20 April 2018

Ms Amber-Jade Sanderson, MLA
Chair
Joint Select Committee on End of Life Choices
Parliament House
4 Harvest Terrace
West Perth WA 6005

By email:

Dear Ms Sanderson

JOINT SELECT COMMITTEE ON END OF LIFE CHOICES, THURSDAY 08 MARCH 2018

I refer to your letter dated 3 April 2019.

Questions 1 and 3

In general terms, the problems associated with the adoption and use of advance health directives are similar to other legal instruments used in the estate planning. Many legal practitioners often observe that attending to matters such as preparing documents such as wills, enduring powers of attorneys and guardianship are matters that are important but, in reality, people put off executing such documents.

It is often said that less than 50% of Australians have made wills. In my experience, people will make an enduring power of attorney or guardianship in the course of making their will and, usually at the suggestion of the legal practitioner. Many practitioners who undertake estate planning would not include the preparation of an advance health directive in the course of providing that advice.

I am aware that, more specifically, Western Australian research has identified that issues in relation to the implementation of aged care planning instruments, such as advanced health directives, include:

(a) low levels of community awareness about aged care planning, particularly among the older generations;

(b) a tendency for people to avoid talking about end of life care;

(c) difficulty for people to plan for hypothetical future scenarios, particularly for people who have been diagnosed with dementia who don't understand the mental and physical changes that are going to occur, or when the illness has an unpredictable time course;

(d) lack of access to specific aged care planning, particularly among less qualified staff;

(e) lack of time or appropriate funding for health professionals, particularly general practitioners to have detailed discussions with patients regarding aged care planning; and

(f) the burden of formalities associated with executing the instruments (which require an evaluation of capacity, the completion of forms and witnessing of the signing of the documentation).

Regarding the incidence and use of advance health directives in residential aged care facilities (**RACF**), it seems that by the time someone may benefit for the use of such an advanced care planning tool and have been admitted to a RACF they no longer possess the requisite capacity to execute a legal instrument of that kind. It is also my understanding that very few residents arrive already having executed such a document.

Question 2

My observation that a more sophisticated mechanism is required in relation to patients with dementia, I was referring to the fact that it appears that the test which applies to assisting the level of someone's capacity permitting them to make an advance health directive under the *Guardianship & Administration Act* the term for capacity is not defined and the legislation provides if a person is able to make her own decisions in relation to her health unless the contrary is proven. This to some extent mirrors the position in the common law however it is observed that the testing under the common law is subjective as the standards set in the Act is objective. In general terms, the problems associated with the question of capacity and dementia generally is that a person's ability to make decisions with dementia is not rigid and it may be, for example, that while a person is found to have not had sufficient capacity under the broader test administered by the Act, that person may nevertheless be regarded as having capacity for other purposes such as executing a Will.

It may therefore be the case that a person who has been diagnosed has having dementia may be regarded as not having the capacity to enter into that particular instrument notwithstanding that the law recognises them as capable of executing other documents such as Wills. This observation may be carried over to the question of decisions in relation to someone's treatment.

Question 6

In the particular example given, the State Administrative Tribunal made orders that the mother and the Public Advocate were appointed joint limited guardian of the son with functions to:

(a) Make treatment decisions for the son; and

(b) Determine the services to which the son had access to.

A few weeks after these orders were made, the son became ill and a someone contacted the mother and advised her that a doctor was recommending that the son be taken to hospital for treatment. The mother made the decision that the son was not to be taken to the hospital. The mother made that decision on her own, without contacting the Public Advocate to advise them of the treatment decision, despite being required to do by reason of the order made by the Tribunal. The Public Advocate was not contacted to be advised of the situation or to make the decision. Early the next day, the son passed away as a consequence of the untreated illness.

Question 9

As a general observation, I believe that a review of the *Guardianship and Administration Act 1990* is required as it has become increasing evident that the current legislation does not provide sufficient protection to prevent vulnerable people such as elderly and / or disabled persons from being financially abused.

Question 10

The issue of prevalence and incidence of elder abuse in Western Australia was considered in the report *Examination of the Extent of Elder Abuse in Western Australia* (April 2011), which found that:

> *Due to a range of complicated, interactive factors, no single source of data provides a comprehensive window into the nature and extent of elder abuse. Based on a range of international prevalence and incidence estimates for elder abuse victimisation, an average prevalence rate for WA was calculated to be 4.6% (ranging between 3.1% and 6.0%). This translates to an estimate of approximately 12,500 victims of some form of elder abuse in WA for 2011. Combined with population estimates for WA, it is anticipated that the total number of victims over the age of 65 will increase by around 90% over the next twenty years.*

Recently, the increase of elder abuse on a national level was considered by the Australian Law Reform Commission in the report, *Elder Abuse – A National Legal Response* (ALRC Report 131, May 2017). This report advises that The World Health Organization has estimated that the prevalence rate of elder abuse in high- or middle-income countries ranges from 2% to 14% and that the potential for elder abuse may grow with an increased aging population. It further provides that in 2014-25, approximately 15% of the Australian population was aged over 65 or over, and this is expected to rise to 23% by 2055.

