



Office of the
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Advance care planning and substitute medical treatment decision making





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The information in this guide relates to the law in Victoria.

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What is advance care planning?

Advance care planning is the process of planning for future medical treatment when someone is not capable of making their medical treatment decisions.

Advance care planning is an expression of autonomy, involving making and communicating decisions, and expressing preferences and values.

Advance care planning is not defined in law and is, therefore, a term used in different ways.

The Office of the Public Advocate (OPA) understands advance care planning to encompass a range of planning options:

- appointing someone to make medical treatment decisions for you
- appointing someone to support you to make medical treatment decisions for yourself
- making an advance care directive which may include either or both of:
 - » an instructional directive: making a medical treatment decision for yourself at a time you have

decision-making capacity for a future time when you are offered the medical treatment but do not have decision-making capacity

- » a values directive: expressing your values and preferences to inform a medical treatment decision maker if, in the future, they need to make a medical treatment decision for you
- writing down your preferences and values for future medical treatment decisions to inform a medical treatment decision maker if, in the future, they need to make a medical treatment decision for you
- discussing your preferences and values for future medical treatment decisions for yourself with your health practitioners, your medical treatment decision maker, your support person and others interested in giving effect to your preferences and values, and in promoting your social and personal wellbeing.

Who does advance care planning?

Advance care planning is done by a person for themselves, when the person has decision-making capacity for the decision(s) in question.

It can be helpful for the person to talk to their health practitioner(s), family members and others close to them.

Where a person is unable to do advance care planning because they do not have decision-making capacity for the relevant decisions, they can, however, continue to express their preferences and values for as long as they are able to do so.

What is decision-making capacity, who has it, and what does it mean if a person does not have it?

All adults are presumed to have decision-making capacity, unless there is evidence to the contrary.

A person has decision-making capacity if the person is able to do the following:

- understand the information relevant to the decision and the effect of the decision
- retain that information to the extent necessary to make that decision
- use or weigh that information as part of the process of making the decision
- communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

When assessing capacity, the question is whether the person has the capacity to make the particular decision. For example, a person may have capacity to make some medical treatment decisions (whether to have a flu vaccination) but not others (whether to have surgery), or a person may have decision-making capacity to make a values directive in an advance care directive but not an instructional directive.

If a person does not have decision-making capacity for a particular decision it does not mean that they cannot express their preferences and values in some way. If, in future, a medical treatment decision needs to be made for them, those preferences and values must be taken into account by their medical treatment decision maker.

What is substitute decision-making?

If a person lacks decision-making capacity to make a particular decision, then another person may be authorised by law to make a decision for them.

In the case of medical treatment decisions, a medical treatment decision maker is authorised to make decisions for the person under the Medical Treatment Planning and Decisions Act.

Other substitute decision-makers include guardians or administrators appointed by VCAT, or an attorney for personal or financial matters appointed by the person.

What is the relationship between advance care planning and substitute decision-making?

Advance care planning is done by a person for themselves as a means of exercising their autonomy, and their freedom of decision and action.

Substitute decision-makers must make decisions according to the criteria set out in the relevant legislation. In the case of medical treatment, the medical treatment decision maker must make the medical treatment decision that he or she reasonably believes is the decision that the person would have made if they had decision-making capacity.

The main purpose of advance care planning, therefore, is for a person to take steps and make decisions such that a future medical treatment decision maker feels well equipped to make the medical treatment decision that they reasonably believe is the decision that the person would have made if they had decision-making capacity.

Advance care planning is an expression of autonomy by the person and substitute decision-making should be the **implementation** of the person's autonomy.

What are the purposes of the *Medical Treatment Planning and Decisions Act 2016*?

The primary purposes of the Act are to provide for:

- a person to execute, in advance, a directive that gives binding instructions or expresses the person's preferences and values in relation to their future medical treatment (advance care directive)
- the making of medical treatment decisions on behalf of people who do not have decision-making capacity
- a person to appoint another person to make medical treatment decisions on behalf of the person when they do not have decision-making capacity and/or to appoint

another person to support the person and represent their interests in making medical treatment decisions.

These purposes reflect the relationship between advance care planning and substitute decision-making.

In order to make an advance care directive or appoint a medical treatment decision maker or support person, a person must have decision-making capacity.

Witnesses are required to certify that the person appeared to have decision-making capacity when they completed the documents.



Who can make an advance care directive?

A person with decision-making capacity can make an advance care directive, including an instructional directive in which the person makes a medical treatment decision in advance to consent to or refuse medical treatment.

An advance care directive can be made in relation to any type of medical treatment, whether or not the person currently has a condition to which the medical treatment decision relates.

No other person, including a medical treatment decision maker, can make an advance care directive for another person, whether that person does or does not have decision-making capacity.

‘Advance care directive’ has a legislative definition. Sometimes people use the expression more broadly but, when OPA refers to an advance care directive, OPA means an advance care directive made under the Medical Treatment Planning and Decisions Act.

What is the status of refusal of treatment certificates?

Prior to 12 March 2018, it was possible for a person to complete a *Refusal of Treatment Certificate: Competent Person* made under the *Medical Treatment Act 1988*.

Refusal of treatment certificates could only be made in relation to current medical conditions.

Prior to 12 March 2018, it was also possible for a medical agent appointed under the Medical Treatment Act, or a guardian appointed by VCAT under the *Guardianship and Administration Act 1986* with powers to make decisions about medical treatment, to complete a *Refusal of Treatment Certificate Agent or Guardian of Incompetent Person*.

