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LAW REFORM COMMITTEE

Inquiry into powers of attorney

Melbourne — 22 October 2009

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Dr K. Pearson, President; and

Dr S. Connelly, Committee Member, Victorian Division, Australian and New Zealand Society for Geriatric Medicine.

The CHAIR — I welcome Dr Kristen Pearson and Dr Sue Connelly from the Australian and New Zealand Society for Geriatric Medicine. Thank you very much for the submission you sent in and for coming in this afternoon. Hansard is recording the conversation we are having, and to conclude the formalities I advise that this hearing is conducted under the Parliamentary Committees Act, the Constitution Act and the Defamation Act. This provides you with protection under parliamentary privilege; however, comments you make outside this hearing obviously will not be afforded that protection.

We have half an hour, so we will hand over to you to address your submission. We will then have some questions and matters we would like to raise with you.

Dr PEARSON — I have a fairly brief introduction. We largely want to provide the opportunity for questions and clarification. We represent geriatricians who are medical practitioners who are quite frequently involved in situations relating to this legislation. As our population ages these issues are obviously only going to become more prominent. We feel that improved clarity, strength and streamlining of the power of attorney legislation would be helpful for lay people as well as legal practitioners and medical practitioners.

We feel that the current system has a lot of strengths and protections and it would be important not to lose those if the legislation were to be revamped. We looked at the federal parliamentary committee report published in September 2000 which was called *Older people and the law*, and without running through the individual recommendations I think we would endorse a lot of them.

There are a couple of specific criticisms of the current legislation which are outlined in the submission. In particular the inclusion of physical disability under the definition of disability seems to be anomalous. There are some provisions allowing medical research which also appear to afford minimal protection to vulnerable people, and overall there seems to be a lack of clear penalties for agents who act without regard to the best interests of any represented person.

I feel that any revised legislation should be more specific about areas such as a definition of competence and the presumption of competence in every person. It should be more specific about the powers covered by each of the specific documents, and we think it is really important to highlight the best interests and wishes of the individual person. Also, in the guardianship section, a medical second opinion could be given further prominence rather than needing to necessarily go straight to guardianship. They are the main comments I would like to make at this point.

The CHAIR — Just to start something in a bit more detail, you say in your submission that the Medical Treatment Act has some strengths in it that could be used as a template for other applications to do with other forms of powers of attorney. Could you expand on that?

Dr PEARSON — I did have to go back and have another look at that. When I say ‘template’, that wording is probably a bit strong. I do not particularly love the way the legislation is written either, but I guess the strengths we felt that Act has relate to the fact that it spells out fairly clearly the obligations of the person who is appointed as a medical power of attorney and it is fairly clear about the protections that are afforded, say, to a medical practitioner who, for example, does not provide treatment in accordance with a refusal of treatment certificate request. There are protections that are clearly spelt out, and there are also some penalties that are clearly spelt out in terms of people going against either the document or a refusal of treatment certificate. I guess those were the strengths we could see in that area that are not so clearly spelt out in the other pieces of legislation.

On reviewing the Act I do not know that it is so much a template; that was probably too strong a word. It seems to be more about refusal than consent, whereas some other legislation is more about consent and agreement. Again, it does not actually specify the definition of competence and it does not spell out what would be the test, whereas the Instruments Act does at least say that to appoint a power of attorney you need to understand this and understand that. I do not think the Medical Treatment Act specifically does, so they would still be areas to expand upon.

The CHAIR — You mentioned in your opening comments the test of a donor’s best interests on the one hand and the donor’s wishes on the other and that there might well be continuity between those two. Could you talk to us about that tension?

