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LAW REFORM COMMITTEE

Inquiry into powers of attorney

Melbourne — 17 December 2009

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Mr D. Goldberg, Solicitor and Senior Adviser, and

Ms M. Fox, Policy Assistant, Australian Medical Association Victoria.

The CHAIR — David Goldberg and Madelene Fox from the Australian Medical Association Victoria are with us this afternoon. Thank you very much for coming to talk to us, and thank you very much for your submission, which we have received. The people from Hansard will be recording the proceedings, and you will be sent a transcript after the meeting to which you can make some minor changes.

This hearing is held under the Parliamentary Committees Act, and that means that anything you say today is protected by parliamentary privilege, so people cannot take legal action against something they might be offended by. But obviously that protection is not afforded outside the confines of this hearing today.

We have just under half an hour. We will throw it open to you to either address the terms of reference or talk to some aspects of your submission that you might want to highlight for us, and then we will have an open discussion.

Mr GOLDBERG — Our apologies for our late submission.

The CHAIR — Not at all.

Mr GOLDBERG — I hope you have had the opportunity to look through it. After hearing the end of the previous speakers, I think AMA Victoria's interests in this specific topic, when we strictly look at our role as a membership organisation on behalf of doctors, is much more narrow than most of the submissions. I will be fairly brief.

The two things, broadly, that doctors are looking for are clarity and clarity. The two areas where doctors basically interface with powers of attorney are capacity and then understanding consent — and I mean that by way of medical consent. They are the broad areas. We consulted fairly widely with doctors who do these sorts of things routinely — GPs, geriatricians and doctors involved in palliative care and mental health, obviously. What they all really said was that the different powers under the different acts are a problem. It is a real problem in a public hospital setting not knowing whether a power of attorney has been appointed, and invariably the relative assumes that role. They are right at the bottom of the list of persons responsible and yet right at the top in reality in a public hospital setting in the absence of information, which gives rise to, I suppose, all sorts of abuse issues, potential issues, which are hard for me to discuss but are certainly quite evident.

Really they are the things the doctors mainly touched on. I think it would be remiss of me not to state AMA Victoria's disappointment that the Medical Treatment Act is not included. I think it hamstringing this Committee in a lot of ways. Certainly AMA Victoria would encourage this Committee to make a recommendation, notwithstanding the terms of reference, that any unifying act or any review should, in time, take into account — if streamlining is a goal — the Medical Treatment Act. Because it seems to me that it is a mammoth task to bring it into line, and unless we assume that the Medical Treatment Act is the act that you are going to bring it into line with, there will be, from a medical perspective, a dual system and all of the problems that that entails.

I will take this as read; I hope I was capable of expressing it.

The advance care directives would be the other area that AMA has a particular interest in. Obviously there are two forms — again, this is the Medical Treatment Act — of advance care directives: the one that is protected by statute, which is very narrow; and then the one that might be a common-law request of any sort.

The way I look at the statutory one is that it has to be for a condition that is known and a directive in relation to that condition. So if one has oesophageal cancer and is concerned about one's airways blocking, they might say in an advance care directive on the treatment of the oesophageal cancer, 'Do not resuscitate me if I am choking'; but if in the days before that occurs you are eating an apple and you are choking, you must be resuscitated. It is very limited even within its own intent, let alone if you are a Jehovah's Witness and you say, 'I do not want a blood transfusion. I do not have a known condition'.

The interplay between advance care directives and powers of attorney is difficult because it seems to me it is quite easy for an advance care directive, particularly a common-law one, to be overridden by the intent of an attorney quite readily. Certainly we see that with, for example, organ donation.

Doctors tell us very commonly that a person who ticks the boxes — it is an opt-in — still ends up in a situation where a relative can override that person's decision, maybe not at law but in reality. We would like to see the

supremacy of the advance care directive. Whether you can fit that within the terms — it is lucky you are sitting on that side of the table, and I can only say the good bit about you being a lovely group is that we can say it!

The difference in definitions of ‘capacity’ both at the time of signing and at the time of loss is a big issue to us. Whether it is a medical or legal question, I mean, the AMA has said we view it to be a legal question. If our president read this closely he would say ‘No, I prescribed you the wrong drug’. It is clearly a medical question. From a doctor’s view of the world, capacity is a medical question.

Capacity is looked at medically all the time, but of course there is a bit more to it than the medical. And certainly when a doctor is asked about loss of capacity it is often in a setting where capacity is less likely to be evident, like a public hospital versus somebody in their home. Very often capacity is not looked at against, I suppose, the subject matter of the capacity.

From our research one of the bigger problems is that the capacity is looked at as an on-off. Obviously capacity can vary from day to day, hour to hour. But in addition a person with severe dementia might not be capable of deciding where they want to live, but they might well be capable of deciding what they want for breakfast. That distinction is important, especially in a public hospital setting, for example, where there might be some other issues going on at the same time; and the gravity of a determination of the loss of capacity is a serious issue, where quite often doctors do not even want to step.