Refusal of treatment certificates made before 12 March 2018 remain valid.

When can a medical treatment decision maker make a medical treatment decision?

A medical treatment decision maker can make a medical treatment decision if the health practitioner has determined that the person lacks decision-making capacity to make the decision, and there is no relevant instructional directive that applies in the circumstances.

In general, a medical treatment decision maker will be asked to make a medical treatment decision at the point in time that the treatment is actually needed to treat the medical condition.

Example

Filip is diagnosed with an urinary tract infection and the health practitioner recommends the immediate administration of antibiotics to treat the infection.

In this case, the health practitioner is able to provide the medical treatment decision maker with all the clinical information they need in order to make the medical treatment decision.

At other times, it may reasonably be anticipated that the person may need medical treatment and the health practitioner is able to provide the medical treatment decision maker with all the clinical information they need in order to make the medical treatment decision.

Example

Cara is scheduled to undergo surgery.

The health practitioner explains to the medical treatment decision maker that, with this type of surgery, it is usual practice to start the person on antibiotics following the surgery as there is a high risk of infection — it is preferable to take pre-emptive action rather than waiting to see if Cara does contract an infection.

In this case the health practitioner is able to provide the medical treatment decision maker with all the information they need in order to make the decision.

However, it is not possible for a medical treatment decision maker to make medical treatment decisions speculatively or in advance in the way that the person can do for him or herself.

How does a medical treatment decision maker make a medical treatment decision?

The Medical Treatment Planning and Decisions Act (section 61) sets out how a medical treatment decision maker must make a decision.

In brief, the medical treatment decision maker must make the decision that they reasonably believe is the one that the person would have made if they had decision-making capacity.

There are various considerations that the medical treatment decision maker must take into account and they must act in good faith and with due diligence.

It is not possible for a medical treatment decision maker to make a medical treatment decision unless the health practitioner has provided them with relevant clinical information, including:

- the likely effects and consequences of the medical treatment, including the likely effectiveness of the medical treatment
- whether there are any alternatives, including refusing medical treatment.

In order to obtain an informed consent to treatment, a health practitioner needs to provide information about the medical treatment and the risks.

Depending on the circumstances, 'due diligence' on the part of the medical treatment decision maker might include making preparations for being able to make a medical treatment decision when called on.

Example

Lyn appoints Hana to be her medical treatment decision maker when she has decision-making capacity.

Lyn subsequently develops dementia.

Hana realises she might need to make decisions for Lyn at some point in the future. Hana meets with Lyn and talks with her about various matters, with a view to getting some insight into Lyn's preferences and values.

Hana makes some notes of what she understands Lyn to have told her, and what she knows about Lyn's previous treatment preferences.

Hana also puts together a contact list of people she would need to consult if she needs to make a decision. Hana contacts Lyn's GP to let the GP know that she is the medical treatment decision maker.

Lyn's dementia worsens and she moves into residential aged care.

Hana speaks with Lyn's GP to become more informed about likely future medical issues and decisions which need to be made so that she can start thinking ahead and not feel rushed if she has to make decisions in a crisis.

What happens in an emergency?

If a health practitioner believes on reasonable grounds that medical treatment is necessary as a matter of urgency to:

- save the person's life or
- prevent serious damage to the person's health or
- prevent the person from suffering or continuing to suffer significant pain or distress

then the health practitioner may administer the medical treatment without seeking consent from the medical treatment decision maker.

However, if the person has refused the medical treatment in an instructional directive or other legally valid and informed refusal of treatment (such as a refusal of treatment certificate) then the health practitioner cannot administer the medical treatment.

In an emergency, a health practitioner is not required to search for an advance care directive that is not readily available.

If a person has made an instructional directive in an advance care directive refusing particular treatment that might be likely to be provided in an emergency (for example, resuscitation or a blood transfusion) then the person should consider how to make the advance care directive 'readily available' to the relevant health practitioners.



What decisions does a health practitioner make?

A health practitioner makes clinical decisions about what medical treatment to offer.

A health practitioner is not required to administer a futile or non-beneficial medical treatment.

A health practitioner determines whether the person has decision-making capacity to make a medical treatment decision in response to the health practitioner's offer or recommendation. If the person has decision-making capacity, then they make the medical treatment decision.

If the health practitioner decides the person does not have decision-making capacity to make the medical treatment decision then the health practitioner must make reasonable efforts to ascertain if the person has an advance

care directive.

If the person has made a relevant medical treatment decision in an instructional directive, then that medical treatment decision takes effect (subject to other provisions in the Act, which permit the health practitioner to refuse to comply with the instructional directive).

The health practitioner refers the medical treatment decision to the medical treatment decision maker if:

- the person lacks decision-making capacity
- it is not an emergency and
- there is no relevant instructional directive.

Other resources

Find a range of resources on the 'Information for health practitioners' page of the OPA website, including the 'Can your adult patient consent?' flowchart and the following fact sheets:

- Do I need the consent of the Public Advocate for emergency treatment?
- Palliative care when the person does not have decision-making capacity
- End of life decision-making when there is no family or medical treatment decision maker
- Health practitioners and the *Medical Treatment Planning and Decisions Act 2016*
- Treatment for mental illness: transition issues from compulsory patient to medical treatment decisions.

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