Dr PEARSON — I guess in most cases wishes and best interests will be similar, but in situations that end up in guardianship or perhaps with a conflict between those two areas there is no magic answer. It does involve a bit of, perhaps, detective work on the individual situation; there is not going to be one right answer for every client. With some of the legislation you are always wanting to veer towards the least restrictive means, whatever they might be. Then, hopefully, in many cases you will be able to find a way where everyone seems to be in agreement about the person's best interests but where it will also accord as closely as possible with their wishes. Their wishes may not be written down; you may need to do a bit of detective work to find the relative who can represent them best, or get a verbal declaration.

The CHAIR — Who is the 'you' in that sense when you say that you might have to do some detective work?

Dr PEARSON — Yes, you might have to. I guess it depends on how this person is presenting. If they present to us as doctors or as part of a service like an aged-care assessment service or as part of a ward treatment team, the detective work really occurs with whichever team members are involved.

The CHAIR — When you are confronted with a situation like that and you are not the person with the power of attorney, how do you make that relationship with the attorney?

Dr PEARSON — I guess I was thinking more in terms of guardianship for that question. What would be an example with powers of attorney in that regard?

The CHAIR — For example, we had discussions earlier in the day about a person wanting to make a large bequest to a lost dogs home. The attorney might think that is placing too much pressure on the person's capacity to provide for themselves in the longer term, and yet the person might have had a long-term interest in the dogs home. They might have been a contributor to it in smaller amounts over time and all of a sudden they want to give a larger amount. How would you weigh up the balance between a person's best interest in terms of finance but also in terms of their preference and their wish? That was one example that was given earlier in the day. Is there a way through that?

Dr CONNELLY — It is one of those things where it depends on the context of the situation. If you have someone, for example, who is dying, you need to consider how much time they have left. The amount of money that needs to be retained for that individual is obviously going to be smaller than for someone who may be looking into, for example, residential care or being supported in the community with a live-in carer or various services. Obviously the situation is different, and it then comes back to the question of the assessment of capacity of that individual and whether they understand the consequences of making a donation of a large amount of money. There are also factors such as their income source. Are they a self-funded retiree who is reliant on that lump sum, or are they someone who is on a pension and is going to continue to receive that pension on a fortnightly basis and be able to continue to live on that? There is no black-and-white answer to a lot of this stuff. It is purely going to be individual circumstances, and as Kristen said, we have to do a lot of detective work with each individual scenario. It may well turn out that this person has been passionate about dogs, cats or whatever it might be for their entire life, and they may have said throughout their life that they are going to leave 80 per cent or whatever it is of their estate to the lost dogs home, in which case the attorney is probably not acting according to the wishes of that individual if they do not do that.

Dr PEARSON — Is also different while they are alive. Once they have deceased, then it is different. There are obviously two different questions there. So I guess you have got to look at the time frames and things. I guess from a medical point of view we are much less likely to be seeing those sorts of financial or legal decisions. We are much more likely to be involved in the lifestyle and the guardianship. Once someone has got a power of attorney or an administrator, I guess we do not have a lot of day-to-day involvement in how they make a financial decision. I guess we are involved in having those people appointed as appropriate, or we are more likely to be involved in teasing out the guardianship or lifestyle sorts of issues. But it does come back to a competency.

Dr CONNELLY — Or part of assessing whether they are actually competent in making that decision anyway. That is probably, as Kristen said, the level we are involved at.

Mr CLARK — Can I sort of go back to the stage of assessing competence or capacity at the point of making an appointment? You have given us some very interesting references there which we will no doubt need to go away and have a close look at.

Dr PEARSON — I do not know if you can record that book in the Hansard transcript.

The CHAIR — Perhaps you can just read out the title.

Dr PEARSON — It is referred to in the submission. But it is called *Who Can Decide? — The Six Step Capacity Assessment Process*. It is edited by Darzins, Molloy and Strang. It is contemporary, and it is Australian based. It is referred to frequently in our submission but also in other guidelines that you read.

Dr CONNELLY — You can actually access it through the Alzheimer's Association bookshop.

