Medical Treatment Planning and Decisions Act 2016

An introduction

About this presentation

The new Act commences on 12 March 2018.

This presentation explains:

- Advance care planning under the new Act.
- The medical consent process under the new Act for a patient who does not have decision-making capacity to make the medical treatment decision.

When the new Act commences, there is a shift away from a best interests model of medical decision making in favour of promoting the values and preferences of patients.

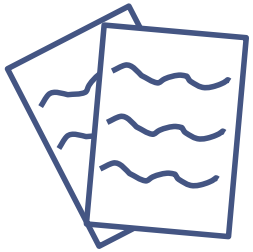
Advance care planning and the new Act

What people can do under the new Act

In Victoria, from 12 March 2018, people can:

- make an **advance care directive**
- appoint a **medical treatment decision maker**
- appoint a **support person** for their medical treatment decisions.

Forms



Formal requirements

There are legal requirements for making an advance care directive and these appointments.

Forms

Forms available from 12 March 2018:

- on the Medical Treatment Planning and Decisions Act page of the health.vic.gov.au website
- on the advance care planning page of the Better Health Channel website
- on the Office of the Public Advocate (OPA) website and in the OPA Take Control booklet.

Advance care directives

An advance care directive is a legal document:

- that sets out a person's
  - preferences and values (values directive)
  - binding instructions (instructional directive)
- in relation to the medical treatment of that person
- in the event that the person does not have decision-making capacity to consent to or refuse the medical treatment they are offered.

Values directives

A **values directive** is a statement of a person's preferences and values as the basis on which they would like any medical treatment decisions to be made on their behalf.

It must be considered by their medical treatment decision maker.

Instructional directives

An **instructional directive** is a statement of a person's medical treatment decision that is directed to the patient's health practitioner(s).

It takes effect as if the person who made it has consented to, or refused, the commencement or continuation of the medical treatment.

Medical treatment decision makers

A person can appoint a medical treatment decision maker with the authority to make medical treatment decisions on their behalf if they do not have decision-making capacity to make the decision(s).

A patient's medical treatment decision maker must make the decision that they reasonably believe is the one that the patient would have made.

Support persons

This is a new role under the new Act.

The role of a support person is to:

- support the patient to make, communicate, and give effect to their medical treatment decisions
- represent the interests of the patient in respect of the patient's medical treatment, including when the patient does not have decision-making capacity in relation to medical treatment decisions.

They can access health information about the patient that is relevant to a medical treatment decision, for example the patient’s medical record.

Medical consent and the new Act

Introduction

Health practitioners need a patient's consent before providing medical treatment, unless they are providing emergency treatment.

The new Act sets out the medical consent process for a patient who does not have decision-making capacity to make the medical treatment decision.

Decision-making capacity

A patient has decision-making capacity for the medical treatment decision if they are able to:

- understand the information relevant to the decision (including their medical condition, treatment options, and risks and benefits of treatment options)
- retain that information to the extent necessary to make the decision
- use or weigh that information as part of the process of making the decision and
- communicate their decision in some way, including by speech gesture or other means.

Health practitioners

The Act applies to registered health practitioners in the following professions:

- medical
- dental
- physiotherapy
- occupational therapy
- chiropractic
- pharmacy
- optometry
- podiatry
- nursing and midwifery
- medical radiation practice
- psychology
- osteopathy
- Chinese medicine
- Aboriginal and Torres Strait Islander health practice

The Act also applies to paramedics and non-emergency patient transport staff.

Definition of medical treatment

The definition of **medical treatment** in the Act has two parts. It is treatment by a health practitioner for one or more of the purposes listed below**,** and for one of the forms of treatment listed below.

Purpose of treatment	**Form of treatment**
○ diagnosing a physical or mental condition ○ preventing disease ○ restoring or replacing bodily function in the face of disease or injury ○ improving comfort and quality of life.	○ treatment with physical or surgical therapy ○ treatment for mental illness ○ treatment with ➢ prescription pharmaceuticals ➢ an approved medicinal cannabis product ○ dental treatment ○ palliative care.

Note: The *Mental Health Act 2014* applies where a person is a compulsory patient under that Act.

