The title of this paper is intended to raise the question of whether or not the law has a role to play in the relationship between carers, doctors (or other health care professionals) and the delivery of care to those in need. At one level, the answer is that the law does have little role in this area and I will briefly explore that. On another level however, the law has been used to help clarify the role of the carer in medical decision-making, and it is that issue that I want to explore in some detail.

In order to address that issue I will begin by talking about health care professionals and their obligations and responsibilities. This will involve raising issues of ‘competence’ and ‘consent’, which I will explain in due course.

I will then return to the position of carers and having identified the legal issues that arise in the context of the health professional/patient relationship, identify what are the rights and responsibilities of carers. In doing this I will distinguish between a Guardian and a person with a Power of Attorney.

**Does the law have a role to play in the provision of care?**

The law means many things. It means the law as handed down by Parliament in the form of a statute or Act of Parliament and it means the common law as developed by the Courts over time. The concept of ‘law’ also means, to many people, the courts and litigation.

We all hear about verdicts for large sums of money (usually American) and see footage of people entering courts on TV. For most of us ‘the court’ represents the law and our greatest fear of the law and its processes.
If we take that as our definition of ‘law’ then the law has little role to play in caring relationships. Litigation, that is the court processes, is a dispute resolution process. (You may think it is an expensive, inefficient and unsuccessful process but that is a different matter). The key to litigation is that it involves a dispute where one party wants a remedy from another party. The usual remedy is money but that is not the only remedy that may be available.

Accordingly in relationships of care, litigation does not arise very often. To see why you only need to consider who would sue who, and why? The person in need of care is unlikely to sue the person providing care for a variety of reasons. Some of these are legal but some are practical. Firstly there is likely to be some personal relationship between the parties that would be destroyed by litigation. Even if the carer was legally negligent, the person in need of care, if competent, is likely to accept that there was a well-intentioned mistake rather than something that should be the subject of litigation. The person likely to be sued is unlikely to have the money to pay at the end of the day. The courts’ primary remedy for any wrong is to order the wrongdoer to pay money. There is no point suing someone who cannot pay.

The care relationship is not like a motor accident where two strangers collide. The strangers have nothing to lose in terms of personal relationships and everything to gain in terms of money, by suing.

There are of course obligations on medical practitioners and health professionals to act with reasonable care toward their patients and they may expect to be sued if they fail to do that. They are also likely to be insured and so it may be worthwhile to sue them, but again that doesn’t happen very often. Further the law that governs that is about the provision of care by a health professional and arises from their claimed professional skill, rather than from the ‘care’ relationship or the relationship between carer and doctor.

So if we think of ‘law’ as ‘going to court’ then the law has little to say about the relationship between the people in need of care, their carers and their health professionals. If, on the other hand, we think of the law in a broader context, as the rules that govern us and help us to make decisions without the need to litigation, then the law has been used to help us understand the rights and responsibilities of carers.
and health professionals when dealing with a person who cannot care for themselves. This is the area that I will now explore in some detail.

**Health professionals and their patients.**

Health professionals owe a number of obligations to their patients. Some of these are:

- An obligation to act in the patient’s best interest
- An obligation to take reasonable care in providing their services;
- An obligation not to provide care without the patient’s consent where the patient is capable of giving consent; and
- An obligation to keep confidential anything that is told to them in confidence.

These issues pose few problems when the patient is a competent adult. As you would know better than I, problems can arise when the patient is not competent or where their capacity to make decisions isn’t clear. Examples here are children, the mentally ill, the developmentally disabled and of course people suffering from dementia. In these cases we have a three-way relationship:

![Diagram](attachment:three-way_relation.png)

Let us look at this from the point of view of the health professional-patient relationship, as there is plenty of law about that relationship. There is also lots of room for conflict between the health professional and the carer.
The first problem that a health professional may face is deciding whether or not a person is competent and then dealing with a carer who may have a different view, or who may want to make decisions on behalf of the patient/person in need of care.

