C O R R E C T E D V E R S I O N

LAW REFORM COMMITTEE

Inquiry into powers of attorney

Melbourne — 14 December 2009

Members

Mr C. Brooks
Mr R. Clark
Mr L. Donnellan
Mr M. Foley
Mrs J. Kronberg
Mr J. Scheffer
Mrs H. Victoria

Chair: Mr J. Scheffer
Deputy Chair: Mr R. Clark

Staff

Executive Officer: Ms K. Riseley
Research Officers: Ms K. Harrison and Ms S. Brent
Administration Officer: Ms H. Ross-Soden

Witnesses

Ms L. Cordone, General Counsel, and

Ms P. Chatfield, Legal Counsel, St Vincent's Hospital, Melbourne.

The CHAIR — Thank you both very much for coming and for sending along a written submission. That has been very valuable. In terms of the preliminaries, this hearing takes place under parliamentary privilege under a range of pieces of legislation. That basically means anything you say here is protected from the kind of action that some may wish to take against you. But if you say that outside the hearing, obviously it will not be afforded to you.

Hansard is taking down the conversations; you will be sent a transcript. You can make some minor changes to that subsequently, but obviously not changes to the substance.

In terms of what we have done so far, this is our third hearing. We have heard evidence from a range of stakeholders including the Office of the Public Advocate, the Victorian Civil and Administrative Tribunal, a number of legal organisations, the community legal sector, legal academics, trustee companies and some seniors groups. That is where we are up to at the moment. We expect to report by the end of next year or actually August.

We have got half an hour, so we have to get our skates on. We will give you some time to speak to your submission and the terms of reference. Then we will have a few questions that we will have time to ask you.

Ms CORDONE — I might start off and provide a brief introduction of the work we do. Given the context of the people you have already consulted, I think it is probably pertinent to hear from lawyers working in a major public hospital in Victoria. St Vincent's Hospital, like major metropolitan health services, is a very large teaching, research and tertiary health service providing integrated health-care across multiple sites.

It operates 890 beds. It has a large operating budget of $460 million and 5000 staff. On top of that, it has a diverse range of adult clinical services. It has acute medical and surgical services. There is subacute, palliative care and aged care. It also provides correctional health services — so it is quite large — but we do not look after children or have residential care. It is a part of the Sisters of Charity of Australia health service which is Australia's largest non-government not-for-profit healthcare provider.

My being the general counsel of a hospital, you would probably think, 'There are a lot of medico-legal issues there', but in fact 80 per cent of our work is mainly commercial. We have employees, we have purchasing equipment, and we lease property. It really is the commercial aspect of the organisation which we provide legal advice to. The medico-legal aspect is a smaller part, but it is a very important part for our clinicians.

On point the issue of capacity is raised by clinicians from time to time. It is not just doctors; it could be nurses and also social workers, but particularly doctors and social workers. For us what tends to happen is that an acute crisis will happen within the health service. Often the patient is sick and is unable to give direction as to where they want to go with their medical treatment. The family might be in dispute, and unfortunately that tends to happen with a stressful situation. A family member might say, 'I have a power of attorney and I can make certain decisions'. That is when we get the phone call. That is what we tend to get. There is an acute crisis, and doctors require some direction as to how to handle the family.

A lot of clinicians do not understand the rights that are provided under a power of attorney document. They do not understand the different types of attorneys you can appoint, but they understand the hierarchy between the documents and how the status of that can be altered by a VCAT order. They have a large workload. They are quite anxious, but under the standard terminology the fact that a lawyer needs to be brought in to interpret, it means it is more hands-off for them. They really appreciate there is a lawyer in the hospital to assist them.

I do not often get involved in therapeutic relationships. I will not go to the ward and speak to the family and the patient, because that is the therapeutic relationship. But what I do is empower the clinicians as to what they need to do. So it is a matter of, 'Fax me through that document, let me have a look at it and I will advise you in the context of what you are dealing with'.

Ultimately what you try to do is to have a consensus with the family rather than use a piece of paper and a document to say, 'This says and provides for X and therefore we will go down that path'. Notwithstanding a person might have a particular power, we ultimately want some harmony and consensus with the family.

We will be advocating, and I have no doubt we will have mentioned things in our submission, that there needs to be a common and consistent approach. The terminology needs to be simplified. There has to be guidelines for

doctors. Doctors need assistance. I believe we did submit also a copy of our policy we wrote. Sometimes I read it for myself when I get a question.