Emergency treatment

Definition of emergency treatment
Medical treatment (or medical research procedure) that is necessary, as a matter of urgency to: ○ save the patient's life ○ prevent serious damage to the patient's health or ○ prevent the patient from suffering or continuing to suffer significant pain or distress.

Consent is not needed for emergency treatment.

However, if the health practitioner is aware that the patient has refused the treatment in an instructional directive, they must not proceed with the treatment.

Obtaining a medical treatment decision

The Act sets out three steps for health practitioners to follow when a patient does not have decision-making capacity to make their own medical treatment decision.

Step 1

Is there an advance care directive with a relevant instructional directive?

A health practitioner must make reasonable efforts in the circumstances to find out if the patient has an advance care directive with a relevant instructional directive.

Yes

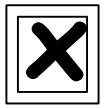
Give effect to relevant instructional directive.

If the patient has **refused** the particular medical treatment in their instructional directive, the health practitioner:

- withholds or withdraws that medical treatment.

If the patient has **consented to** the particular medical treatment in their instructional directive, the health practitioner:

- administers that medical treatment if they are of the opinion that it is clinically appropriate to do so.



No

Proceed to step 2.

Step 2 Is there a medical treatment decision maker?

Medical treatment decision maker hierarchy in the new Act

1. The patient's appointed medical treatment decision maker.

2. Guardian appointed by VCAT under the *Guardianship and Administration Act 1986* who has the power under that appointment to make medical treatment decisions.

3. The first of the following persons who is in a close and continuing relationship:
   (a) the spouse or domestic partner of the patient
   (b) the primary carer of the patient
   (c) an adult child of the patient
   (d) a parent of the patient
   (e) an adult sibling of the patient.

If more than one, the eldest of those persons.

Note: Legal documents made before the new Act commences, are recognised. For example, a medical enduring power of attorney.

Yes Medical treatment decision maker makes the decision to consent to or refuse the treatment.

No Proceed to step 3.

Step 3 Is the proposed treatment significant treatment?

Significant treatment means any medical treatment of a patient that involves any of the following:

- a significant degree of bodily intrusion
- a significant risk to the patient
- significant side effects
- significant distress to the patient.

Find Clinical Guidelines about what constitutes significant treatment on the health.vic.gov.au and OPA websites from 12 March 2018.

Yes

Decision is made by the Public Advocate.

To seek a decision by the Public Advocate, health practitioners complete an online form available on the OPA website from 12 March 2018.

No

The health practitioner may provide treatment without consent if it is routine treatment.

Acting in good faith

A health practitioner who, in good faith and without negligence, reasonably believes they have complied with the medical consent process set out in the new Act, is not guilty of an offence or liable for unprofessional conduct or professional misconduct.

Summary of steps for health practitioners

Advance care directive with a relevant instructional directive**?**

Yes

Give effect to relevant instructional directive.

No

Medical treatment decision maker**?**

Yes

Decision is made by the patient's medical treatment decision maker.

No

Routine treatment**?**

Significant treatment**?**

Yes

Decision is made by the Public Advocate.

Yes

May administer treatment without consent.

Other

The new Act also covers:

- The process for health practitioners where the patient is likely to recover within a reasonable time
- When a health practitioner may administer palliative care
- Futile or non-beneficial treatment
- The consent process for medical research procedures.

Notifications to the Public Advocate

A health practitioner must notify the Public Advocate if:

- a patient's medical treatment decision maker **refuses** medical treatment **and**
- the health practitioner reasonably believes that the preferences and values of the patient
  - are not known or
  - are unable to be known or inferred by that medical treatment decision maker.

Note: To notify the Public Advocate, complete an online form available on the OPA website from 12 March 2018.

Part 2: Case Scenarios

ACD in context of ACP

- Future Planning
  - Advance Care Planning (ACP)
    - Advance Care Directives (ACD)

- All future planning is an expression of autonomy, and should be voluntary
- The purpose of planning is to give people options which best meet their needs
- *One* option of ACP is to complete an ACD
- A well informed decision might be to complete an ACD, or not complete an ACD
- Good planning is required for effective writing
- Planning is a process, an ACD is a product/outcome of that process
- It is important to communicate a story in an ACD which reflects your particular and unique circumstances, preferences and values