The CHAIR — Can we go on with the capacity issue, because we got distracted while chasing that? Respecting the point that you made from the AMA’s perspective about it being always a medical position, it has been put to us by other witnesses that prior to a person having attention drawn to them because they were demonstrating behaviours that would suggest there was a loss of capacity, when they are setting up powers of attorney at the point of creation it is quite appropriate for a lawyer, especially one who has known the person for some period of time, to make that assessment, the test being that they understand what they are doing in completing the documents relating to a power of attorney; but that when capacity came into question, that would be where medical light would need to be shone on that particular situation. So it is at the point when the power is created, and then probably even more so when it is activated, so there is a sort of escalating series of steps.

In your submission you say there should be a single definition of ‘capacity’. I wonder if you could elaborate on that; and then also, given the scenario that I just described, whether you think different classes of medical practitioners should act at different points in that trajectory of diminution of capacity.

Mr GOLDBERG — Sure. Firstly, to be clear, the AMA’s position is that, yes, capacity is a legal question, although there would be members of the medical fraternity who would not necessarily see it so at the time they are presented with the issue, because they do not see the world that way, and quite often they are asked it.

Our position is that it is in fact a legal question, and in fact we have promulgated the position that the role of the doctor should be the Victorian Bar position, which is that a prima facie evidentiary provision may be inserted to the effect that unless the contrary is proved, a person has capacity if a registered medical practitioner has certified that at the time a donee was making the power of attorney they were capable of understanding. So we see a role for the doctor in participating in a legal framework.

In relation to a single definition of ‘capacity’, I suppose, instead of having a definition under the medical treatment legislation and a definition under the Guardianship and Administration Act, and a slightly different one under the Instruments Act — you know, all the different acts having different definitions — we would like to see a unifying act.

There are nuances between ‘of sound mind’, ‘understands the nature of effect’ under the Instruments Act, and the provision in the Guardianship and Administration Act which says ‘a witness must certify the doctor has signed freely and voluntarily’. This is at the point of entering into or of establishing. And on where the capacity has been lost we have reference to ‘incompetent’ under the Medical Treatment Act, then we have ‘unable by reason of disability’ under the other act, and it seems to me they are quite different. It also seems to me that the person who is charged with making these determinations often would not be able to pick up the nuance of it.

In terms of the gravity, obviously it is more grave at the point of a determination of loss, arguably, I suppose; it depends what sort of power of attorney it is. The AMA does not have a position on, I suppose, a tier of

medical — I think our position would be otherwise. I might take it back and come back to you if what I am saying now is not correct, but I would have thought the view the AMA would take is that medical professionals will know whether they are in a position to judge it or would need to refer it to somebody who is in a better position to judge, like a neuropsychiatrist, in certain circumstances where they perceive that to be necessary. But I would have thought a GP who had comfort in this area would know when they similarly needed to refer on any other question of a medical nature.

Mr CLARK — You rightly observe that the Medical Treatment Act power of attorney is outside of our terms of reference, and I presume the government has excluded that because it was enacted in the context of a passive euthanasia debate and the government does not want to reopen a euthanasia debate. Also, it only empowers refusals of treatment; it does not empower authorisations of treatment.

So let us leave that to one side and look at the other instrument that relates to a medical context, namely, the enduring power of guardianship, which of course allows authorisations of treatment. Are there any changes to that power that the Association would like to see to make it more effective and usable in a medical context?

Mr GOLDBERG — Not specifically. It is really more around getting uniformity and clarity around the documentation. We support the submission of the Office of the Public Advocate. It has obviously expanded on each of the individual powers at great length. I would not say we have a specific position, except potentially a state register in time. Again, that is around a different sort of clarity, which is clarity of the existence of it. It in fact becomes an issue for a doctor in achieving informed consent to know whom he is meant to speak to.

Mr CLARK — It could be uniformity of execution and format and layout and stuff like that?

Mr GOLDBERG — Yes, all of that sort of stuff. We have certainly made some comments that it seems to us incongruous that somebody capable of signing a statutory declaration is by the same definition capable of attesting capacity. I think that is very problematic.

Mr FOLEY — Us!

Mr GOLDBERG — Yes, and me. And you might not pick up the nuance.

The CHAIR — Can I just ask who then should be empowered to witness? If you are saying that a person who is empowered to witness a stat dec, for example, is not appropriate to assess whether or not a person has capacity or to witness that, who should witness it? Who would be an appropriate person or officer to do that?

Mr GOLDBERG — I go back to the test the Victorian Bar put in, which is that if you have a medical practitioner who is certifying it, there will be a prima facie assumption. That might be built in — —

The CHAIR — A medical practitioner then to witness it?

Mr GOLDBERG — To me witnessing is quite a different concept to attesting capacity. One is being a witness and the other one is attesting capacity. I am not sure what the benefit of a witness per se is at all except for the benefit that a witness always has with signing a document — I would have thought they were two very discrete things.

I have no problem with a witness being a person capable of witnessing a stat dec, as is currently the case, but I suppose I do not see the skills of a witness being automatically therefore a statement of capacity. I would have thought in terms of capacity that, to the extent that where something was written in the legislation saying that with the prima facie evidentiary provision a person has the power and capacity to create a power of attorney if a medical practitioner has signed that they have capacity, a prudent lawyer would think that in any case where there was any uncertainty you would go and get it tested by a doctor and then potentially the lawyer could sign that, coupled with a doctor's — —

The CHAIR — You have here on page 2 of your submission:

The current threshold and method for assessing capacity belies the complexity of the decision.