Mr CLARK — Yes. You have mentioned that. You have mentioned New Zealand legislation, and you have mentioned an article on the *Internal Medicine Journal*. I was wondering if orally you were able to give us a brief overview of what you think are important elements for a statutory test of competence and then, secondary to that, who are the best people to make the decision. You have put forward the skills of your members and people with similar qualifications. Previously you had lawyers saying it should be a legally administered test. Do you care to buy into that debate as well?

Dr PEARSON — I would be very happy for the lawyers to own this, myself personally.

Dr CONNELLY — Yes. We discussed that yesterday.

Dr PEARSON — What was your general first part of your question?

Mr CLARK — What are the key elements that you think a statutory definition or test of capacity ought to contain?

Dr CONNELLY — I think to begin with you should have a clear understanding of your current situation, be it your health, your financial situation or your living circumstances. I think you need to have insight as to what your current situation is; so, I guess, awareness. I guess the problem with that is that you actually need some sort of collateral history to be able to know whether or not what they are telling you is the actual situation. I guess in the majority of the times there will be someone who can vouch for the information you get given. That would be the first thing you need to have — a clear awareness and knowledge of situation, assets, living circumstances et cetera.

Dr PEARSON — Yes. I do not think we are going to be able to tell you how to write the legislation, because that is really not our expertise. I guess we are more coming from the point of view of how you actually assess it. Obviously the things that Sue said are important. The other things we thought about were just the process of assessment in that it is a fairly time-consuming process in many situations, particularly when there are the grey areas, and they are the difficult ones, of course. We think it is really important for the person who is doing the assessment, whether it is a legal practitioner, medical practitioner or whoever, to make sure they see the person individually, on their own, without the influence of family members or whoever else might be presenting or coming along to the room. It is important you have the opportunity to question this person alone. Really it is just a process. No-one has got a magic wand. It takes time; it takes this background detective work. Then it is just a process of really good communication with that individual as to whether they understand what is involved.

Many of the guidelines refer to having open-ended questions rather than closed-ended questions. You know that some people turn up and are asked, 'Do you understand what a power of attorney is?', and they say, 'Yes'. That is taken as sufficient, whereas you need to have the person to be able to explain it in their own words — sometimes at a reasonably simple level. I do not think you can expect everyone to come out with a word-for-word legal sort of definition or be able to expand on that, but even at that simple level they need to be able to explain it in their own words, using an interpreter if there are language issues. It has to be an independent interpreter, not just a family member or whoever happens to be sitting nearby.

Dr CONNELLY — I guess the other thing we talked about was that for the person who is doing the assessment alarm bells should ring in the sense that if they realise someone has had a recent hospital admission,

it may be they are not of sound mind at that point in time. So if someone has recently been in hospital, you should immediately tread with caution. Also, quite often you will see people who will defer to the person next to them for the answer — this stems back to seeing them alone — and that should just be a big alarm bell going off. The other thing we discussed was that because the population is ageing we are going to be seeing increasing amounts of dementia and cognitive impairment in the population, and we generally do not like to set age limits on things, but it may be that with someone who is over the age of 80, again, we need to be a little bit wary, because there is about a one in four chance that they may have some cognitive impairment. It is a little bit hard to be black and white, but there can be warning signs or alarm bells that can go off in performing that assessment for whoever that may be.

Dr PEARSON — Because we have seen examples of patients who have been whisked out of hospitals by relatives and presented to a lawyer. They say, ‘Sign this paperwork’, and then they pop back into hospital

Dr CONNELLY — Or even worse, the lawyer is brought in.

Dr PEARSON — They are back before you realise they have gone. We think those sorts of things from a medical point of view should be ringing alarm bells with lawyers or whoever else is signing those sorts of documents, because clearly people are in a very vulnerable and often fluctuating state. That is why we think those sorts of things would be red flags or alarm bells. I am not sure if that answers your question.