Writing for an audience

- Witnesses
- Health practitioners
  - health professionals both known to you, and not known to you
  - medical treatment in all sorts of circumstances/environments – emergency, hospital, residential aged care, etc.
- Medical treatment decision maker
  - the MTDM is the person identified to be such at the time a medical treatment decision needs to be made, not necessarily the person you have appointed or the person you presume will be your MTDM
- Support person
  - the support person has an advocacy role, and will most effectively act as an advocate if the ACD is clear and unambiguous
- Family members, other people interested in your welfare
  - what do they need to know
- VCAT
  - VCAT can be asked to make an order about the meaning and effect of an ACD

Scenario 1: Martina

- An ambulance has been called to attend upon Martina following a road accident. Martina is 73 years old and was driving her mobility scooter across the road when she was struck by a car. A bystander who is seated beside Martina when the ambulance arrives explains to the paramedics that she looked in Martina's handbag to see if she had something to indicate her name and discovered a document titled Advance Care Directive. The car driver is in shock and keeps saying "She just deliberately drove into oncoming traffic".
- Martina is unconscious, her left leg looks broken and she has abrasions to her head.

- The instructional directive in the advance care directive reads as follows:
- I have multiple sclerosis. I have been in poor health for some time. I have little quality of life. I cannot tolerate any more suffering. I do not want to live. Under no circumstances do I want to be resuscitated, or intubated or given artificial nutrition and hydration. I refuse categorically such treatment even if it means that I might die. I have communicated these views consistently and persistently to my doctors, to my carers and to my family members.
- (The advance care directive was made 3 months ago).

Scenario 1: Martina

- A health practitioner includes an ambulance operational staff member.
- A health practitioner cannot administer emergency treatment if there is a (readily available) instructional directive which refuses the treatment (s.53(2)).
- A health practitioner may refuse to comply with an instructional directive if they believe on reasonable grounds that circumstances have changed since the person gave the advance care directive so that the practical effect of the instructional directive would no longer be consistent with the person's preferences and values and the delay that would be caused by applying to VCAT for a decision (under s.22) would result in a significant deterioration of the person's condition. (s.51)

- Is the instructional directive relevant to any treatment the paramedics might provide in the circumstances?
- If it is not relevant, what should the paramedics do? If it is relevant, what should the paramedics do?
- Does a health practitioner have to give effect to the refusal of treatment in an instructional directive in the context of a suicide attempt?
- Could Martina have written her instructional directive more clearly? Does the emphatic tone make it clear?

Scenario 2: Loretta

- Loretta has dementia and has been residing in aged care for the past 18 months. She is still able to walk using a walking frame, toilet herself, feed herself and go on outings but needs assistance with showering, dressing, and medication, etc. In general she seems to be of good cheer and participates enthusiastically in activities. Loretta develops pneumonia and her niece, Paula, who is her medical treatment decision maker, is called to make a medical treatment decision about Loretta being administered antibiotics.
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- Eight years ago Loretta completed an advance care directive. The values directive says as follows:
  I observed my beloved partner, Sue, suffer the cruelty and indignity of dementia and live long beyond what she would have wanted. I do not want this for myself. I do not want my life to be a burden to me and to others. If I am demented and develop health conditions from which I might die then my preference would be not to receive medical treatment which might be life-saving; for example resuscitation, tube feeding, antibiotics.
- Paula has not previously sighted this document. She has never discussed medical treatment options with Loretta. She accepted appointment as medical agent for Loretta in 1989 when Loretta was 53 years old and fit and healthy. Paula lived in London between 1996 and 2016 and only had occasional contact with Loretta over these years. She never met Sue.

Scenario 2: Loretta

- Loretta has written an ACD but arguably her ACP has not been comprehensive. When she did the ACD, did she remember that years previously she had appointed Paula her agent (possibly this pre-dated her relationship with Sue)?
- The ACD hints at a story – but the details of it are not known to her MTDM – how does she make of the ACD what Loretta's preferences and values are?
- Can Paula apply Loretta's preferences and values? If not, how does she make her decision?
- Does Paula have to make a decision? If she is not prepared to do so, then who would make the decision?
- Does the values directive help the medical treatment decision maker make her decision? If not, what might have been more helpful?