Fine. Then you say:

The current law requires only that a witness (one of whom must be capable of certifying a statutory declaration) attests that capacity exists.

And then you say:

There is no connection between a person permitted to sign a statutory declaration and the skill and knowledge required to assess capacity.

I am not clear. Are you saying that it does not matter who witnesses, that it is not relevant, or are you saying that a lawyer or a doctor should witness it? It is not clear.

Mr GOLDBERG — I am saying that it seems to me that there is no connection between the person who is given the statutory right to witness something and the skills required to attest capacity, if we put in a multifactorial. I am not sure why they are one and the same person. The connection point is that it is illogical that it is the same person.

I think it demonstrates a lack of understanding of what capacity is and how it is judged that it has just evolved to be the same person. I should not pick on a police officer, but a police officer or a lawyer might have no ability to assess capacity but might well have the ability and be an upstanding enough citizen to sign and certify as a witness. One is a skill and one is a status, if you like.

In terms of signing capacity, I have no particular problem with it being a lawyer. If there were something in the statute that said that the prima facie position was that if a medical practitioner is consulted and agrees that capacity exists medically, it can be assumed to exist — a presumption — then I think that a prudent lawyer who was willing to sign capacity would more than likely go to a doctor to make sure and deliver more certainty in that document.

I think when we say it is not a medical decision, equally it is a partly medical decision and you cannot expect a lawyer, with a lawyer's training, to necessarily pick up on some of the issues that a doctor would. I am happy for the figurehead to be a lawyer, but I would have thought there would need to be some protections.

Mr FOLEY — I would like to follow up on the issue that you touched on briefly about the certainty that a register would bring. Does the AMA have a view as to who should be the holder of that register, whether it should be compulsory, who should have access to it — those kinds of issues?

Mr GOLDBERG — I said on the way here I was hoping you would not ask me that on the basis that I must say when I was presented with this, I thought it was a terrible idea.

Mr FOLEY — It is certainly vexed.

Mr GOLDBERG — I know that the Office of the Public Advocate was supportive of its existence and being the custodian. It is happy to put its hand up and there are other medical submissions that have said it would be useful, but I would be very wary of the form it took and that is why I am sitting on this side of the table. I appreciate there are all sorts of complexities around the privacy.

I do not know how it would be workable if capacity ebbs and flows. Is it a register of assignment of a power of attorney or is it something to do with when it is triggered as well and capacity has been lost? I would have thought it is probably the former. Privacy would have to be safeguarded, I would have thought, to the maximum extent possible. How would a public hospital would access to it? I suppose a medical concern about capacity would potentially be a ground for access.

Mr FOLEY — Which would presumably be a fairly instantaneous kind of request.

Mr GOLDBERG — Yes. It would be someone showing up either mentally ill, in which case they would be in front of someone who would be able to assess that — even the nurse involved in the area potentially — or showing up unconscious or something like that. I think one of the major reasons that at the end of the day we tip the balance towards promoting it, obviously aside from the fact that the Office of the Public Advocate was happy not only to suggest it but take some responsibility, is that if you have noisy relatives in a hospital system, it can be very difficult to know whether that is what the motive might be, and a doctor needs certainty.

It would be one of the more difficult things. That is why there is an advance care directive discussion — because it is one of the more difficult things for a doctor to have to try to understand a patient who they have never met and their interests in the absence of clarity. If we can deliver some form of clarity, that would be good. As you know, powers of attorney are not necessarily lodged correctly, they are not kept in a safe place, they are often not issued at all. Even when they are issued often it defaults down to the noisy relative who is most likely to have a vested interest. They are most likely to have the best interest, but certainly also most likely to have a vested one.

Mr BROOKS — Just quickly, aside from those issues do you think doctors generally have a good grasp of the existing set of powers and the differentiation between the different ones? Do you think there is a generally good grasp of those things or do you think in some cases there could be some room for further education?

Mr GOLDBERG — I think education is a big issue. I think doctors understand what capacity means from a medical perspective. I think in fairness doctors are raising issues about this that they understand better than lawyers — for example, situational capacity and that it should be related to the tasks — because doctors deal with occupational issues all the time like returning to work and looking at the follow-through in a way that lawyers potentially do not. In some ways, doctors have a more complex understanding of the issues, but in terms of the legal nuances and the difference between the different powers of attorney under the different acts, there is total confusion even amongst those who do it often.

The CHAIR — I think we have just about wrapped up. Thank you very much for that. We have finished right on time which is excellent. As I said earlier, you will receive a copy of the Hansard transcript, and I hope you would be open to Kerryn and/or Kerry contacting you to follow up on any matters that might arise out of the record of the meeting. Thank you very much; we appreciate that.

Mr GOLDBERG — Thank you for the opportunity.

Ms FOX — Thank you.

Committee adjourned.