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All correspondence to the
Honorary Secretary

Geriatric
Medicine

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Law Reform Committee
Parliament of Victoria
Spring Street
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Dear Committee,

Re: Inquiry into Powers of Attorney

Introduction

This submission is made on behalf of the Victorian Division of the Australian and New Zealand Society for Geriatric Medicine, which represents specialist medical practitioners in the field of Aged Care. It is made on the basis of a "lay" reading of the current legislation and related documents; the practical interpretation of the legislation as presented by the Office of the Public Advocate; and the practical experience of members involved day to day in the application of the relevant processes.

Firstly to acknowledge that Victoria, through its legislation, VCAT and Public Advocate, has a world class system for regulation and implementing powers of attorney, Administration and Guardianship. It is important these strengths are not lost.

The over-riding principles of maintaining independence and choice wherever possible, protection of vulnerable peoples and prevention of elder abuse should be uppermost considerations in any legislative or practical changes.

This submission starts with general opinions relating to the legislation and context. The second half describes some specific points relating to the individual Acts.

Different types of PoA

The current divisions between medical, financial/legal and lifestyle aspects seem to be soundly based and workable in practice. It is noted that the Medical Treatment Act is not being formally reviewed by this inquiry, which is unfortunate given the stated aim of streamlining and simplifying Power of Attorney (PoA) documents. In general terms the powers currently recognised seem to serve their purpose. Some of the strengths and protections of the Medical Treatment Act 1988 legislation could be used as a template for legislation for other Powers of Attorney – it has a strong focus on best interests of the individual and protection for those who observe these interests.

There may be benefits in streamlining, to minimise confusion. In particular we often come across documents, which appear to be drafted "ad hoc" with regard to wording and format. This can particularly be a problem with Medical Power of Attorney, which has specific

requirements relating to "agent" and "alternate agent" rather than "jointly" and/or "severally". It has also been suggested that lay people have difficulty distinguishing between the three areas and perhaps a combined document be used, with sections for an individual to specify who they wish to appoint for each of Enduring PoA (EPoA), Medical PoA and Enduring Power of Guardianship.

National focus and registration of documents

The society would like to see requirements for Powers of Attorney be standardised nationally rather than state by state. This would minimise confusion and possibility of invalid documents. Most lay people do not understand that a document recognised in one state may not be in another. Aligning documents with New Zealand would have further potential benefits. Although the legislation does refer to recognition between states, it is not clear how well this works in practice.

Further to this, we endorse the recommendations made by the Federal parliamentary committee "Older people and the law", conducted by the House of Representatives Standing Committee on Legal and Constitutional Affairs, published September 2007. This recognizes the potential for financial abuse of vulnerable peoples. The third chapter relating to substitute decision making is particularly pertinent, with recommendations related to:

- uniform legislation
- need for education and raising awareness
- role of registration of documents
- recognizing elder law as an area of specialty.

Many members feel strongly that a mechanism for documents to be registered would be very helpful in avoiding otherwise common situation where no one is certain about the existence of PoA documents. Of course, mechanisms for registration, and funding for this would be required. An extra fee for registration would be a potential barrier, which would need considerable public education to get around. We are unaware as to whether any jurisdictions have achieved a successful model for registration of documents.

Definition of disability

A major criticism of the current legislation is the inclusion of "physical disability" in the definition of disability. This appears anomalous and should be removed. It is difficult to think of any situation where physical disability alone would justify appointing a substitute decision maker. Some other states include inability to communicate wishes under the definition of disability, and this may well be warranted.

Competence

It is noted that the two pieces of legislation considered for review appear to be almost silent on the notion of competence or capacity. Equivalent legislation in New Zealand (http://www.legislation.govt.nz/act/public/1988/0004/latest/DLM126528.html) explicitly spells out the definition of capacity and the presumption of competence, both of which are useful and contemporary concepts. An excellent reference is the book "Who Can Decide? The six step capacity assessment process" edited by Darzins, Molloy and Strang 2000. This book discusses pertinent issues such as "decision specific capacity"; who can assess capacity and processes for assessment. In particular it recognizes that most difficulties occur in the "grey area" of partial understanding and that in many situations there is no evidence that substitute decision makers necessarily make better decisions that the incapable person.

It is understood that the ultimate test of capacity is a legal one, often based on the evidence of lawyers, health professionals etc. This raises the question of the lack of specific

reference to capacity, at least in these two pieces of legislation. It also raises the question of how capacity should be determined on a day-to-day basis, and who should be making this determination. There are no clear answers to this.

Some health professionals are well placed to be involved in the assessment process. In particular Geriatricians, Psychiatrists and Neuropsychologists would often have extensive training and experience. Without clear, standardized guidelines or research it is uncertain how consistently this process occurs in practice. There are also issues related to referral, remuneration (can the impaired individual validly consent to pay for an assessment that may ultimately result in their loss of independence?) and the time-intensive nature of these assessments. Many doctors and other health professionals would have little interest and/or experience in this area. Clearly medical practitioners would be well placed to provide opinions about the existence (and prognosis ie. likely time course) of disability.

Section 118 of the Instruments Act 1958 is fairly explicit as to the test of capacity, although does not specify who should be making such an assessment. The Guardianship and Administration Act 1986 (G&A) appears to be much less explicit. The crux of the G&A Act in testing capacity refers to a person "unable by reason of the disability to make reasonable judgement in respect of all or any of the matters relating to her or his person or circumstances" and "in need of a guardian". This is a circular argument. Also, there is nothing to specify what constitutes "need" in this context – should it relate to a particular category of need; or to potential severity of outcome; or to irreconcilable opinions?