A health professional cannot provide treatment to a person without their consent. To touch another person, without their consent, is an assault irrespective of your motive in doing so. Not everyone, however, can consent to medical treatment. To be able to consent you need to be able to receive information about the procedure, understand it and act on it.\(^1\) In an English case a judge said that there were three questions that need to be answered to determine whether or not someone was competent to give consent to medical treatment. Those questions are:

1. Is she capable of comprehending and retaining information about the proposed treatment?

2. Is she capable of believing the information given to her about the treatment?

3. Is she capable of weighing such information in the balance to make a choice?\(^2\)

Competence can vary in degree. There is no rule that says if you are incompetent for one thing, then you are incompetent for all. It may be then that a person has been found to be incompetent with respect to their financial matters and a guardian has been appointed to look after their finances, but this does not meant that they are incompetent when it comes to making medical decisions. A person may not be competent enough to be able to decide whether or not they should have some sort of surgery, but they may be competent enough to give consent to some more minor procedure.

Deciding whether the patient is or is not sufficiently competent, is, at first instance, a matter for the health professional. If they are of the view that the patient is sufficiently competent to understand what is going on and to give consent to it, then the health professional need not discuss that with anyone else, including the carer.

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1. See *Gillick v West Norfolk Health Authority* [1986] AC 112 although this case related to children.
Where the patient is not competent, there is not, generally speaking, anyone else who can give consent on their behalf and consent is not required. In an English case, called *In Re F*, it was said that health care could be provided to an incompetent person where the care was reasonably necessary in the best interests of the patient, the most appropriate person provided the care and the care was not contrary to the known wishes of the patient.

That general principle means that where there is a person who cannot make health care decisions for themselves, then no-one’s consent is required. It does not mean that a relative or carer must consent (though we will discuss the *Guardianship Act* later that affects this position) but that no consent is needed from anyone.

As a general rule, then, the health professional needs the consent of the patient before they can give medical care, but if the person cannot consent, then they don’t need anyone’s consent. The necessity of acting is sufficient authority to justify the provision of health care in the circumstances.

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The second problem may be that the carer wants information about the patient/person in need of care that the doctor may feel obliged not to disclose.

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When you go to a doctor you expect that doctor not to disclose your medical details to others. There may be good reason why a doctor would discuss your case with another health professional, eg your GP will want to talk to treating specialists, but you would not, generally, expect the GP to talk about your health with your children or your parents. The doctor is in the same position when dealing with a person with dementia who, in the doctor’s opinion, is competent to make medical decisions. If the patient is competent then it is the patient that must consent to treatment and the patient’s privacy protected.

Accordingly, and again as a general rule, prima facie the health professional is under no obligation to tell the carer about communication between them and the patient. In fact the health professional may be under a duty not to disclose that information.

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The health professional may be faced with a number of alleged carers.

It may be the case that a health professional will be fielding a number of demands from various people who claim to have an interest in the affairs of the patient. This may be true if there are a number of children who are seeking information about what is happening to their mother or father. In those cases, even where it would be appropriate to discuss the person’s needs with a carer, the health professional may have difficulty determining exactly who is the appropriate person to discuss the matter with.

If the health professional is able to ascertain who the appropriate person is, eg the person may be living with one child who is the carer, but it is other non-resident children who are seeking information, then many of the problems that arise above will return. The health professional may have consulted with the carer, determined what is in the patient’s best interests and obtained consent to a particular treatment regime. Now other members of the family want details of the confidential discussions or to challenge the decisions. This leaves a health professional in the centre of a difficult conflict.

The rights and responsibilities of carers

How does this discussion deal with the rights and responsibilities of carers? The answer is that if you can see the problems the health professionals face, you can begin to identify what ‘rights and responsibilities’ carers have in relation to those problems. To put that another way, by identifying the sorts of problems that can arise, one can begin to understand how the law deals with the issues.