Mr CLARK — I think you have given us some excellent practical considerations that we have never had in evidence before. That is very worthwhile. In terms of who would be capable of performing that sort of assessment, it sounds like you might need some medical input and maybe also someone with a legal or other sorts of allied health professional background in performing assessments.

Dr PEARSON — I think it was put to me by Kerryn that some percentage of these will be quite clear-cut. I do not think doctors want to get involved with every person who signs an enduring power of attorney. We would see that in almost all circumstances it is largely a legal decision. I think you said to me that 98 per cent, for example, are being assessed by legal practitioners. My other argument was that maybe some people have not even been seeing lawyers and they are just having these documents witnessed, and whether there is as much protection in those situations may be of perhaps more concern. But I do not think doctors want to get involved with most, particularly with enduring powers of attorney. I think with medical powers of attorney there is probably more of an argument for a doctor to be involved just because of the content of the decision being made. But clearly there will be a role for medical practitioners where there is doubt about disability or when there is a disability and perhaps when you are wanting to delve more down that path. But I do not think doctors want to own all of these.

The CHAIR — Just following on from that before we move on, you are right; our experience and our evidence is that it is at the point where the loss of capacity is starting to noticeably affect a person where there would need to be some medical judgement being exercised. Within that I suppose what our question here is: do you think there are particular types of medical expertise that would be more appropriate here, like geriatricians, psychiatrists, neurologists or psychologists?

Dr CONNELLY — All of those.

The CHAIR — But do you think this is a general decision? Because I am not entirely persuaded when you say that if it relates to medical areas, it should be a medical issue and that for a medical power of attorney there should be a medical person. It is about an assessment of capacity; is that fundamentally a medical issue?

Dr PEARSON — Capacity?

The CHAIR — Yes. Because you were implying before that capacity is assessed by law and that it depends, but then you shifted and said that if it is related to a medical power of attorney, then it should be more in the medical area. I am asking you if it is in the medical area, are there particular specialties or expertise that would be more pertinent?

Dr PEARSON — It is more, as I said, if the content of the document is relevant. So an enduring power of attorney is more perhaps relevant — the content of it — to a lawyer. They might be more comfortable having

discussions about finances and legal sorts of situations, whereas with a medical power of attorney the content is more medical.

In terms of assessing the capacity, if it is straightforward and you have gone through the checklist, in a large percentage — and no-one knows what percentage — it will be straightforward, and if you go to the JP or the pharmacist or whoever to witness it, I guess it would be straightforward. My understanding is that competence is ultimately determined by the court, not by a doctor or an individual legal practitioner. I think any of those people can give evidence about capacity in terms of what process they have gone through and they can document it: 'I spoke to this person, and I asked them these questions. They were able to give me these answers, and they had an understanding of these points'. That is the framework around which I see it. Ultimately the test is a legal test, as I understand it. Of course most of these documents do not end up at VCAT or somewhere where it is ultimately tested, but I guess when we as doctors are assessing somebody, we are providing an opinion. We are not making an ultimate determination; that is the way I would see it, and I think that is the same situation for a legal practitioner. They are documenting their evidence: 'I asked these questions, and the person understood X, Y and Z'.

As I say, medical practitioners do not have a magic wand. I sometimes think that people think doctors somehow have a magic wand in terms of determining capacity, but we do not. We just go through the same process, and as this book points out, the difficult ones are in the grey areas, and they can be time-consuming.

Dr CONNELLY — There are also different degrees of capacity. I will use the example of a lady I recently saw who was a relatively young woman in her late 60s who was clearly starting to dement. She still had the capacity to take \$20 out of the bank and go down to the milk bar and buy a loaf of bread and a litre of milk and all the rest and bring it home, but her son was with her and they were talking about selling the house, and she clearly was not going to be able to manage dealing with the circus that goes on with selling a house between dealing with real estate agents and bank managers and arranging bridging loans if she was buying somewhere else. She had the concept, but there was absolutely no way she was going to be able to actually follow that process. She had capacity to do everyday things — the run-of-the-mill acts — but when the tasks became more complex at a more executive level, there was absolutely no way she was going to be able to do that. So there are degrees of capacity, depending on the circumstance.