Scenario 3: Francesca

- You are an advance care planner and meet with Francesca. Francesca tells you the following about herself:

- She is 68 years old. Her husband died last year. She has a son who lives in Bangkok and they skype regularly. She has a daughter who lives a chaotic life – history of drug use, petty crime, dubious boyfriends – and from whom she has reluctantly ceased contact. Her daughter is older than her son. She has a brother, John, who has been a great support.

- Francesca has metastatic stomach cancer. Over the past several years she has had many rounds of chemotherapy and immunotherapy. She might be eligible for medical research trials but her prognosis at this stage is that there is no further active treatment.

- She is not ready to give up on life yet but is a realist.

Scenario 3: Francesca

- Advance care planning considerations and options for Francesca
- Her MTDM would be the first of the following who is available and willing (1) her daughter, (2) her son, (3) her brother
- Francesca should consider appointing a MTDM – unless she is satisfied with the above
- How will her family members deal with any decision making and communication?
- Does she want her daughter to be given information about her health condition?
- What does she want family members to understand about her?
- What does she want health practitioners to understand about her?
- What does she understand of her own decision making process?
- What does it mean that she is a realist?
- What is it about life now that she enjoys, and is meaningful?
- What might make life lose meaning, make life intolerable?
- What does suffering mean for her?
- Does she want to make an ACD?

Scenario 4: Nathan

- Nathan is 23 years old and a cyclist courier. He has been involved with a local Jehovah's Witness temple for the past several months and has just been baptised. He is disappointed that his parents and siblings do not respect his beliefs and lifestyle choices. He is in good health and has no medical conditions. He decides he would like to prepare an advance care directive, with an instructional directive, refusing any type of blood transfusion for any medical purpose whatsoever.

- I refuse blood transfusions for any purpose whatsoever regardless of the reason for the transfusion being recommended. If any health practitioner ignores my clear and unambiguous instructional directive then I request a member of my spiritual community to make a complaint to AHPRA about serious professional misconduct and to make a complaint to the police for the health practitioner to be charged with assault.

Scenario 4: Nathan

- Nathan is trying to make his point clear but do you think the instructional directive is in fact clear and unambiguous?
- Can you imagine any circumstances where it may not be regarded as valid and relevant?
- How is anyone to know about the instructional directive? Where would you advise Nathan to store it, and with whom would you advise that he discuss it?
- On what basis might a health practitioner refuse to comply with this instructional directive?
- If a health practitioner did provide a blood transfusion knowing about the instructional directive, do you think AHPRA and the police would investigate any complaints?
- What are the recording obligations of the health practitioners?
- Would it be advisable for Nathan to consider appointing a MTDM. If he does not appoint someone, who would be his MTDM?

Scenario 5: Bradley

- There is Huntington's disease in Bradley's family. He decides, at age 35, that he will get genetic testing as he and his girlfriend are thinking of starting a family. He tests positive. He has witnessed how this disease has affected his grandmother and his father. He is scared of what lies ahead and wants to manage the possibilities as best he can. He knows he can trust Arlene to be supportive of any decisions he might make but also knows that some of his family members hold different views to his own.
- Bradley decides to:

1. appoint Arlene to be both his support person and his medical treatment decision maker.
2. prepare an advance care directive with a values directive including the following:

Scenario 5: Bradley

- I have lived my life to now in the shadow of knowing that I might develop this disease. However, I determined not to get tested until age 35 on the basis that I did not want a diagnosis to stop me living. I feel I have lived my life to the fullest and hope that there is plenty of good life ahead of me.
- I do not like being dependent upon others for anything. I am very self-reliant. A life of complete dependence upon others is an intolerable prospect to me.
- If I am dependent upon others for activities of daily living then my preference would be to be allowed to die of natural causes; for example not to be treated with antibiotics for pneumonia.
- I do not want to end my days as my Nana did – living in aged care, distressed, confused, agitated or as my father did – in trouble with the police, alienated from family.
- I am aware that as the disease progresses I might form different views to those communicated above. I therefore propose to review this document on an annual basis and confirm that these remain my preferences and values.

Scenario 5: Bradley

Imagine that you are Arlene

- Do you think this would be helpful for her in the future when she might be required to make any medical treatment decisions?
- What else might Bradley include in his advance care directive or what else might he do in relation to advance care planning generally?
- How do you review an ACD if you have lost decision making capacity? Would it be advisable to have an expiry date in the ACD?