Scope of powers

The authority of the guardian is spelled out fairly clearly in S24(1) "all the power and duties .... if he were a parent and the represented person his child." It is suggested that the authority to hold a driver's license should be explicitly included in S24(2). It would be not unusual for a person to be cognitively impaired but continuing to drive. This individual may well not have insight into the risk that driving holds for themselves or others. They may therefore be unable to appropriately notify the relevant driving authority of their disability or diagnosis. Similarly they may be unable to validly consent to, or refuse, to undertake a driving assessment.

An article in the Internal Medicine Journal 2005, Volume 35(8), pages 482-487 gives a good review of the medical perspective on relevant legislation and its interpretations, comparing states of Australia. It refers to the need to consider whether informal solutions are available before appointing a substitute decision maker. This is referred to in current legislation, as whether "less restrictive" measures are available. These references then beg the question as to what these informal, less restrictive measures include. Have these measures been systematically catalogued? Has the legality of these measures been examined? Research and documentation to clarify this would inform both lay and professional people with regard to options available prior to application for Administration and/or Guardianship.

Specific comments related to Instruments Act 1958

To a lay person reading the legislation, it is not clear what powers an attorney holds or can hold. The statement that a donor may "authorize one or more persons (attorneys) to do anything on behalf of the donor that the donor can lawfully authorize an attorney to do" appears circular. Medical treatment decisions are explicitly excluded, but not lifestyle or other welfare decisions. It would be generally understood of course that the powers cover legal and financial decisions. However, it is our experience that many people confuse the extent of authority.

It is of concern that it is not explicitly or strongly stated that an EPoA should act in the individual's "best interests" and as far as possible according to the individual's own wishes. There are protections from liability but there appear to be no penalties for abusing the position of trust. There also appear to be no penalties for fraudulently gaining appointment as an EPoA, for example by enticing someone to sign a document they do not understand. There is some requirement for simple record keeping but there is little emphasis upon other safeguards, including the need for the role of an appointed EPoA to be challenged if there is evidence of improper use of their authority.

There is little in the legislation relating to loss of capacity and subsequent activation of the EPoA.

<u>Specific comments relating to G&A Act 1986</u>

This legislation is better covered with the over-riding principles including "best interests"; "least restrictive" and "wishes given effect to". However it appears weak in terms of enforcing this, with lack of penalty for someone abusing this power.

S27 relating to "special powers" appears anomalous and unrelated to surrounding sections.

S35B relating to guidelines for appointing an Enduring Guardian could be better aligned to those relating to appointing an EPoA.

For Part 5 Administration Orders, we would generally understand the term "estate" to be used to describe the property and possessions of a person who has died, but here used in different manner.

<u>Specific comments relating to G&A Act 1986 Part 4A Medical and Other Treatment</u>

Definition of "Person responsible" section appears to be aligned with Medical Treatment Act. For some other sections, particularly those described below, it is not clear how well this act aligns with the Medical Treatment Act.

Throughout the areas covered by this Part of the Act, could more weight be given to discussion, conciliation and use of a medical second opinion, as methods to resolve conflicting opinion, rather than resorting to the Act?

S 37 (6) and (7) and S38 (2) and S42U(2) – these clauses seem bizarre. When is a situation likely to arise where a patient is not capable of consenting, yet likely to be able to give consent later, yet at the same time is able to object to a relative being involved?

S42A (1) – are there any instances of "emergency medical research procedures" that should be allowed under this type of arrangement? By definition, a research procedure is not of proven benefit and should not be allowable in this circumstance.

S42K – does this section only apply to major procedures ie. ones which would typically require written consent? One can imagine that, in hospitals at least, medical procedures would be performed regularly without consent of person responsible eg. blood tests, scans, interventions.

S42L(2)and S42M are very confusing relating to various timings, sections etc. Again, in this situation where the person responsible does not consent, is there a stronger role for a medical second opinion? One would have understood that if this situation could not be resolved, an independent guardian would be sought. Do these sections duplicate/contradict related sections of Medical Treatment Act?

Division 6 relating to Medical research procedures appears cumbersome and confusing. Does this duplicate/contradict Medical Treatment Act? S42T implies that a medical research procedure can be carried out on a patient before a certifying certificate is completed. Surely either the person responsible needs to consent prior? S42T appears completely inappropriate and lacks protection for vulnerable patients.

S42V(3) is confusing.

Some of the sections are repetitive eg "may seek advice" and "protection of registered practitioner" sections – these could be streamlined.

Conclusions

Geriatricians are frequently involved in situations relating to this legislation. Issues around future planning for individuals and substitute decision makers are only going to be come more prominent as the population ages. Improved clarity, strength and streamlining of PoA legislation will be helpful for lay people, legal practitioners and medical practitioners.

It is important not to lose the strengths and protections available within the current system.

We endorse the recommendations of the Federal parliamentary committee "Older people and the law", published September 2007.

Our strongest criticisms of the current legislation relate to:

- inclusion of physical disability under the definition of disability;
- provisions which allow medical research procedures to be carried out with minimal protection;
- lack of clear penalties for agents acting without regard to the best interests of the represented person.

The lack of clear protections against Elder Abuse in other areas of legislation is also of relevance and concern.

The Victorian Division of the Australian and New Zealand Society for Geriatric Medicine thanks the Law Reform Committee for their work and the opportunity to contribute to this Inquiry.

Yours sincerely

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ANZSGM