



# End of Life

## Decision making when there is no family or medical treatment decision maker

### Principles and purposes of the *Medical Treatment Planning and Decisions Act 2016*

One of the purposes of the *Medical Treatment Planning and Decisions Act 2016* is to provide for the making of medical treatment decisions on behalf of persons who do not have decision-making capacity.

A person exercising a power or performing a function or duty under the Act must have regard to a number of principles (section 7) including that a partnership between a person and the person's family and carers and health practitioners is important to achieve the best possible outcomes.

Section 8 of the Act states nothing in the Act requires a health practitioner to administer a futile or non-beneficial medical treatment (or medical research procedure) to a person.

### Why do health practitioners consult with family members and carers about medical treatment options for a patient who lacks decision-making capacity?

As indicated, it is a principle of the *Medical Treatment Planning and Decisions Act* that a partnership is important to achieve the best possible outcomes. This is because the health practitioner brings their expertise about the medical condition and treatment options and the family members and carers bring their expertise about the preferences and values of the person.

### Who makes the medical treatment decision?

The health practitioner exercises clinical judgement in determining if there is medical treatment which can be offered. As indicated above, a health practitioner is not required to offer futile or non-beneficial treatment.

If a health practitioner is offering medical treatment and the person:

- lacks decision-making capacity to make the medical treatment decision and
- did not previously make an instructional directive in an advance care directive (or a Refusal of Treatment Certificate\*) relevant to the medical treatment

then the health practitioner asks the medical treatment decision maker to make the medical treatment decision — that is, to consent to or refuse the proposed treatment.

The medical treatment decision maker must consult with any person who the medical treatment decision maker reasonably believes the person would want to be consulted in the circumstances.

\* A Refusal of Treatment Certificate was made under the *Medical Treatment Act 1988*. That Act has been repealed as of 12 March 2018 but any Certificate made before then remains valid. A Certificate might have been completed by the person themselves, or by a medical agent or guardian, with relevant powers, for a person lacking decision making capacity.

## What if there are no further medical treatment options?

If there are no further treatment options then medical treatment is not being offered and therefore there is no medical treatment decision for a medical treatment decision maker to make.

It is a matter of communicating this sensitively to family members and carers.

## What about palliative care?

If the person requires palliative care (the provision of reasonable medical treatment for the relief of pain, suffering and discomfort or the reasonable provision of food and water) then this should also be discussed. However, this is not a medical treatment decision to be made by a medical treatment decision maker.

Refer to the Office of the Public Advocate (OPA) fact sheet:

**Palliative care when the person does not have decision-making capacity.**

## What if the person does not have any family members or medical treatment decision maker?

The question of whether medical treatment should be offered is a clinical decision for a health practitioner. It is only if medical treatment is offered that it is necessary to request a medical treatment decision maker to make a medical treatment decision.

If there are no family members or others interested in the welfare of the person, then clearly there is no one to advise that there are no treatment options and that possibly the person is approaching end of life.

## When would you contact the Office of the Public Advocate (OPA)?

OPA has statutory functions, powers and duties to make representations

on behalf of or act for a person with a disability (advocacy) and to promote informed public awareness and understanding about legislation dealing with or affecting persons with a disability (education).

OPA also acts as medical treatment decision maker in two circumstances:

1. If the Public Advocate has been appointed guardian to make medical treatment decisions and
2. If the person does not have a medical treatment decision maker, then the Public Advocate can make decisions about significant treatment. (Refer to the **DHHS guidelines on significant treatment**).

If medical treatment is not being offered then, from an advocacy perspective, OPA will want to ensure that the determination of the health practitioner is a clinically formed view and not a discriminatory presumption about the quality of life of a person with a disability. However, OPA is not able to provide any clinical view as to whether the decision not to offer treatment is clinically a sound determination. Health practitioners should consult with their peers and superiors for this input.

If no medical treatment is to be offered then there is no medical treatment decision to be made. Therefore there is no need for any health practitioner to contact OPA to advise that no medical treatment is to be offered to a person, whether or not the person is expected to die.

It is OPA's experience that sometimes health practitioners feel discomforted that there is no family member or medical treatment decision maker for them to consult when a person with a disability is nearing the end of their life, and there is no medical treatment which is clinically indicated. The health practitioner may think they need to contact OPA. However, this is not the case.

### Example 1

Bernadette lives at Evergreen Terrace. She is aged 54 and is in aged care for want of other more suitable accommodation. Bernadette has multiple sclerosis and has limited mobility and has mild cognitive impairment.

Bernadette has no family members and has never had any visitors. Following a blood test the GP notes that Bernadette has poor kidney functioning and refers her to a renal specialist.

The specialist says that she is not proposing to offer Bernadette dialysis. The GP is surprised by this and contacts OPA to discuss.

OPA's approach would be to establish that the specialist is not discriminating against Bernadette due to her disability and presumptions about the quality and value of her life. If dialysis would be futile and non-beneficial then there is no need to offer it.

However, if this is not the case, dialysis should be offered and if Bernadette lacks decision-making capacity to make the medical treatment decision, then the decision should be referred to her medical treatment decision maker.

The medical treatment decision maker decides whether to consent or to refuse the treatment.

In this case, because Bernadette does not have a medical treatment decision maker, the decision is referred to OPA, pursuant to s.63 of the Act.

### Example 2

Bill also lives at Evergreen Terrace, Aged Care and has lived there for the past 8 years. He is aged 93 and has end stage dementia. Bill has no family members and has never had any visitors.

Bill stops eating and drinking. The GP says that Bill is dying and prescribes morphine to manage any pain.

In this situation OPA would not expect to be contacted. There is no decision for OPA to make.

For more information see the OPA website at [www.publicadvocate.vic.gov.au](http://www.publicadvocate.vic.gov.au) or contact OPA's Advice Service on 1300 309 337.



The material in this fact sheet is intended as a general guide only and readers may require legal advice for specific circumstances.