or 'models' for domestic law-making, resulting in widespread adaptation of foreign laws and domestic harmonization with international legal frameworks.<sup>20</sup> While there are significant socio-cultural and psychological differences between the countries,<sup>21</sup> similar drivers of reform and socio-economic challenges indicate the Australian adult guardianship model may provide a useful starting point for China as it grapples with the significant challenges of an ageing population.

## I. THE AUSTRALIAN GUARDIANSHIP MODEL

In Australia, laws dealing with guardianship – that is, decision-making on behalf of adults who have impaired capacity – are a matter for individual states and territories. The legislation across Australia differs in some respects; however, many key features are present throughout and these define the Australian guardianship model.

### A. *Principles of Adult Guardianship Law in Australia*

One feature of the Australian model has been the creation of guardianship legislation that adopts a 'principle-based' approach.<sup>22</sup> This means Australian guardianship legislation commonly includes a number of general principles that guide how those acting within the guardianship regime, on behalf of a person with impaired

19. Pierre Legrand, 'The Impossibility of Legal Transplants' (1997) 4 *Maastricht Journal of European and Comparative Law* 111, 114-120; David Nelken, 'Towards a Sociology of Legal Adaptation' in David Nelken and Johannes Feest (eds), *Adapting Legal Cultures* (Hart Publishing, 2001) (*Adapting Legal Cultures*) 21-28; Roger Cotterrell, 'Is there a logic of Legal Transplants?' in *Adapting Legal Cultures* 75-82; Peter Grajzl and Valentina Dimitrova-Grajzl, 'The Choice in the Lawmaking Process: Legal Transplants vs Indigenous Law' (2009) 5(1) *Review of Law & Economics* 615, 619-624 <<https://www.degruyter.com/view/j/rle.2009.5.1/rle.2009.5.1.1402/rle.2009.5.1.1402.xml>> accessed 27 April 2017; Randall Peerenboom, 'Toward a methodology for successful legal transplants' (2013) 1(1) *The Chinese Journal of Comparative Law* 4, 14-15.

20. *ibid.*

21. Geert Hofstede, *Culture's Consequences: International Differences in Work-Related Values* (Sage Publications 1980); Neal Ashkanasy, Edwin Trevor-Roberts and Jeffrey Kennedy, 'Leadership Attributes and Cultural Values in Australia and New Zealand Compared: An Initial Report Based on "GLOBE" Data' (2000) 2(3) *International Journal of Organisational Behaviour* 37, 39; Robert House, *Culture, Leadership, and Organisations: The GLOBE Study of 62 Societies* (Sage Publications 2004); Xiumei Shi and Jinying Wang, 'Cultural Distance between China and US Across GLOBE Model and Hofstede Model' (2011) 2(1) *International Business Management* 11, 12-16; The Hofstede Centre, 'Cultural Dimensions of China and Australia' (11 September 2013) <<http://geert-hofstede.com/australia.html>> accessed 20 January 2017.

22. Shih-Ning Then, 'Evolution and Innovation in Guardianship Laws: Assisted Decision-Making' (2013) 35 *Sydney Law Review* 133, 144-5.

capacity, should act.<sup>23</sup> In recent times, jurisdictions reforming guardianship laws have looked to align their legislation with those principles in the CRPD.<sup>24</sup> Modern Australian guardianship laws are therefore increasingly shaped by international human rights law. Common principles that are generally contained within guardianship legislation are described here.

The first is the presumption of capacity. It is recognized, both at common law and in some guardianship legislation, that a presumption of capacity for all adults exists.<sup>25</sup> Therefore, evidence must exist to rebut the presumption of capacity before a person has impaired capacity for a particular decision.

The second is the ‘least restrictive option taken by decision-maker’ principle. This is a key feature of modern guardianship regimes.<sup>26</sup> Where two options are available for the person with impaired capacity, the decision-maker should choose the one that is less restrictive. This principle has led to a preference for partial rather than plenary guardianship orders, acceptance that the appointment of a substitute decision-maker should be a last resort, and increasing recognition of supported rather than substitute decision-making.

Third, there is a principle of respect for autonomy. The right of people with impaired capacity to exercise their autonomy is clearly recognized in Australian guardianship legislation.<sup>27</sup> This is embodied through the requirement that a person with impaired capacity’s views are to be taken into account. In addition, the practice of adopting the least restrictive option and the move towards encouraging supported decision-making are both measures which seek to respect the autonomy of the person with impaired capacity for as long as possible.<sup>28</sup>

The fourth principle is inclusion as a valued member of the community. Sometimes described in terms of the principle of ‘normalization’,<sup>29</sup> Australian legislation generally

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23. Recent examples include the recommendations by the Queensland Law Reform Commission (n 7) and Victorian Law Reform Commission (n 7) ch 6.
  24. See e.g. Queensland Law Reform Commission (n 7) vol 1 ch 3.
  25. See e.g. Guardianship and Administration Act 2000 (Qld) sch 1, s 1; Advance Personal Planning Act (NT), s 6(2); Advance Care Directives Act 2013 (SA), s 10(c); Guardianship and Administration Act 1990 (WA), s 4(3); Powers of Attorney Act 2014 (Vic), s 4(2). See also the Minister’s Committee Considering Rights and Protective Legislation for Intellectually Handicapped Persons, ‘Report of the Minister’s Committee on Rights & Protective Legislation for Intellectually Handicapped Persons’ (Parliament of Victoria 1982) 26; Australian Law Reform Commission, *Guardianship and Management of Property* (Report No 52, ALRC 1989) [2.3] <[www.alrc.gov.au/report-52](http://www.alrc.gov.au/report-52)> accessed 27 April 2017. See also internationally, United Nations, CRPD (n 3) Article 12; Yokohama Declaration (n 5) Article 3(1).
  26. Parliament of Victoria, Report of the Minister’s Committee (n 25) 25; Australian Law Reform Commission (n 25) [2.4]; Robin Creyke, ‘Who Can Decide? Legal Decision-Making for Others’ (Aged and Community Care Service Development and Evaluation Reports, No 19, Department of Human Services and Health, Aged and Community Care Division, September 1995) 40–41; Queensland Law Reform Commission (n 7) vol 1, 40–41; Victorian Law Reform Commission (n 7) 79.
  27. Creyke (n 26) 41–43; Terry Carney and David Tait, *The Adult Guardianship Experiment: Tribunals and Popular Justice* (The Federation Press, 1997) 29; Queensland Law Reform Commission (n 7) vol 1, 40–41.
  28. See Terry Carney, ‘The Limits and the Social Legacy of Guardianship in Australia’ (1989) 18 *Federal Law Review* 231, 237–38, (referring to these principles as ‘maximising’ the size of the ‘zone of autonomy’).
  29. Wolf Wolfensberger, ‘The Principle of Normalization as a Human Management Model: Evolution of a Definition’ in Wolf Wolfensberger (ed), *The Principle of Normalization in Human Services* (National Institute on Mental Retardation 1972) 26.

endorses that people with impaired capacity should be included and treated as ordinary members of society to the extent possible.<sup>30</sup> Many jurisdictions' legislation state that those with impaired capacity should be encouraged to participate in community life and that their existing social relationships should be taken into account in any decision-making process.<sup>31</sup>

Finally, Australian guardianship legislation also usually includes the requirement for decisions to be made having regard to the adult's welfare and interests.<sup>32</sup> The courts also apply the 'best interests' test in dealing with guardianship matters.<sup>33</sup> The test is an individualized one and excludes consideration of others' interests.<sup>34</sup> At common law, the test has been criticized for being unclear with the outcome arguably being based on the values of the person applying the test.<sup>35</sup> Under guardianship legislation, applying this welfare test requires the adult's past and present views to be taken into account when a decision is made on their behalf.<sup>36</sup> This is now seen to be an important component relevant to determining a person's well-being and also respects a person's dignity by seeking, rather than ignoring, a person's views.<sup>37</sup>

Although these principles overlap and have been expressed in various ways, they remain the core principles on which Australian guardianship laws have been shaped.

## B. *Decision-making Mechanisms in Australia*

### 1. *Incapacity: a threshold concept*

In Australia, a finding of a lack of 'capacity' is a prerequisite to the appointment of a substitute decision-maker under guardianship legislation. The assessment of whether or not a person has capacity must be decision-specific.<sup>38</sup> This means that a person may be found to lack capacity for one decision, but retain capacity for

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30. Australian Law Reform Commission (n 25) [2.6]; Carney and Tait (n 27); Queensland Law Reform Commission (n 7) vol 1, 40–41.
  31. See e.g. Guardianship and Administration Act 2000 (Qld) sch 1, ss 4, 5, and 8; Guardianship Act 1987 (NSW) s 4(c) and (e). See also Victorian Law Reform Commission (n 7) 94.
  32. However, the Victorian Law Reform Commission recommended moving away from explicitly including the 'best interests' principle as a guiding principle in the guardianship legislation: Victorian Law Reform Commission (n 7) 94.
  33. See e.g. *Northern Sydney and Central Coast Area Health Service v CT by his Tutor ET* [2005] NSWSC 551.
  34. Note that this approach has been criticized on the basis that where a person with impaired capacity is cared for informally, 'it is simply impossible to make every decision based on what will promote the best interests of the incapacitated person': Jonathan Herring, 'Entering the Fog: On the Borderlines of Mental Capacity' (2008) 83 *Indiana Law Journal* 1619, 1647.
  35. See the comments of Justice Brennan in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 *CLR* 218, 270–71. See also Ian Kerridge, Michael Lowe and Cameron Stewart, *Ethics and Law for the Health Professions* (4th edn, Federation Press 2013) 375.
  36. See e.g., Guardianship and Administration Act 1993 (SA), s 5(a)-(b); Guardianship and Administration Act 1995 (Tas), s 6(c); Ben White, Lindy Willmott and Shih-Ning Then, 'Adults Who Lack Capacity: Substitute Decision-Making' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (2nd edn, Thomson Reuters 2014) 206–7.
  37. Norman L Cantor, *Making Medical Decisions for the Profoundly Mentally Disabled* (The MIT Press 2005) 204–11.
  38. Marshall B Kapp, 'Legal Interventions for persons with dementia in the USA: ethical policy and practical aspects' (2001) 5(4) *Aging & Mental Health* 312, 313.