But I think even though we have got policies and guidance for the doctors, it is quicker for them to pick up the phone and speak to us rather than read a document, because they are very time poor. They do not have much education and training about legal documents. They are very confused with the terminology.

At St Vincent's we have been very proactive in ensuring on admission each patient is asked whether or not they have got these documents that exist. Then they are followed up by social work within a short time of admission, so they learn they need to bring these documents in. So we have been quite proactive in trying to identify that these documents exist.

But staff are very intimidated by the process. There is a bit of miscommunication and misunderstanding. Obviously there are different vocabularies that the medical profession and legal profession use. They feel that lawyers will usurp them in any case. So where does the doctor fit in that process?

I thought I would just give that as a brief introduction of the work we do in this context.

Ms CHATFIELD — My name is Paula Chatfield. I am a legal counsel on a part-time basis at St Vincent's Hospital. I have been there nearly three years. I have been in private practice for almost 20 years. So when I speak to you, I will be blending my experience in private practice and my experience at St Vincent's.

I drafted that policy that you have. I have more time to do these kinds of tasks. Lucy really does not have the time. The issue of capacity is a major issue, as you well know. One of the concerns I have is that I do not understand why the test is lesser for a power of attorney than for a will. But particularly with the financial enduring power of attorney, it is such an enormously significant document. I do not think, based on my own experience, that people understand the implications of that necessarily.

I have actually practised elder abuse law, so I have seen the downside. I need to qualify my comments to say that most of my experience is when things go wrong. I do not see things when they are working, so I am not going to get to comment on that. I know it does work at lots of levels, but I get all of the things that go wrong.

One of the things I think is important is that the certificate of witness of the statutory declaration, to the power of attorney should remain in place because I just think it is such a crucial document. If you are creating a power of attorney, I feel that members of the public really need a professional to be involved. I know that cost issues come with that. That is not what I am talking about. I know that is an important issue, because I see that with clients.

One of the problems I also see is that with an enduring power of attorney, a general one, that comes into existence when a person loses capacity, so they fill in the box that says, 'On this occasion when I might lose capacity'. I think it is very difficult. In a hospital setting you know when a person has lost capacity, because between doctors and lawyers we can work that out. But once the patient is outside that environment, you simply have the deed without any evidence that the person has lost capacity and whether it is a temporary loss of capacity, or permanent.

I do not think that the legislation addresses that particularly well. Whether or not medical staff need to start supplying certificates to show this power of attorney deed has been triggered is just something I have thought about.

When I was doing the policy, you will see from it, there were quite a lot of clinicians involved with that process. My experience of them was they were very nervous about this whole issue of capacity. They were very keen to get it right. That is what they really want: they want to get it right. That is why we came up with the notion that the legal office and some of the senior doctors should create a checklist, because doctors like working with checklists. They are always under pressure. They like to tick a box to make sure they have met all of the criteria. So that is something I will probably work on over the Christmas and new year period.

In my submission I have referred to the Kelly Purser article that is in the *Journal of Law and Medicine*. That was a very helpful article. I just want to read out the author's definition, because I think this is critical for the way legal staff approach the whole issue of capacity to the difference between the medical staff. She says:

> The legal practitioner questions whether the individual is legally able to make these types of decisions …

She calls that competency. That is what we do as lawyers. We say, 'Can they make this decision?' but we do not understand their medical condition. Then she says:

> The medical practitioner, on the other hand, will attempt to assess physical and mental abilities and the effect of these on sickness or distress …

She calls that capacity. This is where we go back to the terminology issue. When I sit and talk with doctors, it is very muddled. What they understand is capacity and what we as lawyers understand capacity to be are two different things. I think that really has to be addressed with any changes to the legislation.

The CHAIR — You talk in your submission about the importance, and how it would be valued, of having a consolidated power of attorney document. In some of the evidence we have received, some of the jurisdictions in Australia do that — Queensland and New South Wales come to mind. From what perspective would you see as being a good model that already exists that you could point us to?

Ms CHATFIELD — I looked at the Queensland one; I did not have time to look at the New South Wales one. It depends on whether you are drafting these for lawyers or for the public. These are complex documents. Queensland had the long and short-length form, and you had to work out which one was the correct form to use. I would think, automatically, a member of the public is going to opt for the short form, because it is easier to understand possibly. I did not feel that they had got this fully right.

The CHAIR — Sorry?

Ms CHATFIELD — That it was fully right; it just seems to me they are too long documents. There is still potential for confusion. My experience of sitting down with clients and doing powers of attorney is that they do not want to know the detail, and they get confused by things so easily. I think you have got a difficult problem.