Mr BROOKS — We had some evidence at our previous day's hearing — certainly one example, in particular — of some confusion at an aged-care facility, or it might have been a hospital, where medical staff were not clear about differences between the different types of powers of attorney and guardianship and medical powers of attorney. I think the example given was there were going to be some fairly end-of-life type outcomes — an outcome for a particular person based on an enduring power of attorney, I think it was, and luckily it was avoided. But is your sense that there is not a lot of awareness amongst medical professionals about the differences?

Dr CONNELLY — I would make the argument that it is more the general population. I cannot speak for all medical practitioners, and I guess we are in a skewed field where we do have a reasonable amount of knowledge about the different types of powers of attorney. We certainly try to educate the junior medical staff about the different types. A lot of families come in saying, 'I have got enduring power of attorney, and I am making all the decisions', and what they do not realise is that that is purely a financial scenario. It does not refer to their health care and their living situation. But a relative comes in with a document, and occasionally it is actually a medical one, but I can tell you that 95 times out of 100 it is not, it is a financial one. It is more that a member of the general population thinks they have got this document so they can make decisions on behalf of their relative, and that is where I often spend time. I will have a relative say that, and I will say, 'Do you have any other documents, because that relates to financial situations? Do you know what your mum's, dad's, aunt's or uncle's wishes were in these circumstances?' to try to defuse the situation. But in my experience it is more coming from the lay population. Not all doctors get it. We are often educating other doctors, but it is more the lay population that do not get it.

Mr BROOKS — Putting to one side the issue of awareness of the actual attorneys and what the differences are.

Dr CONNELLY — What the differences are, yes.

Mr BROOKS — In terms of the medical professionals who would have to make a decision and say, ‘Yes, you have got the power’ or ‘You do not have the power’, what are the issues in terms of them having a better understanding and making sure that they do not make decisions based on incorrect assumptions about what powers an attorney might have? Is it just a general increase in education?

Dr PEARSON — We thought about this a little bit as well. I think there are a number of programs across probably all the health services, but in particular the Respecting Patient Choices program is quite strong in Victoria. It runs certainly at a number of health services, and there is a focus on respecting patient choices. But increasingly there is more of a focus on educating people about the role of a medical power of attorney and the concept of the person responsible as understood in the Medical Treatment Act. I think there is a lot of education rolling out through the health services on that, and I think that hopefully that will include the doctors. I think increasingly health services will be asking people when they present ‘Who is your medical power of attorney?’ and looking for those documents, which will be prompting everyone. So instead of talking so much about next of kin or asking ‘Who will we ring up if there is an issue?’, they will increasingly be systemically asking for the medical power of attorney. I think there is an education program that is rolling out. I am not saying it is perfect and everyone has got it right yet, but I think that is happening.

The other thing we thought about is that you can train people until you are blue in the face, but until they come across practical examples on a day-to-day basis it is fairly dry and it is fairly abstract. Until people — students and junior doctors, whoever they may be — actually come across examples they can hang their hat on, it is actually quite hard for them to really take it on board, particularly when they are presented with someone who presents with authority. That person who is presenting with that document may still be the person responsible. If you look through the list, they may be the person who is able to have that conversation, so you do not exclude them because they are presenting the wrong document, but it is a matter of, I guess, the clarity, and I think that there are processes in place. It does not mean it is there yet.

Mr FOLEY — I will approach that whole issue of competence maybe from another angle. If, as we have heard, there is increasingly a coming together of the complexities around medical treatment and people are coming in and out of different levels of competence or incompetence as a result of medical advances and all sorts of things, and at the same time we are moving away from what has been described as a welfare or a substituted decision-making process as a legal right of concept towards a more supported decision-making environment, when those two come together and you have people coming in and out of different levels of competency and a view that says we should be assisting people to make decisions when they are competent, for all sorts of reasons, is there anything in the medical world or the medical approach that can inform how the legal instruments should be framed to measure up as valid and be able to withstand any of the grey or difficult areas of competency and also to support the supported decision-making approach, or is it, as I think you are probably going to say based on your earlier evidence, really that every case is different and there needs to be a general framework?