other decisions.<sup>39</sup> In addition to the decision-specific nature of the capacity assessment it should also be time-specific. For example, a person may experience fluctuating capacity due to mental illness or the effects of medication.<sup>40</sup> As such, his or her decision-making ability needs to be assessed at the time the decision is required to be made. Also, it is generally recognized that just because a person makes a decision that is unreasonable, eccentric, or considered to be a ‘bad decision’, this does not automatically mean that the person has impaired capacity.<sup>41</sup>

Capacity as a legal concept has variously been defined in guardianship legislation using three main models: the diagnostic or status approach; the outcome approach; and the functional approach.<sup>42</sup> The diagnostic or status approach links, either solely or as one of a number of preconditions, the finding of incapacity with a particular medical condition.<sup>43</sup> The outcome approach looks at the ‘reasonableness’ of the outcome that the person wants.<sup>44</sup> This requires an assessment of whether the decision the person has made is a reasonable one but has been critiqued on the basis that the person assessing the reasonableness of the decision is essentially ‘free to apply their own notions as to what is “incompetent” behaviour’.<sup>45</sup> The third approach is the functional approach which requires an assessment of a person’s understanding of a particular decision. For a person to lack capacity under the functional approach, the person must be found to be incapable of understanding the nature and effect of the decision or incapable of communicating their decision.<sup>46</sup> While at common law it is generally accepted that the notion of ‘capacity’ encompasses the ability to weigh information and balance the risks posed by the treatment,<sup>47</sup> the legislative definitions of capacity adopting a functional approach (in relation to medical decisions), generally omit this aspect.<sup>48</sup>

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39. This may occur where a person has sufficient capacity to decide less complicated decisions such as what to wear, or what to eat for breakfast but may not have capacity to deal with complex financial decisions: Heather Wilkinson, ‘Empowerment and Decision-making for People with Dementia: The Use of Legal Interventions in Scotland’ (2001) 5(4) *Aging & Mental Health* 322, 323.
40. Kapp (n 38).
41. See e.g., *Guardianship and Management of Property Act 1991 (ACT)* s 6A; *Advance Personal Planning Act (NT)* s 6(5); *Victorian Law Reform Commission* (n 7) 94.
42. White, Willmott and Then (n 36) 193, 212–15.
43. Penelope A Hommel, Lu-in Wang and James A Bergman, ‘Trends in Guardianship Reform: Implications for the Medical and Legal Professions’ (1990) 18(3) *Law, Medicine & Health Care* 213, 215; White, Willmott and Then (n 36) 193, 214.
44. Charles P Sabatino, ‘Competency: Refining Our Legal Fictions’ in Michael Smyer, K Warner Schaie and Marshall B Kapp (eds), *Older Adults’ Decision-Making and the Law*, Springer Series on Ethics, Law and Aging (Springer 1996) 1, 8–11; Amita Dhandu, ‘Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?’ (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 431.
45. Lawrence A Frolik, ‘Plenary Guardianship: An Analysis, a Critique and a Proposal for Reform’ (1981) 23 *Arizona Law Review* 599, 628. See also the criticisms in White, Willmott and Then (n 36) 193, 215, fn 119.
46. See e.g., *Guardianship Act 1987 (NSW)*, s 33(2); *Guardianship and Administration Act 2000 (Qld)*, sch 4 (definition of ‘capacity’) (which also includes the element of voluntariness in its definition of capacity).
47. *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290, 291, [1994] 1 All ER 819, 820 (Thorpe J).
48. See e.g., *Guardianship and Administration Act 1995 (Tas)*, s 36(2); *Guardianship and Administration Act 1986 (Vic)*, s 36(2).

While in the past the diagnostic or status approach, solely or in combination with the outcome approach, appeared to be favoured, in recent times the functional approach has come to be the most widely accepted.<sup>49</sup> In Australia, the majority of jurisdictions adopt the functional definition of incapacity.<sup>50</sup> Some combine this with the diagnostic approach, while only Western Australia adopts an outcome approach to defining incapacity in relation to healthcare decisions.<sup>51</sup>

In Australia, often the finding of impaired capacity is not the sole criterion for determining if a guardian ought to be appointed under a guardianship regime. Usually, it must also be determined whether there is a ‘need’ for a guardian to be appointed (see discussion below).<sup>52</sup>

## 2. *Adult appointed decision-making mechanisms – enduring documents*

Another feature of the Australian guardianship model is the legal recognition of enduring documents which survive an adult losing capacity. These include: (1) enduring powers of attorney for financial, personal, and health matters; and (2) advance directives in relation to future healthcare.

These instruments allow people to plan ahead to a time when they may lose capacity, allowing them to either: (1) give power to a specific trusted person to legally make decisions on their behalf if they lose decision-making capacity; or (2) express their wishes regarding certain healthcare decisions in advance should a specific situation arise. This has clearly advanced the autonomy of those who anticipate losing decision-making capacity. While any adult with capacity can execute such a document, it has particular significance to those who know that their decision-making capacity is likely to deteriorate – for example, those in the early stages of Alzheimer’s disease.<sup>53</sup>

While the appointment of enduring power of attorneys for financial, personal, and health decisions are generally expressly dealt with in most jurisdictions’ legislation, legal recognition of advance directives in guardianship legislation around Australia is not uniform.<sup>54</sup> Both types of instruments must be executed by a person when they have capacity and are used to make their wishes known and legally applicable in the future when the person may suffer from impaired capacity for certain decisions.

49. Sabatino (n 44); Herring (n 34) 1624–25; Queensland Law Reform Commission (n 7) vol 1, 270; and White, Willmott and Then (n 36) 193, 212 fn 103.

50. See e.g., Guardianship Act 1987 (NSW), s 33(2); Guardianship and Administration Act 2000 (Qld), sch 4 (definition of ‘capacity’) (which also includes the element of voluntariness in its definition of capacity); and in relation to medical decisions specifically, Guardianship and Administration Act 1995 (Tas), s 36(2); Guardianship and Administration Act 1986 (Vic), s 36(2). See also White, Willmott and Then (n 36) 193, 212–14.

51. Guardianship and Administration Act 1990 (WA), ss 110ZD(1), 110ZG(1), and 110ZJ(1).

52. White, Willmott and Then (n 36) 193, 238–40.

53. Wilkinson (n 39) 322.

54. Advance directives are also recognized at common law and some jurisdictions (such as New South Wales), rely on the common law, and do not have specific provisions recognizing statutory advance directives in their guardianship legislation.

Practical issues inevitably exist in utilizing such instruments. The number of people who utilize these documents are low.<sup>55</sup> In addition, issues of whether the intention expressed in an instrument has been superseded persist. These instruments are also only useful when they are made known to the relevant person. For example, where a person with impaired capacity presents at a hospital, unless medical staff are informed and provided with a copy of the instrument, it will not be taken into account in any decisions that are made.

### 3. *Tribunal appointed guardians*

Throughout Australia, the guardianship legislation allows people or statutory officials to be appointed as ‘guardians’ on behalf of adults lacking decision-making capacity, should the need arise. Usually an application to a tribunal is required, and it needs to be shown that the adult with impaired capacity is in need of an appointed guardian.<sup>56</sup> Where there are no suitable persons from the adult’s network of family, friends, and carers to act as a guardian on behalf of the adult, then statutory officials can be appointed.<sup>57</sup>

### 4. *Default decision-makers*

The issue of people with impaired capacity accessing healthcare has been considered within, or as an adjunct to, guardianship regimes. Generally, legislation has provided for statutory recognition of certain people – usually relatives or close friends of the person with impaired capacity (in the absence of appointed attorneys or guardians) – to be able to give a legally valid consent to most healthcare decisions on behalf of that person. This clarifies the legal position of family and friends ensuring that there is always someone to provide legal consent to treatment.<sup>58</sup> Generally, this automatic statutory recognition prioritizes family members over medical professionals or public officials to make decisions on behalf of the person with impaired capacity.<sup>59</sup>

55. Herring (n 34) 1637; Annette Rid and David Wendler, ‘Can We Improve Treatment Decision-Making for Incapacitated Patients?’ (2010) 40(5) *Hastings Center Report* 36, 37; Queensland Law Reform Commission (n 7) vol 2, 7–8.

56. White, Willmott and Then (n 36), 193, 238–40.

57. *ibid* 193, 238.

58. Gordon and Verdun Jones listed the following reasons for having such provisions:

- 1) to clarify the issue of informed consent and thereby protect those providing care and treatment;
- 2) to dispense with the need for protracted and costly guardianship proceedings in cases where a patient is deemed incompetent and requires a substitute decision maker but only while receiving treatment...;
- 3) to ensure that the person authorized as substitute decision maker is the individual most closely related to a patient and, therefore, it is assumed, best able to decide whether or not to consent (or withhold consent) on a patient’s behalf; and
- 4) to provide some safeguards in the form of directions regarding the way in which a substitute decision maker should perform duties.

See Robert M Gordon and Simon N Verdun-Jones, *Adult Guardianship Law in Canada* (Carswell 1992) 3-100–3-101 (Although Gordon and Verdun-Jones made these comments in the context of mental health patients, these observations were equally applicable to legislatively recognized substitute decision-makers for patients who have impaired capacity generally).