The CHAIR — How simple can you make it, given what you described before about the complexities that are out there in the non-clinical environment?

Ms CHATFIELD — I think you need to lean on making it simple, but you need to encourage members of the public to always have a lawyer involved. I know that raises a cost issue. Some people cannot afford it or they do not like lawyers, and maybe State Trustees or the Public Advocate needs to deal with those types of people.

Ms CORDONE — Or VCAT.

Ms CHATFIELD — Or VCAT. What I would like to see are very simple documents. When I thought about it, at first I wanted one document that you could just make your choices and go through it. But having seen these, I do not know what the answer is; I think it is very hard.

The CHAIR — You are not supposed to say that; we need the answers.

Mrs VICTORIA — You are supposed to enlighten us.

Ms CHATFIELD — I will say to you I do not think it is working as it is. I think that is a really important point. I think there are too many aspects. You have got conflicting situations, you have got the guardianship orders, and you have got which power takes precedence over which power.

The CHAIR — Can I just press a little bit further and then we will just throw it open to other people? If there are two or three things in the Queensland document — it is the Queensland one you have looked at, is it not?

Ms CHATFIELD — Yes, I am looking at the Queensland one.

The CHAIR — So you have looked at two or three things that are good. What would you say they were?

Ms CHATFIELD — They do have a lot of information here explaining things, and that is good.

The CHAIR — Okay, so explanation is good.

Ms CHATFIELD — They are set out fairly clearly, but it is just that they are such long documents.

The CHAIR — It is the length. So they need to be much briefer.

Ms CHATFIELD — I just do not think people read.

The CHAIR — And the third thing I think you mentioned was that they really need to be done in conjunction with a legal adviser.

Ms CHATFIELD — Yes, I think it is really important.

Mr CLARK — Could I take up your point about revocation of powers of attorney? You recommend they cannot be revoked orally. I can see what you are getting at in terms of certainty, but is not the risk on the other side of the ledger — that a patient is not able physically to either sign a revocation or to access someone to complete the revocation documents?

Surely they are entitled to say in effect to their attorney, 'You're fired', or to say to the medical practitioners, 'You're no longer to act on this power of attorney'. Obviously if the person has lost legal capacity, that is irrelevant, but if they have got the capacity, surely you cannot expect them to not be able to withdraw authority from the attorney unless they can fill out all the paperwork.

Ms CHATFIELD — The reality is, if they are out on the hospital ward and the son says, 'I am mum's attorney, and here is the deed', how do we know whether mum still wanted him as her attorney, or whether she has revoked it? That for me is very problematic. She may have said orally she did not want him — and that is fine — but there is no evidence, because we still have a signed deed.

Mr CLARK — That is one half of the dilemma; the other half is, as I say, if mum says, 'I do not want you to act for me anymore', then surely the attorney should not be allowed to continue to act if the attorney has been told that power has been revoked?

Ms CHATFIELD — That assumes the attorney is honest.

Mr CLARK — Exactly.

Ms CHATFIELD — I am coming to it from a very skewed point of view, because I have only dealt with the ones that have all gone wrong. Maybe Lucy would be a better person to ask in that regard.

Ms CORDONE — I think the fail-safe position for us at the hospital would be that, so long as they are acting in the best interests of the individual, it is okay, because they are not really exercising their power, they are just doing the right thing for the patient. If they were not exercising their power in what we thought was the best interest, then we would be going to VCAT. That is a very cumbersome process for a hospital to have to go through, and they rely on in-house counsel to provide assistance. That is okay for the major metropolitan health services, but every other health service does not have in-house counsel, and it is not all right; it will come at a cost.

Mr CLARK — That is a good point. It may be that you could say that the attorney was acting illegally if they knew it had been revoked, but third parties were entitled to act on it. That then leads on to the question of whether you need some form of registration of powers of attorney to know whether or not it has been revoked.

Ms CHATFIELD — If you have executed your will, you do not just say, 'I revoke it'. You have to cross it out, and you have to show that that deed has been revoked, because it is such an important document.

Mr CLARK — Sure, but you keep possession of your will; you hand over your power of attorney to someone else — so that creates a practical difficulty?

Ms CHATFIELD — It does. I am very down on oral revocation from the point of view when people are dealing with the documents, people are going to assume that this is not a revoked power of attorney. The

doctors will not ask the question, 'Has this been revoked?', 'Is mum still wanting this?' — it will not occur to them.

The CHAIR — Could you not get it on that checklist you were talking about?