Dr PEARSON — I have not actually heard that model described as a supported decision-making model, but I can see what you mean and it certainly has a lot of merit. I guess if you were looking at that sort of model, you would want someone who is appointed as the enduring power of attorney well before the person starts to have grey areas, to use that example. I guess maybe you are talking about a partnership between the person and their supporting decision-maker or substitute decision-maker, so that perhaps they bounce things off each other and work it out together almost as a partnership. I like the idea of that model, and I am sure that does happen.

Dr CONNELLY — I was going to say that often happens in practice; it is just not formalised. That is quite often what you will see. You will see, for example, an elderly couple, and they support each other through it, or it might be a particular supportive son, daughter, niece or nephew who is the linchpin connection they bounce ideas off. They ask, ‘What do you think?’, and they discuss it and come to a decision together quite often. So that actually often happens in practice without there being a formal document behind it, if that makes sense.

Dr PEARSON — In terms of some way of constructing understanding, because that is people fluctuating in and out of a grey area and it is dynamic, again, I think you could think about red flags where you would need to be worried if someone has just been in hospital, for example, or if they have been unwell. There are so many grey areas. We have said that 1 in 4 people over the age of 85 has dementia, but just because you have dementia does not mean that you are not competent to the point of power of attorney. Even a diagnosis does not give you a definite answer, and that is even if your diagnosis is actually available and is a reasonable diagnosis. A

diagnosis is not going to help you; it really is an individual thing and it certainly can be dynamic — it will change over time. The hierarchy in terms of someone going from being able to make simple decisions to making more complex decisions potentially can fluctuate.

Mr FOLEY — So in the medical field is there the equivalent of, I do not know, AMA guidelines or your college guidelines around what constitutes best practice in dealing with these kinds of things, and if there is, is that instructive?

Dr PEARSON — Dealing with the fluctuations and the grey areas?

Mr FOLEY — Yes. Or how you deal with the whole area of capacity and competency. Is that instructive in any way for the legal representatives?

Dr PEARSON — I looked for a number of guidelines last night — you can search the web and find a number of guidelines — and many of the ones I found seemed useful. Some of them were legally based and some of them were medically based. I will mention a couple of the medical examples: the Australian General Practice Network put out a document in 2007 that seemed to be written by a legal practitioner but was written for general practitioners. The RACGP silver book has guidelines for general practitioners working in residential care, and they have got some simple guidelines. Then there were some more perhaps legally written guidelines that I came across. They are all good guidelines but none of them have a magic answer to that fluctuating and that grey area; that is tricky. I did not actually search whether the AMA had guidelines but I know that I have some written recommendations from the AMA which similarly reflect basically a step-by-step basis of going through: do they understand this? Do they understand that? Do they understand they can revoke it? All those sorts of guidelines are fairly similar but some are more in-depth and I guess some recognise the complexities better. I do not know that there is — —

Dr CONNELLY — We do not have a position statement, I do not think, do we?

Dr PEARSON — We do not. Our society puts out at a federal level position statements and we have asked it to put out a position statement on this area because our state by state committees have met with similar issues but we do not have a position statement. Any position statement would say that when people are fluctuating or in the grey areas, it is a case-by-case scenario.

The CHAIR — Time has beaten us. Thank you both very much for coming to talk to us this afternoon — we appreciate it very much. Thank you again for your submission. You will be sent a copy of the Hansard transcript and you can make minor changes to that but obviously not completely change it.

Dr PEARSON — Thank you all for your time.

Witnesses withdrew.