59. See e.g. Powers of Attorney Act 1998 (Qld), s 45. See also, White, Willmott and Then (n 36) 193, 244–46; Carney and Tait (n 29) 54.

A 'default decision-maker' is required to consider or apply a number of guardianship principles (including those listed at Section I.A above) in making a decision on behalf of the adult with impaired capacity.

### 5. *Tribunals and courts*

The final way in which decisions can be made on behalf of adults with impaired capacity is for a tribunal or court to make a decision. In Australia, the supreme court of every jurisdiction and the relevant tribunal in most jurisdictions have the power to make decisions on behalf of an adult with impaired capacity where an application regarding the adult comes before them.

In addition, a number of 'serious' healthcare decisions lie outside of the normal ambit of substitute decision-making provided for under guardianship legislation. These serious decisions require a court or tribunal to authorize or provide consent to some medical interventions for the adult with impaired capacity.<sup>60</sup> These are viewed as particularly invasive, life-changing procedures and questions may arise over whether the adult with impaired capacity will actually benefit from undergoing such procedures or treatments. These can include, for example, sterilization, removal of tissue or organs for transplantation, termination of pregnancy, and experimental treatment.<sup>61</sup>

## C. *Administration of Guardianship Regimes in Australia*

Prior to the enactment of specific guardianship legislation in Australia, it was recognized that there was a need for an effective and relatively inexpensive mechanism for dealing with decision-making on behalf of adults with impaired capacity. Approaching the courts for these matters was considered expensive, time-consuming, and unduly complicated. In Australia, the solution to this dilemma came about through the creation of specific guardianship public officials and the use of tribunals, rather than courts, to deal with guardianship matters.

### 1. *Tribunals*

In Australia, specialist quasi-judicial forums – separate from the court system – were developed. The majority of jurisdictions now have multi-disciplinary tribunals (the membership of which was to be a mixture of professional and legal persons) who are legislatively tasked with making decisions regarding people with impaired capacity.<sup>62</sup> Taking guardianship proceedings away from traditional courts to be dealt with by a specialist tribunal was, and still is, anomalous in the rest of the Western world. It was suggested that:

The tribunal model has three primary advantages. First of all, a tribunal need not be bound by the rigid rules which apply in court hearings. For this and other reasons, a hearing

60. See e.g., Guardianship and Administration Act 2000 (Qld), s 68, and sch 2, s 7; Guardianship and Administration Act 1986 (Vic), s 3 (definition of 'special procedure'), and 39(1)(a). See also White, Willmott and Then (n 36) 216-19, 249-52.

61. See e.g., White, Willmott and Then (n 36) 216-19.

62. See generally Carney and Tait (n 27).

before a Tribunal is likely to be a good deal less costly than a court hearing. Secondly, a tribunal is likely to be more accessible to members of the public than a court. Thirdly, in the tribunal model the decision-making power can be placed in the hands of a person or persons with appropriate expertise.<sup>63</sup>

In addition, it was considered that the traditional adversarial model of court proceedings was generally inappropriate for guardianship proceedings. Tribunals dealing with guardianship matters have some inquisitorial powers to assist them, should it prove necessary, in making decisions.<sup>64</sup> In Australia, the majority of jurisdictions have administrative tribunals with a dedicated guardianship jurisdiction.

## 2. *Statutory officials*

Around Australia, statutory bodies – variously known as the ‘Public Guardian’ or ‘Public Advocate’ – are tasked with advocating on behalf of those with impaired capacity. In Australia, these bodies have dual functions of investigating allegations of abuse and neglect of adults with impaired capacity, and advocating on their behalf. They are able to be appointed as a guardian on behalf of an adult lacking capacity where no one else is available to act. They tend to ‘[i]nvestigate issues of systemic abuse or exploitation, and speak on behalf of individuals with disabilities who are denied their rights’.<sup>65</sup> In some jurisdictions, the work of these statutory bodies is helped by a network of legally recognized and appointed ‘visitors’ who visit people with impaired capacity to collect information.<sup>66</sup>

Despite the existence of this seemingly comprehensive guardianship system, a proportion of decisions for adults with impaired capacity continue to be made informally by persons who are not formally appointed. The legislation in some jurisdictions in Australia acknowledge the role of such informal decision-makers, but it has been recognized that making decisions on an informal basis is becoming increasingly difficult, especially if the decision-maker has to deal with third parties (such as banks) on behalf of the adult.<sup>67</sup>

### D. *Future Directions: Promoting Assisted Decision-making*

A recent international development in guardianship laws has been the introduction of the concept of supported decision-making that seeks to legally recognize that some adults may have trouble making decisions, but are capable of doing so if provided with appropriate support.<sup>68</sup> The concept of supported decision-making is not foreign to Australia’s guardianship model; implicit support for it exists through adoption of the principle of the ‘least restrictive approach’ (discussed above), and one state has recently

63. Parliament of Victoria, Report of the Minister’s Committee (n 25) 28-29.

64. *ibid* 31.

65. Carney and Tait (n 27) 33.

66. See e.g. Queensland Law Reform Commission (n 7) vol 4 ch 26.

67. Then (n 22) 143.

68. See generally Then (n 22).

introduced legislation to recognize a legal form of supported decision-making via ‘supportive attorneys’.<sup>69</sup>

Today, express inclusion of a statutorily recognized supported decision-making scheme – which includes legal recognition of persons who act as ‘supporters’ or ‘assistants’ – is becoming more accepted. Internationally, law reformers and policy makers are suggesting the incorporation of tiered decision-making practices to be introduced into guardianship regimes.<sup>70</sup> In Australia, pilot schemes have been run trialling supported decision-making in various contexts.<sup>71</sup> The Victorian Law Reform Commission’s recommendations for some forms of statutorily recognized supported decision-making has, at least partially, been recognized in the form of ‘supportive attorneys’ in the *Powers of Attorney Act 2014* (Vic).<sup>72</sup> This is a new legal position in the Australian State of Victoria that allows an adult with sufficient understanding to appoint a legally recognized ‘supporter’. Decision-making rights are retained by the adult during the period of the appointment, but the supporter is legally recognized as being able to obtain personal information about the adult to assist with decision-making; communicate information on the adult’s behalf; and take reasonable action to give effect to the adult’s decision.<sup>73</sup> In addition, with the introduction of the National Disability Insurance Scheme in Australia, there is an added impetus to provide a workable support model to the many adults with some decision-making impairment who will be given more choice and power over the government services they receive.<sup>74</sup>

Legally recognized supported decision-making models, if introduced, would give more legal options to those wishing to adopt the ‘least restrictive’ approach. They also ensure that a person is able to participate, with legally recognized assistance, in daily activities and transactions. This approach respects the autonomy of individuals requiring some assistance, allowing them to participate in society to the maximum extent possible.<sup>75</sup> It has been recognized, however, that a number of legal and practical difficulties exist to implementing a comprehensive legislative scheme in Australia.<sup>76</sup>

69. See *Powers of Attorney Act 2014* (Vic), pt 7.

70. Then (n 22) 148-154; Leslie Salzman, ‘Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act’ (2010) 81 *University of Colorado Law Review* 157.

71. See e.g. New South Wales Attorney General and Justice, ‘New South Wales Trustee & Guardian, Annual Report 2010-11’ (New South Wales Government 2011) 37; Terry Carney and Fleur Beaupert, ‘Public and Private Bricolage – Challenges Balancing Law, Services and Civil Society in Advancing CRPD Supported Decision-making’ (2013) 36(1) *University of New South Wales Law Journal* 175, 191-92.

72. Victorian Law Reform Commission (n 7), ch 8-9; *Powers of Attorney Act 2014* (Vic), pt 7. For a discussion of the initial proposed changes and those that finally resulted in Victorian legislation see Terry Carney, ‘Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective?’ (2015) 4 *Laws* 37, 51-52.

73. *Powers of Attorney Act 2014* (Vic), ss 87-89.

74. Carney (n 72) 48-51. See also Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (ALRC Report 124, ALRC 2014) <[www.alrc.gov.au/sites/default/files/pdfs/publications/alrc\\_124\\_whole\\_pdf\\_file.pdf](http://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc_124_whole_pdf_file.pdf)> accessed 27 April 2017.

75. Then (n 22) 143.

76. *ibid* 155-66.

## II. CHINESE ADULT GUARDIANSHIP LAW AND PRACTICE

China does not have a comprehensive guardianship regime that ensures health decisions will always be made on behalf of an adult who lacks the ability to make those decisions him- or herself. The Chinese framework is a fragmented one, comprised of different forms of regulation, not specifically designed to regulate the making of health decisions, that has evolved over more than three decades. Many uncertainties still exist about who has authority to make health decisions, for whom such decisions can be made, and the principles which should inform the decision-making process.

In this section, the laws in China that are relevant to decision-making on behalf of adults with impaired decision-making capacity are described. It commences with an overview of the regulatory framework, followed by a consideration of who falls within the ambit of the regime and who can act as decision-maker for that person, together with the duties and responsibilities of the decision-maker. This section concludes with a consideration of the challenges that continue to exist with the regulatory framework.

### A. *The Regulatory Framework*

The *General Principles of the Civil Law of the People's Republic of China*<sup>77</sup> (*General Principles*) is a legal framework that deals with civil law generally, and includes a consideration of adults who lack capacity to make decisions about 'civil conduct'. Also relevant here is the Supreme People's Court's interpretation of the *Implementation of the General Principles of the Civil Law of the People's Republic of China (For Trial Implementation) (Implementation of the General Principles)*.<sup>78</sup> This is a judicial interpretation by the Supreme People's Court and, while not technically binding, is very important in the practices of courts. Therefore, the Court's interpretation of the *Implementation of the General Principles* should be taken into account in addition to the *General Principles* as a whole.