The first question that the law has tried to answer is ‘who is the carer? Giving a legal answer to this question makes it easier for people to know whom they should be dealing with. The relevant law is the Guardianship Act 1987 (NSW). This Act deals with, amongst other things, the appointment of guardians who have various powers to make decisions on behalf of people who are not able to make their own decisions. It

[1990] 2 AC 1.
is possible however, to make some decisions on behalf of others even without a formal appointment of a guardian.

The Act has the concept of a ‘person responsible’ for the care of another. The person responsible for another person is, in order:\(^4\)

1. The person's guardian, (provided that when they were appointed as guardian they were given the power to consent to medical or dental treatment).

2. The person’s spouse (provided they continue to have a close and continuing relationship, so it does not mean an estranged spouse).

3. A person who has the care of the person. (A person has the care of another person if they provide domestic services and support or arrange for domestic services and support to be provided.\(^5\))

4. A close friend or relative of the person. (A person is a close friend or relative if they maintain a close personal relationship through frequent personal contact and a personal interest in the other person's welfare.\(^6\))

If a person is not able to give consent to medical or dental treatment, then the person responsible may give that consent.\(^7\) It is an offence, emergencies excepted, to treat a person without consent from the relevant person.\(^8\)

The effect of this Act is to change the general rule stated above. Firstly it is now possible to identify, by working through the list, who is the relevant person that the health professional should seek consent from. Secondly the Act makes clear what the common law does not, that is that the person responsible in fact has the power to give consent to treatment.

If a person is going to give consent to treatment, then they must be informed at least of the material risks inherent in the treatment.\(^9\) The fact that the person responsible is

\(^4\) Guardianship Act 1987 (NSW) s 33A.
\(^5\) Guardianship Act 1987 (NSW) s 3D.
\(^6\) Guardianship Act 1987 (NSW) s 3E.
\(^7\) Guardianship Act 1987 (NSW) s 36.
\(^8\) Guardianship Act 1987 (NSW) ss 35 and 37.
\(^9\) Rogers v Whitaker (1992) 175 CLR 479.
the person to give consent means that they must get the necessary information. The health professional must of course communicate with the person responsible if the person responsible is to give the necessary consent.

The position is not however clarified where the patient, although suffering from dementia is still able to give effective consent for his or her own treatment. If they are not incompetent, then the Act doesn’t apply and privacy issues again arise. The general guiding principle, in my view, with respect to confidentiality, is that information must not be used other than for the purpose for which it was intended. It is no breach of privacy for a treating doctor to tell other people on the health care team about the patient’s condition, it is no breach of privacy for nursing staff to report to a patient’s doctor about matters they have become aware. A person usually tells a health professional information about himself or herself in order to allow the health professional to provide health care. It is consistent with that purpose if the information is disclosed to other health professionals who are involved in the patient’s care.

A doctor or other health professional may be satisfied that the patient is competent to consent to treatment but realise that the patient will need assistance eg to take their medication. Then it is clearly appropriate for the health professional to consult with the carer about that and to ensure the carer is aware of what is required and why. In that context the carer is, in my view, acting as another part of the health care team and needs to be involved.

The carer should also be involved in discussions with the health professional in order to give information to the health professional so that he or she can make an informed decision about what is in the patient’s best interests. If (again to use the example of a doctor) a doctor is to provide treatment that will be most efficacious, he or she needs to understand the patient’s position in order to know what treatment options are reasonably open to them.

10 Guardianship Act 1987 (NSW) s 34.

11 See for example the Privacy And Personal Information Protection Act 1998 (NSW) s 17; Privacy Act 1998 (Cth) Privacy Principles 9 and 10.
So a carer does have rights and responsibilities with respect to the giving, and receiving, information about a person's health care needs. The extent of those rights and responsibilities depends in turn on how able the person in need of care is. The more that they can decide and do for themselves, the less rights and responsibilities the carer has.