Question 11

Although someone may have capacity, they may still be unduly influenced so as to make a decision which is not made voluntarily or of their own free will. Undue influence is a legal construct that can be defined as the improper use by a person of an ascendancy over another person, for their or a third party's benefit, so that the acts of the other person are not free, voluntary acts. They nature of the relationship between the parties (one of ascendancy by one person over the other) is the foundation for the influence. Risk factors of undue influence include older age, family conflict, isolation, physical disability, mental disorder, recent bereavement and English language difficulties.

For example, an Enduring Power of Attorney (EPA), might be made by someone who has decisional capacity and meets the legal requirements in that regard, but is dependent socially, emotionally and financially upon the person whom they are appointing. Therefore, while the instrument itself is validly executed, it may be that the instrument is executed by virtue of inappropriate pressure, or importunity and for a purpose which would see the person devested of substantial assets or financial resources.

While it is acknowledged that close family members are often appropriate choices for these instruments, some mechanism by which non-financial interest or a greater level of independence can be implemented.

This is currently more obviously required in relation to EPAs, but the growing relevance of a similar approach to be taken with advanced health directives of enduring powers of guardianship should be considered in the context of the concerning emergence of the early inheritance syndrome.

Yours faithfully

Cameron Eastwood

JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

Our ref: A678989

3 April 2018

Reverend Margaret Court AO, MBE & Reverend Belinda Dover
Victory Life Centre

Mr Cameron Eastwood
Eastwood Law

Via email:

Dear Reverend Court, Reverend Dover and Mr Eastwood

Questions on notice from public hearing

Thank you for appearing before the Joint Select Committee on End of Life Choices on Thursday 8 March 2018.

Apologies for the delay, but as you may recall, at the hearing you undertook to provide information in relation to several questions taken on notice.

1. In relation to advance health directives, Mr Eastwood mentioned that they are currently ineffective and underutilised, why do you think that is?
2. Mr Eastwood outlined that with regards to patients with dementia, a more sophisticated mechanism is required, what would you see that mechanism being?
3. Mr Eastwood mentioned that advance health directives are rarely used at all in residential aged-care facilities, why do you think they are so rarely used in those facilities?
4. What about the legal framework that medical practitioners are currently working under in regards to palliative care and the Criminal Code; in particular the futility of treatment, withdrawal of life-sustaining treatment and relying on the doctrine of double effect? Do you have a view on the current legal framework in regard to palliative care at the very end of life relating to those issues?
5. Hon Robin Chapple MLC noted (on page 5 of the transcript) the notion that palliative care can relive suffering for the terminally ill, as a statement, is a bit too broad. Do you have any comments on that?
6. Mr Eastwood gave an example during the hearing, which can be found on page 6 of the transcript, in relation to a mother, who was a joint guardian for her son, deciding to refuse medical treatment and her son dying. How was the mother able to make that decision? Were two people involved in the decision-making?
7. In relation to arguments against euthanasia in the media, and specifically that there is a negative social consequence from the legislation of end-of-life choices or euthanasia, could you identify what they are?
8. Are there any other aspects of concern that you believe create the slippery slope in what might be defined legislation?

Enquiries to Dr Jeannine Purdy Tel: (08) 9222 7442
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9. Do you think a review of the *Guardianship and Administration Act 1990* is required?
10. In relation to your response to the question above, could you also include references to the material that supports Mr Eastwood's view that there has been an increase in cases relating to elder abuse?
11. To create an advance health directive, you must have full legal capacity, which must be certified by a medical practitioner. However, Mr Eastwood indicated that there are other factors relating to undue influence that should be considered. How do you think consideration of those factors could be incorporated in the Act?

It would be appreciated if you could provide this information to the Committee by **Friday, 20 April 2018.**

Unless otherwise directed by the Committee, your evidence is public and will be published on the WA Parliament website.

If you require any further information, please contact Dr Jeannine Purdy on 9222 7442.

Yours sincerely

MS A. SANDERSON, MLA
CHAIR

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