The second major influence on guardianship law in China is the *Law on the Protection of Rights and Interests of the Elderly (Law of the Elderly)*,<sup>79</sup> which was amended in 2012. This amendment effectively expands the reach of guardianship laws to the elderly generally. This statute allows an 'elderly person' (defined to be a person over 60 years of age) with full capacity to appoint a legal guardian in advance of losing capacity. This more recent option for the appointment of a guardian, the relationship

77. Zhonghua Renmin Gongheguo Minfa Tongze (中华人民共和国民法通则) [General Principles of the Civil Law of the People's Republic of China] (promulgated by the National People's Congress, 12 April 1986, effective 1 January 1987).

78. Zuigao Renmin Fayuan Yinfa Guanyu Guanche Zhixing Zhonghua Renmin Gongheguo Mingfa Tongze Ruogan Wenti de Yijian Shixing de Tongzhi (最高人民法院印发《关于贯彻执行〈中华人民共和国民事诉讼法〉若干问题的意见(试行)》的通知) [Notice of the Supreme People's Court on Several Issues concerning the Implementation of the General Principles of the Civil Law of the People's Republic of China (For Trial Implementation)] (issued by the Supreme People's Court and effective on 2 April 1988).

79. Zhonghua Renmin Gongheguo Laonianren Quanyi Baozhang Fa (2012 Xiuding) (中华人民共和国老年人权益保障法(2012修订)) [Law of the People's Republic of China on the Protection of the Rights and Interests of the Elderly (2012 Revision)] (promulgated by the Standing Committee, National People's Congress, 28 December 2012, effective 1 July, 2013, amended 24 April 2015).

between the amended *Law of the Elderly* and the *General Principles*, and how this amendment facilitates the autonomy of the elderly person are explored further below.

The third significant statutory development in the guardianship field in China is the *Mental Health Law*.<sup>80</sup> While many aspects of the *Mental Health Law* are beyond the ambit of this article (including issues about involuntary detention and treatment, and review procedures governing involuntary detention and treatment), the law is relevant to decision-making for medical treatment in some cases where the person with a ‘mental disorder’ lacks capacity to make a decision about healthcare. The role of the *Mental Health Law* in the guardianship context is explored later, but it should be noted that the CRPD has been influential in drafting the *Mental Health Law*. Article 4 of the *Mental Health Law* provides that:

the human dignity, personal safety and safety of the possessions of persons with mental disorders shall not be violated. The legal rights and interests of persons with mental disorders to education, employment, medical services, as well as governmental and non-governmental welfare are protected by law.

As such, human rights have become a more significant driver generally in the provision of health services for people with mental disorders.

Finally, two developments in tort law have had not only a profound impact on decision-making in the healthcare context generally, but also for individuals who lack decision-making capacity. The first is the doctrine of informed consent which was introduced into Chinese laws in the 1990s<sup>81</sup> to replace paternalistic practices under which doctors made healthcare decisions. Second, in 2009, the *Tort Liability Law* provided further safeguards around the decision-making process and the protection of the patient.<sup>82</sup>

### *B. Individuals for whom Decisions can be Made*

The *General Principles* provide that a guardian can act on behalf of a person who is suffering from a ‘mental illness’ and has no capacity or only limited capacity for civil conduct.<sup>83</sup> Individuals suffering from dementia can fall within this category of mental illness.

The Court’s interpretation of the *Implementation of the General Principles* provides that:

a people’s court shall determine whether a person is suffering from a mental illness according to the forensic psychiatry evaluation or by reference to the relevant hospital

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80. Zhonghua Renmin Gongheguo Jingshen Weisheng Fa (中华人民共和国精神卫生法) [Mental Health Law of the People’s Republic of China] (promulgated by the Standing Committee, National People’s Congress, 26 October 2012, effective 1 May 2013).
81. Yiliao Jigou Guanli Tiaoli (医疗机构管理条例) Medical Institutions Management Ordinance (issued by the State Council, 26 February 1994, effective 1 September 1994). Zhonghua Renmin Gongheguo Zhiye Yishi Fa (中华人民共和国执业医师法) [Law on Practising Doctors of the People’s Republic of China] (promulgated by the Standing Committee, National People’s Congress, on 26 June 1998, effective on 1 May 1999).
82. Zhonghua Renmin Gongheguo Qinquan Zeren Fa (中华人民共和国侵权责任法) [Tort Liability Law of the People’s Republic of China] (promulgated by the Standing Committee, National People’s Congress, 26 December 2009, effective 1 July 2010).
83. General Principles (n 77) Article 13.

diagnosis or evaluation. Such determination may be made based on the mental status of the person concerned as commonly recognized by the public when no such diagnosis or evaluation exists due to lack of the conditions or necessities for the same [...].<sup>84</sup>

In Australia, a person must lack capacity before a guardian can be appointed to act on that person's behalf. It is generally irrelevant whether incapacity results from dementia, intellectual disability, acquired brain injury, or mental illness.<sup>85</sup> By comparison, on a strict interpretation of the Chinese law, it does not extend to individuals with an 'acquired brain injury' or 'intellectual disability'. However, courts have exercised their discretion in a number of recent cases to extend the definition of 'mental illness' to include people with acquired brain damage, people with intellectual injury, and people who are in a permanent vegetative state.<sup>86</sup>

The *Mental Health Law*, on the other hand, regulates individuals with 'mental disorders'. Pursuant to Article 83, a person may have a mental disorder 'as the result of variety of causes, including disturbances or abnormalities of perception, emotion, thinking or other mental processes that lead to significant psychological distress or to significant impairments in social adaptation or in other types of functioning.' Given the nature of mental disorders, some individuals will have no or limited capacity as understood and regulated by the *General Principles*, while others may still retain civil capacity for some matters, possibly including medical treatment decisions. As such, whether a person with a mental disorder needs a guardian will be determined according to the criteria in Article 13 of the *General Principles* that refers to a person having a mental illness, and no or limited capacity for civil conduct.

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84. Notice of the Supreme People's Court on Several Issues concerning the Implementation of the General Principles of the Civil Law of the People's Republic of China (For Trial Implementation) (n 78) Article 7.
85. White, Willmott and Then (n 36) 195.
86. The Jiangbei District People's Court of Chongqing City, Hechuan District People's Court of Chongqing City, Jimei District People's Court of Fujian Province, and Xuyi County People's Court of Jiangsu Province announced that people suffering from non-mental diseases that lead to unconsciousness are 'without or with limited capacity for civil conducts' in the following cases: (1) *Jiang v Jiang* for declaring incapacity of Jiang, the People's Court of Jiangbei District, Chongqing (2013) Special Case No 39. Mr Jiang suffered from bilateral frontal and temporal lobe lesions, massive cerebral infarction, coronary atherosclerotic heart disease, heart failure, pulmonary infection and bilateral pleural effusion, which resulted in his unconsciousness. The court decided that he was unable to recognize his own behaviour and thus is without capacity for civil conducts; (2) *Zhang v Zhang* for declaring incapacity of Zhang, the People's Court of Hechuan District, Chongqing (2013) Special Case No 13. Mr Zhang accidentally fell from about 3 metres high at his workplace on December 25 2011, resulting in brain injury, occipital fracture, pulmonary contusion, and multiple body soft tissue injuries. The court declared Mr Zhang with limited capacity for civil rights due to organic brain dementia (moderate and severe) caused by the brain trauma; (3) *Yang Jiacheng v Wei Xiuhua* for declaring Wei's limited capacity, the People's Court of Jimei District, Xiamen, Fujian Province (2013) Special Case No 1. Wei Xiuhua was diagnosed with brain disease caused by intellectual impairment and motor aphasia according to the expert's forensic psychiatric opinion. Ms Wei was announced by the court as having limited capacity for civil conduct; (4) *Luo Shilin v Luo* for declaring incapacity of Luo, the People's Court of Xuyi County, Huaian, Jiangsu Province (2003) Special Case No 424. Mr Luo suffered severe brain damage from a traffic accident on 25 October 2002. He was diagnosed as being in a persistent vegetative state, and totally unable to recognize his own behaviour. The court considered Mr Luo's situation as a loss of cognitive ability and unconsciousness, thus without capacity for civil conducts.

### C. *Who Can Act as Decision-maker?*

The *General Principles* provide mechanisms for guardians to act on behalf of individuals who lack decision-making capacity. Pursuant to Article 63 of the *General Principles*, '[c]itizens and legal persons may perform civil juristic acts through agents'. The *General Principles* recognize three types of agents: entrusted agent; statutory agent; and appointed agent.<sup>87</sup> These are considered, in turn, below.

An entrusted agent is appointed by the principal when he or she has full capacity for juristic acts. Article 63 of the *General Principles* provides that it is the duty of an entrusted agent to conduct juristic acts on behalf of the principal. Under Chinese law, entry into a health service contract between a hospital and a patient is considered to be a juristic act, which can be performed by an agent. However, making a decision about accepting or refusing treatment does not constitute such an act. Accordingly, under the *General Principles*, an entrusted agent does not have authority to make decisions on health matters on behalf of another person. The *Tort Liability Law*, referred to earlier, also prevents an entrusted agent from providing informed consent for a healthcare matter for another person.

In an important respect, the *Law of the Elderly* augments the *General Principles* in that it facilitates healthcare decisions being made by an entrusted agent when a senior loses capacity.<sup>88</sup> Article 26 of the *Law of the Elderly* allows a senior person with full capacity to choose his or her guardian. The guardian may be his or her close relative, or 'other individuals or entities who have close relations with him or her, and is willing to take the responsibility of a guardian.' The guardian shall act as a guardian when the senior person loses all or partial civil capacity. The guardian will make, or assist the ward to make, healthcare decisions. If the elderly person does not make such an appointment, the appointment of a guardian for an elderly person who lacks decision-making capacity would be regulated by the *General Principles*.