Ms CHATFIELD — Yes, that would absolutely have to go in there.

Mr BROOKS — I am just going to pick up on the issue you raised about capacity and the concern you had determining capacity outside of the walls of the hospital, if you like. You noted there was a test that you guys were developing, and I was wondering what sorts of things would be in those guidelines or that test for capacity. What would the key elements of testing capacity be? Can you go into more detail around that?

Ms CHATFIELD — Is this capacity to actually create the deed or capacity when the deed's powers start kicking in?

Mr BROOKS — It is more when the powers kick in.

Ms CHATFIELD — When it is triggered, with the checklist what I would propose doing is putting in the various elements in section 118 of the Instruments Act so the doctors would be able to talk to the patients and say, 'This power of attorney is here. Do you understand what this means, that you are giving this person these powers?'. We are not going to talk about a person who clearly has no capacity — who is unconscious, for example. It is one where they may be in and out of capacity, or there are questions because of their mental health admission.

I emailed one of our senior doctors to get his questions that he had asked, but he did not get that back to me in time so I cannot answer the clinical side. Maybe Lucy would have a better answer with her clinical background.

Ms CORDONE — With our policy what we have done — and I think it is well known throughout our hospital — is that a senior doctor, not junior doctors, must assess capacity because of the uncertainty. There is no medical test to assess capacity. We do it every day about consent to medical treatment — that is easy and that is straightforward; we have no issue — but when we start talking about legal documents, people are a bit reluctant.

Having said that, I think that doctors are very competent in assessing capacity or even competency. I do not doubt that they are otherwise capable; they just need some assistance. But we do reserve that assessment to a very senior doctor, because there is no medical test. They will start asking the patient questions.

They will have regard to their medical file, their medical condition, the medication that they are on. They will do some mini-mental examinations. They will document it. It is important that they actually document it, if it later gets pulled into question. It is really up to them. There is no medical test, per se.

Mr BROOKS — Have you got thoughts about outside the hospital setting in terms of how one might determine capacity when those powers kick in?

Ms CHATFIELD — Not how it would be determined, but I have thoughts on how it would be evidenced, which would be that perhaps it would be a good idea to have a medical certificate. It would not be saying what the person's medical condition is at all. It is simply a certificate — let us say it is put under the Instruments Act as a new certificate — saying that so-and-so has lost capacity for the purposes of section 118 of the Instruments Act for the following period.

It might want to say 24 hours, 72 hours or for three months if it is a temporary loss. Therefore anyone who is looking at that deed — say they go to the bank and they want to take out substantial sums of money — could see yes, 'Okay, we are within this period and this deed is operative', or they can say it is permanent in their certificate.

It is actually a certificate that is issued under the act. There is no medical information at all, except that it has to be certified by a doctor who has done the assessment.

The CHAIR — Just before we move to Heidi, could you quickly explain what you meant when you said there is no medical test for capacity, yet you talked about mini-mentals. They are not a medical test?

Ms CORDONE — No, it is a medical test.

The CHAIR — What did you mean by that?

Ms CORDONE — There are various, I suppose, neuropsych tests that doctors engage in. Sometimes these are done by neuropsychologists or psychiatrists et cetera. A mini-mental is getting people to draw a clock and repeating words and then giving them a series of words and then 3 minutes later or 5 minutes later asking them to repeat them. So it tests a bit of memory, if you like.

The CHAIR — But you would not call that a medical test?

Ms CORDONE — It is a medical test, but it is not a test specifically for capacity. It is one test that sometimes the doctors do just to assess people's memory and their ability to repeat information. They draw a clock with the time et cetera and are asked questions like, 'Who is the Prime Minister?', 'When did World War II end?', those sorts of things. But it is not telling. It really is in a sense of where you actually engage with the patient, which is probably a better way of doing it, and speak about what they are about to embark upon; it is more that conversation.

Mrs VICTORIA — Robert touched briefly on some sort of a central registry. What are your thoughts on a central registry, about how it would work and whether it would benefit what you two do?

Ms CHATFIELD — My views on the central registry are that you might have Liberty Victoria or someone like that against it. It might be good to have it as an opt-in so that you are not going to have issues about privacy rights and more regulation from the state. But if it was there and lawyers and doctors were able to access it, particularly doctors, I feel that would be a good thing, because you would then know, 'Look, this person who has presented has actually got an attorney, a medical attorney'. Maybe it only needs to be linked to medical attorneys, because that is the most important one in a hospital setting; whether a person has a financial attorney is probably quite a different issue.