This discussion of the law has still not resolved two issues that I identified above. They are:

1. What happens when there is disagreement over the patient’s competency? and

2. What happens if the health professional cannot identify whom the appropriate carer is?

If either of these situations arise, then it is useful to have a formal appointment as a guardian. Guardian’s can be appointed in two ways. The first is that a person, when competent, can appoint an Enduring Guardian who is to be their guardian if they are not competent.¹² The second method of appointing a Guardian is by order of the Guardianship Tribunal. The Tribunal can appoint a Guardian when it is satisfied that the person is in need of a guardian.¹³

Proceedings before the Guardianship Tribunal for a Guardianship order may have two significant consequences. The first is that the person appointed the Guardian has clear legal authority as the decision maker on behalf of the person in need of care. Issues as to who should be contacted for decision-making are clarified when there is a formal appointment of a Guardian. Secondly the proceedings themselves will test issues of competency where there is a real disagreement as to whether or not a person is competent to make relevant health care decisions.

On the other hand, proceedings for any order can be expensive and emotionally draining, so I do not particularly advocate that in every case one should get guardianship orders. It would always be a question of what is most efficacious but if there are real disputes between family members or health professionals and carers,

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¹² Guardianship Act 1987 (NSW) s 6.
¹³ Guardianship Act 1987 (NSW) s 14.
then obtaining a guardianship order may resolve some of those issues and formalise the situation. Where however health professionals, families and patients are all working together in the patient’s best interests, then formal orders may not be necessary.

**The difference between an Attorney and a Guardian**

I will take the opportunity for a sidetrack and discuss the difference between a person who has a power-of-attorney and a guardian. Attorneys (i.e. someone who holds a power of attorney, not a lawyer) are appointed under the *Conveyancing Act 1919* (NSW). A person grants to another person a ‘power of attorney’ and that authorises the attorney to act as if they were the grantor of the power. They can in particular, deal with the grantor’s property as if they were the grantor. They can sell their house, withdraw money from the bank etc. Powers of Attorney relate to matters of finance and property, not health care. My colleague Robyn Allen will be addressing issues of Powers of Attorney in the workshop sessions.

With respect to health care, recent amendments to the *Guardianship Act* allow a person to appoint an Enduring Guardian. An Enduring Guardian is like an attorney in that the person ‘appoints’ the Guardian themselves. The difference is that an Enduring Guardian’s powers commence if and when the grantor becomes incompetent or otherwise in need of a guardian. Some confusion over the difference between an Enduring Guardian and an Attorney may arise because of the way these are phrased in different states, for example, a person who would be called an ‘Enduring Guardian’ in New South Wales would be called an ‘agent’ and appointed under an ‘enduring power of attorney (medical treatment)’ in Victoria.

**Conclusion**

What can we, in conclusion, say about the rights and responsibilities of cares of people with dementia in the area of health care? In *Hewer v Bryant* the English judge,
Lord Denning talked of the ‘dwindling’ rights of parents. A parent’s right over his or her child, he said ‘starts with a right of control and ends with little more than advice’. It appears that the same is true with dementia. Where there is a person with mild dementia, the carer’s right and responsibility may be to give advice, but it can extend to control. The question will always be how much can the person in need of care do for themselves, and where they remain competent to act on their own behalf, then no one has the right to act for them.

The rights and responsibilities that I have discussed here can be reduced to a table:

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<table>
<thead>
<tr>
<th>Can the carer consent to medical treatment on the person’s behalf</th>
<th>Person competent</th>
<th>Person incompetent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes, if they are the ‘person responsible’ (as defined in the <em>Guardianship Act</em>).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can the carer be consulted on health care matters?</th>
<th>Person competent</th>
<th>Person incompetent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, if that is consistent with the patient’s wishes and necessary to facilitate the person’s health care.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can a person who has Power of Attorney consent to medical treatment for another?</th>
<th>Person competent</th>
<th>Person incompetent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

I trust that this has been of some assistance, and I thank you for your attention.

**Michael Eburn.**

27 October 2000.