The reform of the *Law of the Elderly* as described above is a significant one, and promotes the autonomy of the senior person in two important ways. First, the person is able to choose who they trust to be a decision-maker for future health decisions. This empowers the person to appoint a guardian who may reflect their will and preferences should the person later lose decision-making capacity. Second, the law recognizes the reality of partial rather than entire loss of decision-making capacity. It facilitates the entrusted agent assisting the person to make decisions where there has been only a partial loss of capacity. Again, this reform promotes the autonomy of the senior person.

The second type of agent is a 'statutory agent' and this role is performed by a 'guardian'. The *General Principles* designate a guardian for a person when that person lacks full capacity. A guardian is an agent to the principal in almost everything in the person's life including in relation to healthcare decisions. Unlike the entrusted agent, a guardian will only be the decision-maker when the principal lacks full capacity. When the principal acquires full capacity, the guardianship automatically ends.

87. General Principles (n 77) Article 64.

88. Law of the Elderly (2012 Revision) (n 79) Article 26.

According to the *General Principles*, any of the following can act as a guardian for a person who is regarded as being mentally-ill: his or her spouse; a close relative; a close friend; or his or her unit or neighbourhood committee that is qualified by law to act as a guardian.<sup>89</sup>

The final category deals with ‘appointed agents’. An appointed agent is one that is appointed by a court or appointing unit<sup>90</sup> where there is a dispute as to which of the possible statutory agents should be the guardian. If a person is not satisfied with the decision, he or she is entitled to appeal against the decision. The appointed agent will then act as the person’s guardian. If the person has a ‘mental disorder’, the *Mental Health Law* is relevant. Article 83 of the *Mental Health Law* provides that, ‘[g]uardians of persons with mental disorders are persons who may assume the role of guardian as specified in the relevant regulations of the General Principles of the Civil Law’. As such, the guardian will be appointed according to the provisions of the *General Principles*. Although the *Mental Health Law* does not alter the provisions of the *General Principles* in terms of who will act as guardian, the *Mental Health Law* will have an impact on *how* decisions should be made by the guardian as it embraces the principles of the CRPD.

#### D. Duties and Responsibilities of a Guardian

Article 18 of the *General Principles* stipulates the duties and responsibilities of a guardian:<sup>91</sup>

[a] guardian shall fulfil his duty of guardianship and protect the person, property and other lawful rights and interests of his wards. A guardian shall not handle the property of his ward unless it is in the ward’s interests.

In addition, Article 10 of the Court’s interpretation of the *Implementation of the General Principles* states that guardianship duties include:

... protecting the physical health of the ward, taking care of the living of the ward, managing and protecting the property of the ward, conducting civil activities on behalf of the ward, exercising control over and educating the ward, and representing the ward in an action involving an infringement on the lawful rights and interests of the ward or a dispute between the ward and any other person.

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89. A unit is a factory or enterprise for whom a person works or used to work. Following social reforms in the mid-20th century, most people in urban areas and some in rural areas belonged to a factory or enterprise of some kind. Collectively, these factories and enterprises are called ‘units’. In more recent times, fewer people are working for government owned factories and enterprises, and more people are working for privately owned enterprises. Accordingly, there has been less reliance on the ‘unit’ and increased focus on ‘neighbourhood committee’. There are two kinds of such committees: street neighbourhood committees which occur in the cities; and village neighbourhood committees which operate outside urban areas. These committees are established to assist people living in the vicinity. They are not government agencies, and the people working in them are not public servants.
90. An ‘appointing unit’ is a community committee, a factory, or an enterprise where a person works or used to work.
91. These duties and responsibilities apply whether the guardian derives authority from the *General Principles* or has been appointed by the adult under the *Law of the Elderly*.

Given the broad scope of guardianship duties, the guardian's authority extends to making decisions that will promote the physical and mental well-being of the ward. As such, the guardian is authorized to make decisions about the person's healthcare.

### E. Regulating Healthcare Decisions

In the previous sections, the overarching regulatory framework that may be relevant to a person who lacks decision-making capacity was discussed. This section examines the regulation of certain kinds of healthcare decisions.

The *Medical Institutions Management Ordinance*<sup>92</sup> is relevant where a person needs to undergo an operation or needs another form of more serious examination or treatment. Pursuant to that Ordinance, either the patient or family member can provide consent to an operation, a special examination, or a special treatment.<sup>93</sup> The *Medical Institutions Management Ordinance* makes no distinction on the basis of whether or not the patient has decision-making capacity. As a result, even when the patient has full capacity, pursuant to this Ordinance, consent can be given by either the patient or the family. When the patient lacks capacity, consent will need to be provided by the family.

The operation of this Ordinance, however, is tempered by the *Tort Liability Law* which was amended in 2009 to strengthen the role of the patient in providing consent to treatment. Pursuant to Article 55 of the *Tort Liability Law*, a doctor is required to explain the condition and proposed treatment to the patient. If surgery is being contemplated, he or she must inform that patient of the risks of the operation, and any alternatives to the procedure, and obtain written consent from the patient.

The situation is different if the doctor assesses the patient as 'not suitable' to be informed of these matters. A patient will be 'not suitable' if the doctor forms the view that providing the information will have a negative influence upon the patient either physically or psychologically. A doctor who forms such an assessment is entitled to exercise his or her 'therapeutic privilege' not to inform the patient. In such a case, consent will be provided by a 'close relative' of the patient. A determination that a patient is 'not suitable' effectively deems the patient to lack decision-making capacity, and requires that a decision be made on his or her behalf. Some scholars suggest that this broad interpretation of Article 55 should apply more generally to people who lack decision-making capacity, so that a 'close relative' could provide informed consent on behalf of the person.<sup>94</sup>

92. Medical Institutions Management Ordinance (n 81).

93. Medical Institutions Management Ordinance (n 81) Art 33. Pursuant to Yiliao Jigou Guanli Tiaoli Shishi Xize (医疗机构管理条例实施细则) [Rules for the Implementation of the Medical Institutions Management Ordinance] (issued by the State Council, 29 August 1994, effective 1 September 1994) Art 88, a procedure is likely to be regarded as a special examination or a special treatment if it is dangerous and likely to cause adverse events, dangerous because of the special physical condition of a patient, experimental or costly and likely to become too great a burden to a patient.

94. Wang Zhu, Jieshilun Shiye Xia de Qinhai Huanzhe Zhiqing Tongyiquan Qinquan Zeren (解释论视野下的侵害患者知情同意权侵权责任—王竹) ['The Tortious Liability for the Infringement of the Patient's Right to Information Consent — From an Explanatory View'] (Fa Xue [Law Science], 2011) 11, 93 <<http://lawscience.ecupl.edu.cn/s/288/t/71/p/1/c/3658/list.htm>> accessed 9 May 2017.

Who then are the ‘close relatives’ for the purpose of this provision? There are several different definitions of ‘close relatives’ under Chinese civil law, criminal procedure law, and administrative procedure law. In the civil law domain, Article 12 of the Court’s interpretation of the *Implementation of General Principles*, describes close relatives as ‘spouse, parents, children, brothers and sisters, paternal or maternal grandparent, grandchildren, and maternal grandchildren’. Accordingly, it is not only the guardian of the patient, but also this potentially wide range of close relatives who have authority to make the healthcare decision.

Different regulations apply if the person has a ‘mental disorder’. The *Mental Health Law* contains several provisions concerning the guardian’s role in decision-making relating to diagnosis and treatment of the mental disorder. Article 28 states, ‘in addition to going to a medical facility for a psychiatric assessment on their own, persons with a suspected mental disorder may be taken to a medical facility for a psychiatric assessment by a close family member.’ If the person with a mental disorder satisfies the criteria for inpatient treatment, Article 31 authorizes his or her guardian to consent to such treatment. Similarly, the guardian has a role in relation to any surgery that results in loss of function of body organs or experimental clinical treatments for the mental disorder. Pursuant to Article 31, the patient’s guardian must be informed of the risks of treatment, alternative treatments and other relevant information, and give written consent. The surgery or treatment must then be approved by the ethical committee of the medical institute.

#### F. *Remaining Uncertainties and Deficiencies*

Although there has been some progress in China in developing laws that facilitate decision-making for healthcare when a person loses capacity, and recent amendments to the *Law of the Elderly* and the *Mental Health Law* go some distance to promoting that person’s autonomy, there still remain some regulatory shortfalls.

##### 1. *Limits on nature and scope of regulation*

As Chinese laws have not been crafted specifically to regulate healthcare for individuals who lack decision-making capacity, they are unsurprisingly piecemeal in coverage. This has resulted in the nature and scope of regulation being unsatisfactory in two important respects. The first is that there is not a single regime that extends to all individuals with decision-making incapacity. The *General Principles* apply to individuals who have a mental illness, and this category has been expanded by the *Interpretation of the General Principles* to include people with dementia. However, the regime does not extend to those with intellectual disability, brain injury, or in a persistent vegetative state. The inclusion of individuals falling into the latter category within the *General Principles* will depend on the preparedness of courts to exercise their discretion to expand the operation of the provisions in the *General Principles*.

Second, for the most part, the current regulatory framework was not specifically designed to govern health decisions. The primary goals of many of the laws in China that relate to guardianship (and described above) are for other purposes. For example, relevant provisions of the *Medical Institutions Management Ordinance*, the *Law on*

*Practicing Doctors*, and the *Tort Liability Law* are concerned with how medical institutions or their staff should act to avoid liability, rather than how decisions should be made on behalf of another with decision-making impairment to ensure they receive treatment that is in the patient's best interests or promote the autonomy of that patient.