Ms CORDONE — Although the financial is important for a lifestyle change. So if an aged person needed to go to an aged care facility, the financial would be important if they needed to rearrange their finances so they could pay for their ongoing care outside of an acute hospital setting.

Ms CHATFIELD — Yes.

Ms CORDONE — But with the opt-in, although I share part of Paula's views, the problem is that it will not be a comprehensive register then, so it will not be given the level of comfort that we as lawyers like when we advise the doctors — 'Do they have one or don't they have one?'. I mean, we always act in the best interests of the patient, that is not an issue. If there is conflict with a family, we attempt to manage that conflict. But I would like some more certainty, I guess, and I think the doctors would want certainty.

Mrs VICTORIA — So you would like it to be compulsory, but only with limited access?

Ms CORDONE — Yes.

Mrs VICTORIA — By obviously certain people?

Ms CORDONE — Yes.

Mrs VICTORIA — So doctors and lawyers, in certain settings?

Ms CHATFIELD — We talked about that. We thought it could just be perhaps the senior doctor on that shift in that department who has access.

Ms CORDONE — It could be. There are certain pieces of legislation that appoint a senior medical officer of a hospital and alternates. There is various legislation — the Health Act, for example — where you have powers to compulsorily take blood tests. You have the chief medical officer and you can have a deputy and another senior doctor, so there is someone always available who could access the registry — an in-house lawyer could probably be one, if there is one. So limited access, and certainly for our setting health practitioners need to access it.

The CHAIR — We have 5 minutes to go, so just a couple more questions; maybe three if we are quick. In your submission you mentioned, and you talked about it in your presentation just now, the development of a checklist that medical staff would use for assessing capacity. Could you briefly talk to us about what necessitated that, how you are developing it and how you think it will be used?

Ms CORDONE — I might talk about why it was necessitated and Paula might speak about what goes into it, which we are waiting for. What necessitated that is just how many phone calls there are to us — there are just constant phone calls. Therefore we felt there was a need to meet with the doctors to work out why this is causing a bit of angst and what we can do to help. Obviously the policy was one of those documents, but I can say that since we have got the policy they are more likely to pick up the phone and speak to us: they just do not have time to work through the policy. Therefore we thought that a checklist would streamline the process, and a checklist is something that they could all readily adopt, with senior clinician involvement — not just doctors but also social workers, because they have a different viewpoint — and legal. We have not worked on that; it would have been nice for us to obviously submit something to you in that regard. But that was the impetus — the phone calls that came to us.

Ms CHATFIELD — With the actual checklist, which I have not done yet, it would need to have very open questions. One example would be to say to the person, the patient, 'What can your attorney or medical agent do with their powers now?'. I would try to address questions in an open-ended way that addresses section 118 in the Instruments Act, and then, as with the doctors, they are going to have to sit down and work out what they think are the most generic questions that junior doctors should be testing on. But the senior doctors are going to have to do that with me, and a couple of them have agreed to do that.

The CHAIR — One last question in the few minutes we have got left which arises out of both the checklist and the policy you have talked about together, around the medical training you talked about before. The doctors and the medical staff would have been involved in the development of it, and then you have mentioned a number of times that they do not have time to read the policy or that sort of thing. How do you step them through that, given that they are so time poor?

Ms CORDONE — Early in the year there is a big influx of new doctors, so around about February-March is a good time to do some training. I estimate it would take about an hour to train.

The CHAIR — On this issue?

Ms CORDONE — Yes, 1 hour. Making it more hypothetically-based, because if it is just straight law, they will just switch off, so it would be scenarios, 'What you would do in this instance', and that is the way they would learn. They are interested in it and there are opportunities, so we just need to get out there and sell it a bit more.

We do have education officers, but there could also be OPA, State Trustees or other bodies out there. The coroner comes out and they do training on the new Coroners Act, so there are other bodies that could come in as well. That is one way, and I think from the junior docs, or the new doctors, all the way up. The junior doctors are clued-in; they are a bit more aware of this. I do not know if they are having legal training in their medical degrees; they probably should have. I do lecture postgraduate medical students at Gippsland Medical School, and postgraduate students ask a lot more questions, but they are much more alert and aware and on the ball. That will go up and also down. You need to educate both docs.

The CHAIR — We are out of time. I apologise for moving you through so briskly this morning. We only had half an hour. It has been very much appreciated, and there are some other matters that maybe Kerry or Kerryn might contact you about. As I said earlier, you will be sent a copy of the transcript to make whatever changes you need to make. Thank you very much.

Witnesses withdrew.