2. *Uncertainty regarding how decisions are made and by whom*

(a) *Lack of clarity regarding the decision-maker*: As we have seen in the preceding description of Chinese law, several different terms have been used to describe the decision-maker who will act on behalf of the person lacking capacity. The *Medical Institutions Management Ordinance* uses 'family member or relevant person', the *Tort Liability Law* uses 'close relatives', while the *Mental Health Law* uses 'guardian'. This inconsistency has brought confusion and uncertainty. For instance, as the *Tort Liability Law* stipulates, when the patient is 'not suitable' to give consent, his or her close relatives shall have the right to consent. However, in the case of statutory guardianship, 'close relatives' include not only the guardian (i.e. the spouse), but also other members of the family, which means the guardian's decision-making is shared by other 'relatives'. In other words, the patient's family members can make a decision without the participation of the guardian, which is in conflict with the primary principle underpinning guardianship.

Furthermore, in practice, the opinions of other family members are often taken into account when the guardian makes a decision. However, there is no mechanism, which regulates the role of family members who are not guardians, so it is unclear how their opinion should be obtained and weighed in the decision-making process.

(b) *Resolution of disputes about healthcare decision*: Where there are a number of potential decision-makers (for example, two or more family members who qualify to act as guardians), disputes may arise regarding the appropriate healthcare to be provided to the patient. Disputes may also arise between the family member who makes a healthcare decision and the treating team.

In relation to the former, Chinese law does not facilitate a process whereby the decision of a family member can be stayed until the dispute about the appropriate healthcare decision can be resolved. The unit or neighbourhood committee to which the guardian belongs does have a qualified power to mediate disputes. However, such entities are designed for other purposes and have not proved effective for resolving legal disputes generally, let alone such specific disputes as healthcare decision-making between guardians. Indeed, given the increasing mobility of the Chinese population, these entities are losing much of their effectiveness as the arbiter of disputes.

In limited circumstances, a person employed by a medical institution may have the authority to make a healthcare decision on behalf of a person. The *Medical Institutions Management Ordinance*, *Tort Liability Law*, and the *Mental Health Law* provide that appropriate medical treatment can be administered under urgent circumstances if the person in charge of the medical institution or a person authorized to act in his or her capacity approves. What is less clear, however, is the role that a doctor (or a medical institution) plays when he or she disagrees with a decision that has been made by a guardian about healthcare. Article 33 of the *Medical Institutions Management*

*Ordinance* provides that: ‘when the opinions of the family members or related persons are not available or other special circumstances arise, the doctor in charge may put forward a treatment plan and execute it if approved by the person in charge of the institution or a person authorized by him/her’.

However, it is unclear whether this authority allows the institution or person working within that institution to provide treatment contrary to the direction of a guardian, or even to challenge that decision. Given the potentially significant nature of decisions that can be made about healthcare, it is important for this safeguard to exist. However, it remains unsatisfactory that there is not another avenue for resolving disputes that may arise where a family member has concerns about the proposed treatment plan for a patient.

(c) *Lack of guidance in how to make a healthcare decision*: Chinese law provides virtually no guidance on how a guardian should make a healthcare decision, for example, the extent to which the focus should be on the current or previously expressed views and wishes of the person or that person’s best interests. Under Chinese law, no distinction is drawn between healthcare, property, and other decision-making. As will be recalled, pursuant to Article 18 of the *General Principles*, the guardian is required to ‘protect the person, property and other lawful rights and interest of his wards’. No assistance is provided on how such decisions should be made. There is also no guidance on the extent to which an advance directive made by a person is relevant in decision-making. Unlike the Australian common law (which is reflected in the legislation in most jurisdictions), there is no obligation to comply with the directions previously given by a person about his or her treatment.

(d) *Lack of protection of person’s autonomy*: An important component of Australia’s guardianship regime is the promotion of autonomy of the person who lacks decision-making capacity. Assessments of capacity are decision-specific so it may be that a person is assessed as having capacity to make some healthcare decisions but not others. Where a decision has to be made on behalf of the person, it is also important to consider the person’s previously expressed views and wishes on the topic. Indeed, there is now a trend to support the person him- or herself to make his or her own decision if that is possible. These are important components in ensuring that intervention into the life of a person accords with the least restrictive option that is available, and promotes his or her autonomy to the greatest extent that is possible.

Equivalent measures and protections are not embedded in the same way in Chinese law. First, although the *Law of the Elderly* now provides support for decision-making when a senior person has partial decision-making capacity, this law is restricted to the elderly and does not apply more broadly to others with decision-making impairment. Second, assessment of capacity to make decisions is generally a blunt process under Chinese regulation: it is not recognized that a person may be able to make some decisions about healthcare, but not others. Except as prescribed by the *Law of the Elderly*, there is no obligation to determine if a particular healthcare decision is within a person’s ability. Third, there is no requirement to ensure a healthcare decision made on behalf of the person is consistent with previously expressed views and wishes, or

even that such views and wishes be taken into account. That said, it should also be noted that autonomy is promoted, at least to an extent, under the *Mental Health Law*. Pursuant to this law, a person with a mental disorder has the choice about whether or not to accept a diagnosis and treatment (Article 30). Nevertheless, the patient will be subject to involuntary hospitalization if he or she is diagnosed with a severe mental disorder, and is at risk of self-harm or causing harm to others. In this case, the right of decision-making is transferred to the guardian.

In summary, despite some progress with the *Law of the Elderly* and the *Mental Health Law*, it remains the case that autonomy has not been embedded within the Chinese law operating in this field to the same extent that has occurred in Australia.

### III. FACTORS RELEVANT TO ADAPTING AUSTRALIAN LAW TO THE CHINESE CONTEXT

With the ageing of China's population and the increasing number of adults likely to suffer some kind of decision-making impairment, it is important for China to develop a framework for making decisions about their medical treatment. The previous section describes the current regulatory framework operating in China, and identifies inadequacies with that model. In considering possible alternatives, the Australian guardianship model may be one which has some advantages. As mentioned earlier, Australia's adult guardianship model has been operating for some decades, so many lessons can be learnt from approaches that have been successful, and some which have been less so. Moreover, several Australian state law reform commissions have undertaken reviews of guardianship law in recent years, informed by international developments in the field. Accordingly, some of the models currently being proposed in Australia reflect modern thinking in terms of supporting and enabling adults with decision-making incapacity to be as involved as possible in decisions that will have an impact on them.

The modern Chinese legal system has, for the most part, been transplanted from the civil law jurisdictions and, in recent years, it has been increasingly influenced by common law jurisdictions.<sup>95</sup> However, the fact that Australia's guardianship regime is innovative and effective does not necessarily guarantee success if adopted in China. Laws must reflect and influence society's values and culture.<sup>96</sup> A legal model that is introduced into a country which is neither reflective of nor consistent with that

95. For example, China has adopted the United States concept of punitive damage into its civil law, and has been heavily influenced by the common law in many aspects of its commercial law. Vincent R Johnson, 'Punitive Damages, Chinese Tort Law, and the American Experience' (2014) 9(3) *Frontiers of Law in China* 321, 323; Mo Zhang, *Chinese Contract Law: Theory and Practice* (Martinus Nijhoff Publishers 2006) 12.

96. Roger Cotterrell, *Law, Culture and Society: Legal Ideas in the Mirror of Social Theory* (Ashgate 2006) 15-20, 54-63; Lawrence Friedman, 'Some Comments on Cotterrell and Legal Transplants' in *Adapting Legal Cultures*. See further Lawrence Friedman, *The Legal System: A Social Science Perspective* (Russell Sage Foundation 1975) 223, who refers to two categories of legal culture: (a) External legal culture, describing the general attitude of society towards the law and its instrumental use for social purposes; and (b) Internal legal culture, which are the thoughts, modes and institutions of participants.

society's values or culture runs the risk of not operating in a way that achieves its desired goals.

The existence of socio-cultural and psychological differences between Australia and China underscores the need for some caution in adopting aspects of Australian guardianship laws into the Chinese context.<sup>97</sup> This is reinforced by China's socialist politico-legal system, collectivist culture, and historical aversion to Westernized legal structures.<sup>98</sup> Furthermore, adult guardianship law impinges on communities which privilege intimacy and multi-faceted relationships, and therefore any foreign system must be adapted to the Chinese familial context.<sup>99</sup> For example, the Hong Kong Law Reform Commission did not recommend conducting a legislative framework for advance directives, instead suggesting an informal policy-based framework better suited to Chinese culture, family structure, and concepts of 'self'.<sup>100</sup> Furthermore, Hong Kong previously sought to establish the Guardianship Board, modelled on Australia's successful tribunal system, which attracted only 26 applications in the first six months.<sup>101</sup> Whilst this has been partially attributed to inadequate training for tribunal members, the dominant explanation for its poor performance was the model's inconsistency with Chinese cultural values, in particular, the perception that eldercare is properly a 'family matter'.<sup>102</sup>

Nevertheless, the Australian system is regarded as a highly innovative and effective model<sup>103</sup> that may enhance its authority and acceptability for adaptation in China.<sup>104</sup> The critical socio-economic drivers of reform in Australia, including an ageing population, changes in family structure, and developing patient-centric welfare concepts, apply in the Chinese context. Australia's adult guardianship model, which relies heavily on informal dispute resolution processes, family involvement and non-judicial processes is closely aligned with China's collectivist culture,<sup>105</sup> family-oriented support infrastructure,<sup>106</sup> and preference for informal

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97. Ashkanasy, Roberts and Kennedy (n 21) 39; House (n 21); Shi and Wang (n 21) 12-16; the Hofstede Centre (n 21).
98. Jianfu Chen, *Chinese Law: Context and Transformation* (Martinus Nijhoff Publishers 2008) 65-75.
99. Cotterrell, 'Is their Logic in Legal Transplants?' (n 19) 75-82; Cotterrell, *Law, Culture and Society* (n 96) 116-125.
100. Hong Kong Law Reform Commission, 'Substitute Decision-Making and Advance Directives in Relation to Medical Treatment' (HKLRC 2006) <[www.hkreform.gov.hk/en/docs/rdecision-e.pdf](http://www.hkreform.gov.hk/en/docs/rdecision-e.pdf)> accessed 20 January 2017.
101. Terry Carney, 'Globalisation and Guardianship – Harmonisation or (Postmodern) Diversity?' (2001) 24 *International Journal of Law and Psychiatry* 95, 105.
102. Carney, 'Globalisation and Guardianship' (n 101) 105; Terry Carney, 'Challenges to the Australian Guardianship and Administration Model?' (2003) 2 *Elder Law Review* 11, 11-13; Terry Carney, 'A Regional Disability Tribunal for Asia and the Pacific: Changing the Conversation to a "Conversation"?' (2011) 7(3) *International Journal of Law in Context* 319, 325.
103. Carney and Tait (n 27) 192-97; Terry Carney, 'Protection, Populism and Citizenship' (2000) 17 *Law in Context: A Socio-Legal Journal* 54.
104. These factors are essential criteria for the success of a legal transplant: Nelken (n 19) 40-41.
105. Ashkanasy, Roberts and Kennedy (n 21) 39; House (n 21); Shi and Wang (n 21) 12-16; the Hofstede Centre (n 21).
106. Helen Chiu, Joshua Tsoh and Xin Yu, 'Care arrangements for patients with dementia: China' in Ennapadam Krishnamoorthy, Martin Prince and Jeffrey Cummings (eds), *Dementia: A Global Approach* (CUP 2010) 107-109.

dispute resolution.<sup>107</sup> Finally, China's ageing population and changing family structure create a strong social need for adult guardianship law reform.<sup>108</sup> Whilst a complete survey of the factors pertaining to legal transplants is beyond this article's scope, the success of the Australian model, coupled with the similarity of socio-economic forces driving the change, indicate Australia's guardianship system may be a suitable reference model for the further development of Chinese guardianship laws, with appropriate adaptations to account for socio-cultural differences. Factors requiring consideration include Chinese values, both traditional and emerging, that are engaged in the healthcare context, and practical realities such as the cost of medical treatment and responsibility for those costs.

The concept of 'family' in particular is central to traditional Chinese social and cultural values.<sup>109</sup> Indeed, the Chinese system of government and national identity is founded on quasi-filial responsibilities and reciprocal duties, with the State often perceived as an imagined family.<sup>110</sup> Care of the sick, the disabled, and the elderly is regarded as the responsibility of the family, and any problems regarding medical treatment are usually solved within a familial context.<sup>111</sup> In previous times, taking responsibility for family members was more feasible because families tended to be large, and family members worked and lived in close proximity.<sup>112</sup> The responsibility for caring for sick people included making medical decisions on their behalf. Traditionally, the integrated family unit was thought to make better decisions about healthcare than the patient alone.<sup>113</sup> This will be true particularly when the patient lacks decision-making capacity. It was also thought that the practice of making healthcare decisions for a family member spares that person from the burden of knowing the details of his or her condition, and having to make a potentially difficult decision about treatment.<sup>114</sup>

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107. Xiaohua Di and Yuning Wu, 'The Developing Trend of the People's Mediation in China' (2009) 42(3) *Sociological Focus* 228.
108. Which, according to the functionalist approach, supports the efficacy of transplantation: Konrad Zweigert and Kurt Siehr, 'Jhering's Influence on the Development of Comparative Legal Method' (1971) 19 *American Journal of Comparative Law* 215.
109. Ruiping Fan, 'The Confucian Bioethics of Surrogate Decision Making: Its Communitarian Roots' (2011) 32(5) *Theoretical Medicine and Bioethics* 301.
110. Vanessa Fong, 'Filial Nationalism among Chinese Teenagers with Global Identities' (2004) 31(4) *American Ethnologist* 631, 633-35. The concept of 'family' here is deployed in an expanded idiomatic sense.
111. Thomas Wong and Samantha Pang, 'Holism and Caring: Nursing in the Chinese Health Care Culture' (2000) 15(1) *Holistic Nursing Practice* 12; Fan (n 109).
112. Wang Yuesheng, 'An Analysis of Changes in the Family Structure between Urban and Rural Areas: On the Basis of the 2010 National Census Data' (2014) 35(4) *Social Sciences in China* 100, 108-13.
113. Ruiping Fan, 'Confucian Familism and its Bioethical Implications' in Shui Chuen Lee (ed), *The Family, Medical Decision-Making and Biotechnology* (Springer 2007) 21-22; Xiaoyang Chen and Ruiping Fan, 'The Family and Harmonious Medical Decision Making: Cherishing an Appropriate Confucian Moral Balance' (2010) 35 *Journal of Medicine and Philosophy* 573, 579; Ding Chunyan, 'Family Members' Informed Consent to Medical Treatment for Competent Patients in China' (2010) 8(1) *China: An International Journal* 139, 140-42; Fan (n 109) 305-307.
114. Fan, 'Confucian Familism and its Bioethical Implications' *ibid* 20-21; Alexander Wuensch *et al*, 'Breaking bad news in China – the dilemma of patients' autonomy and traditional norms' (2013) 22 *Psycho-Oncology* 1192.

Pushing against this historical decision-making role of family members is the emerging focus on individual rights. Under the influence of foreign legal systems, individual rights and freedoms are coming to the fore. In the context of healthcare decisions, this is illustrated by the 2012 amendments to the *Law of the Elderly* allowing a person over 60 years who has capacity to appoint another person to act as his or her legal guardian when the elderly person subsequently loses capacity.<sup>115</sup> The ability to make such an appointment signifies the increasing importance of self-determination. Any proposed guardianship legislation would need to tread a careful balance between acknowledging the central role played by the family, while recognizing the emerging importance of individual autonomy.

It is also important to acknowledge the traditional roles played by units and committees within Chinese communities. Disagreements that arose within communities were resolved at local levels rather than being escalated to courts. The desire for informal, local processes should also inform any reform proposals.

In addition to ensuring a 'legal transplant' is sensitive to relevant values, a proposed regime must also 'work' in a practical sense. One relevant consideration to decision-making for all patients in the Chinese context is the expense of medical treatment. A person's healthcare insurance cover<sup>116</sup> and income levels<sup>117</sup> will be relevant factors, as an inability by a patient or his or her family to pay for treatment often means that it will not be provided. Doctors and medical institutions commonly look to the family of the patient to pay, at least in part, for the cost of treatment. For this practical reason, as well as the inherent importance of the family, family members will be involved in healthcare decision-making for all patients (regardless of their level of capacity). The relevance of cost in healthcare decision-making is therefore a factor that must be considered when proposing how healthcare decisions should be made under a new system.

#### IV. POSSIBLE FUTURE DIRECTIONS FOR CHINA

In this section of the article, we suggest a possible way forward for China to regulate the making of healthcare decisions for individuals who lack decision-making capacity. Drawing on the issues raised earlier, this section begins with the argument that a change in current law and practice in this field is needed in China. We then make some suggestions about what that reform might look like.

##### A. *Demonstrated Need for Change*

There are three compelling (and almost irresistible) drivers for changing the status quo in China. The first is the social imperative for change. The ageing Chinese population will inevitably bring with it an increased incidence of people suffering from age-related cognitive decline and, as a result, an enormous number of individuals will be unable to make health decisions for themselves. The system must be able to facilitate appropriate

115. Law of the Elderly (2012 Revision) (n 81) Article 26.

116. *China Social Security System Development Report* (No. 4, Social Sciences Academic Press 2010) 223.

117. *ibid* 233.

healthcare decisions for this vulnerable cohort. The second is the increasing move towards individualism. As discussed earlier in the article, under the influence of foreign legal systems, China has seen an increased focus on individual rights and freedoms. Individuals in China will be seeking more control over their healthcare should they lose decision-making capacity.

The third driver for change is the failure of China's current laws to provide a clear framework for this kind of decision-making. Uncertainties arising from the piecemeal and unintegrated nature of different pieces of legislation, lack of coverage of all individuals with decision-making impairment, lack of clarity about who is the decision-maker in any given case, and the lack of criteria guiding how treatment decisions should be made, are critical shortcomings. Historically, reliance on families who assumed responsibility for the health and welfare of all family members, and units and committees regulating affairs within communities, may have been adequate. However, as people become increasingly mobile, units and committees are having less influence and are not as effective in resolving family issues. In addition, family decision-making becomes more difficult between smaller and more geographically disparate family members. Traditional systems and practices are arguably no longer sufficient to address the growing need for decision-making on behalf of those with decision-making impairments.

Change will provide greater clarity to the healthcare providers, and to family members who are currently uncertain of their role in decision-making for patients who lack capacity. Increased clarity would also enable individuals themselves to make plans for their future in anticipation of a loss of decision-making capacity.

### B. *Proposed Model*

The challenge, then, is to develop an adult guardianship framework, which draws on the successful Australian experience, but which accommodates the values that underpin Chinese society and the practical considerations that currently affect medical decision-making. The proposed model should, as far as possible, build on existing processes, structures, and entities that are in place and working effectively to deliver healthcare to individuals who lack decision-making capacity. In an attempt to achieve these outcomes, we propose an adult guardianship regime containing the features outlined below.

#### 1. *Capacity as a threshold*

In all Australian jurisdictions, a person will only be empowered to make healthcare decisions on another's behalf if the latter lacks decision-making capacity. We suggest that the same principle should operate under any Chinese guardianship regime.

While this may impose on health professionals an increased need to formally assess the decision-making capacity of some patients, we nonetheless recommend this for two reasons. Firstly, having a capacity threshold provides clarity about when a substitute decision-maker is entitled to make a healthcare decision for another. In section II.E above, we observed that, at least in some cases, another person is entitled to make a healthcare decision if the patient is not regarded as 'suitable' to do so. However, it is unclear what is meant by this term and how a doctor would make an assessment of

‘suitability’. Secondly, having a threshold of ‘capacity’ would promote personal autonomy. A decision about medical treatment could not be made for any person who has capacity, thus promoting that person’s right of self-determination. The focus should be on a person’s ability to make a healthcare decision, rather than whether he or she makes a decision that is suitable or about which others agree.

## 2. *Decision-making framework*

We also recommend adopting the Australian guardianship decision-making framework that operates when the person loses capacity. That framework has a two-pronged approach: first, it allows persons with capacity to plan ahead and organize his or her decision-making arrangements to operate at a later time when capacity is lost; and second, it provides a default decision-making process in the absence of such arrangements having been made by the person when he or she has capacity.

(a) *The person makes his or her own arrangements*: Under the Australian framework, the person could appoint another adult to be his or her decision-maker in relation to health matters if he or she is later unable to make such decisions (Option A). Alternatively, a person is able to make their views about future healthcare decisions known through an advance directive, and such directives will govern treatment if the person later loses capacity to make these decisions (Option B). We believe that these proposals would be effective in the Chinese system for two reasons. First, these options (or variations of them) are not foreign to Chinese law. As we have seen, the *Law of the Elderly* enables a senior person to appoint a guardian when he or she has full capacity. This mechanism could easily be extended to all individuals who have capacity and wish to appoint a guardian. Second, such reform would also provide clarity around who is tasked to make the decision.

Amending the law to allow a person to draft an advance directive (Option B) is also recommended. This, however, is not currently possible under Chinese law. There is limited recognition (albeit in a different context) that a person’s previously expressed views and wishes can be relevant. Article 8 of the *Regulations on Human Organ Transplantation*<sup>118</sup> states that ‘[...] any organization or person shall not donate or remove any human organ of a citizen who has disagreed with the donation of any of his or her human organs while alive [...]’. If the views and wishes of a person should be considered in this context, arguably a statement about the medical treatment that they would like to receive or refuse should also be influential (or indeed followed) if he or she later loses capacity. Other issues, such as the affordability of the medical treatment requested in an advance directive, may be relevant to whether that direction about medical treatment is followed, but these could be addressed in any legislative regime.

(b) *Default decision-making framework*: The statutory provision for default decision-makers has been critical to the success of the Australian guardianship system. In the

118. Renti Qiguan Yizhi Tiaoli (人体器官移植条例) [Regulation on Human Organ Transplantation] (promulgated by State Council 31 March 2007, effective 1 May 2007).

absence of an appointment made while a person retains capacity, Australian legislation sets out a hierarchy of default decision-makers. First would generally be a spouse, and further down the list are carers, relatives, or friends. For decisions that need to be made about medical treatment, the decision-maker is the person (and generally just one person) who is highest on that list and who is readily available and culturally appropriate to make the decision.

The philosophy underpinning the Australian model is that decisions about healthcare will be made by those who are closest to the person and who best know his or her personal circumstances (which may include how they feel about particular medical treatments). This concept is likely to resonate well in the Chinese context where the family is the core of society. The Australian model, where a decision is made by one member of the family only, may be further adapted to the Chinese context where medical treatment is a matter more likely to be discussed between and determined by the family as a whole. Further modifications, for example, about whether or not the decision should be a unanimous one, or whether any one person would have a determinative position, could also be considered.

(c) *Resolution of disputes*: Disagreements will inevitably arise regardless of the system of regulation, and it is important to have an effective way to resolve them. Disagreements could arise in a variety of contexts: (1) Whether the person has lost his or her capacity to make medical decisions; (2) Whether a person was validly appointed to be an ‘entrusted agent’ or equivalent; (3) What should be the decision about treatment if those responsible for making that decision have different views; and (4) What should be the treatment decision if the treating team disagrees with the decision made by the family.

The Australian legislation contains a range of mechanisms for dealing with such disputes, but the most frequently used are the tribunals established in the various jurisdictions which are specifically designed to resolve guardianship issues. The informality and accessibility of these tribunals have been key to their success in quickly and cheaply resolving disputes such as those described above.

It is difficult to predict whether establishing an equivalent regime in China would have the same success. As noted earlier, traditionally, units and committees were involved in resolving disputes arising at the local community level. Although the influence and effectiveness of these particular entities have been declining over recent times, comparable entities designed to operate at the community or local, rather than a central, level may be more effective. The Hong Kong experience may be instructive in this regard. As mentioned earlier, a Guardianship Board was set up in Hong Kong, modelled on the Australian tribunal system. This initiative was unsuccessful with failure attributed to the fact that resolution by a Board was incompatible with Chinese values that healthcare for the elderly was a family matter and should not require the intervention of state mechanisms.<sup>119</sup> In 2010, China promulgated the *Law on People’s*

119. Carney, ‘Globalisation and Guardianship’ (n 101) 105; Carney, ‘A Regional Disability Tribunal for Asia’ (n 102) 325; Carney, ‘Challenges to the Australian Guardianship and Administration Model’ (n 102) 11–13.

*Mediation.*<sup>120</sup> Under this law, mediation committees are established in local communities with the goal of encouraging parties to reach agreement on matters that are in dispute. Mediators are chosen from the neighbourhood. There may be scope for such committees to resolve the kind of disputes that are generally brought before Australian tribunals. Of course, there would be a need for review at a higher level if agreement could not be mediated locally.

(d) *Criteria:* The final critical feature of a guardianship model is establishing the criteria that should govern decisions about appropriate medical treatment for the person lacking capacity. The principles that underpin Australian guardianship law which were outlined in section I.A above include the presumption of capacity, the least restrictive option, respect for autonomy, inclusion as a valued member of the community, and best interests.

While all of these principles inform medical decision-making on behalf of a patient without capacity, the criteria of ‘best interests’ and ‘substituted judgment’ are regarded as the two most important considerations. In determining what is in the ‘best interests’ of the person, the decision-maker (or decision-makers) must be fully appraised by the treating team of the relevant information regarding the patient’s condition, prognosis, and treatment options, while a consideration of ‘substituted judgment’ requires the decision-maker (or decision-makers) to determine what the views and wishes of the patient may have been in the situation that has arisen.

These two criteria, ‘best interests’ and ‘substituted judgment’, may be a good starting point in considering a Chinese model of guardianship. However, in a culture where historically family interests are regarded just as (or perhaps more) important than individual interests, it may be that it is not as critical to prioritize a person’s previously expressed views and wishes regarding their health. A modified ‘best interests’ test that takes into account the views of both the family and the previously expressed views of the person who now lacks capacity may therefore be an attractive model.

In addition, it is possible that factors that are not significant in the Australian context may feature prominently in China. As we have seen, the cost of medical treatment is frequently borne, at least in part, by the family rather than the state. This makes healthcare costs a crucial factor in deciding what medical treatment is possible. In such a system, it may be legitimate for healthcare costs to be one of the criteria that is considered in determining treatment.

It is beyond the scope of this article to articulate precisely what criteria would be suitable for a Chinese guardianship model. We do however suggest that the principles that have developed in Australia, more recently informed by international human rights standards, and modified to more closely reflect Chinese values and culture would be a useful starting point worthy of consideration.

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120. Zhonghua Renmin Gongheguo Renmin Tiaojie Fa (中华人民共和国人民调解法) [The Law on People’s Mediation] (promulgated by the Standing Committee, National People’s Congress, 28 August 2010, effective 1 January 2011).

## V. CONCLUSION

China, like Australia, has an ageing population and will experience an increasing percentage of its population being unable to make health decisions for themselves. It is therefore important to develop regulations that facilitate how health decisions are made for this cohort. This article offers Australian guardianship law as a model worth considering. Australia's guardianship laws are reasonably well developed, having evolved over some decades. And these laws have increasingly been informed by international human rights standards that promote the dignity and autonomy of individuals who lack decision-making capacity.

There are, of course, challenges in suggesting that China consider adopting statutory mechanisms that have been successful in a common law country. The most obvious tensions arise from different understandings in each country regarding familial involvement and control in healthcare decision-making for the vulnerable. The social and historical differences between Australia and China cannot be ignored. Despite this, due to recent social and political change, there is evidence that China may benefit from aspects of overseas guardianship models such as Australia's.

One such change is the shift in the way individual rights are perceived in China. The rights of the individual have not assumed primary importance in the traditional Chinese legal system; an individual was perceived as being part of a family or broader unit or community. However, as Chinese society has been increasingly exposed to external influences, individual rights have assumed greater significance. The Chinese government now places greater focus on individual rights – as seen in the amendments to the *Law of the Elderly* which allows an older person to appoint another to be his or her legal guardian – and Chinese people are increasingly demanding that personal rights and freedoms are placed at the forefront of reform measures.

Many of the principles that underpin Australia's guardianship laws resonate with traditional (and emerging) Chinese culture and values. Central to the Australian guardianship system is empowering the family to make decisions about what is essentially a very personal matter, the provision of medical treatment. Providing authority to Chinese families to do so, and clarity around that role, would be a welcome reform.

To deal with the growing demands of an ageing population, China will inevitably be faced with the need to develop laws to deal with healthcare decision-making for those with decision-making impairments. We hope that this analysis provides food for thought for policy makers and law reformers who take on the challenge of developing a legal regime suited to cultural and social expectations in China.