Scenario 6: Vlad

- Vlad was diagnosed with motor neurone disease in November 2016. He has immersed himself in medical literature about the likely trajectory of this disease. He has spoken at length with his GP and neurologist. He has spoken with his partner, Stan, about his fears, hopes and values. He is alienated from his parents Denise and Malcolm who do not recognise his relationship with Stan.
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1. He appoints Stan as his medical treatment decision maker to avoid giving his parents the opportunity to contest that Stan is his domestic partner. He also completes an advance care directive.
2. He makes an advance care directive with both an instructional directive and a values directive:

- I refuse the following medical treatment absolutely in all circumstances:
- artificial nutrition or hydration administered via PEG or naso gastric tube and a tracheostomy.

Scenario 6: Vlad

- Values directive
- In relation to medical treatments other than those specified in my instructional directive, I consider that my partner Stan would be best placed to make decisions for me. I know that my condition is terminal. Although I currently value my life I do not want treatments which might prolong my life at the expense of my comfort. I fear many of the likely consequences of the trajectory of my disease – incontinence, loss of verbal communication skills, incontinence, immobility. I recognise, however, that I may adapt better to these consequences than I currently anticipate. If I lose decision making capacity then I trust that Stan will assess my ability to manage these stages of the disease progression and to make medical treatment decisions accordingly. Unlike my parents who hold a firm religious view that life is sacrosanct and all life sustaining treatment should be accepted, I think there are limits. I think it is difficult for me currently to set those limits,
- except for those matters detailed in my instructional directive) but trust Stan to do so, knowing that we will continue to discuss these matters over the coming months/years. I consent to Stan sharing news about my medical condition and any decision he makes with my parents, but I do not consider that my parents can meaningfully contribute to any discussion about what my preferences and values are. I hope ultimately that they can respect my life, and death, choices.

Scenario 6: Vlad

- Do you think Vlad's approach will effectively promote his values and preferences?
- Do you think Vlad's approach will help Stan manage his communication with Denise and Malcolm?
- Do you get a sense of Vlad's story – his circumstances, his preferences and values, his relationship/family issues, his personality, his fears, his hopes, etc. etc.
- Does the ACD have the feel of being a product/outcome of an ACP process?

Scenario 7: Maude

- Maude is 77 years old. She has been widowed for 5 years. Her only son, Angus, has a moderate intellectual disability. Her older sister recently died. She has no other siblings. She has no one to ask to be her medical treatment decision maker and is concerned there will not be anyone to speak for her if she loses decision making capacity. Lately, she has noticed problems with her memory. Otherwise she is in good health.
- Maude completes an advance care directive and includes the following in the section titled instructional directive:
- I do not want to be resuscitated.
- I do not want to be sedated.
- I do not want to go into a nursing home.
- I do not want to be kept alive if I can no longer walk, talk, toilet myself, feed myself.
- I do want to donate organs for transplantation and/or my bodily remains to medical science.

Scenario 7: Maude

- She takes it to her GP to get witnessed

- What is the role of the 2 witnesses?
- Does the GP have a different role to the other witness?
- How might the GP assist Maude?
- Who else might assist Maude?
- Could the ACD be drafted in a way which might more effectively ensure her preferences and values are given effect to?

Scenario 8: Chau

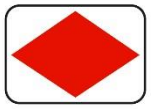
- Chau has had a stroke. A naso-gastric tube was inserted as an emergency procedure. The treating team now recommends the insertion of a PEG feeding tube.
- Prior to the stroke, Chau had completed an advance care directive. Her values directive states:
- "I do not want to be kept alive by machines, and have tubes and needles coming out of me. I could not tolerate life if I could no longer enjoy eating healthy foods, bushwalking, gardening, reading. I do not want to have a long lingering dying process like my brother Ang endured. I fear lack of independence. I am a fiercely independent person. I think doctors sometimes offer treatments when it would be better not to do so. I don't want treatments where the burden of the treatment results in the loss of my independence and functions."
- Chau does not have a medical treatment decision maker and so it is the Public Advocate who is required to make a decision. There is no one with whom the Public Advocate can consult to understand Chau's preferences and values.
- Do you think Chau's ACD will be helpful for OPA in making the decision that Chau would have made if she had the decision making capacity to do so herself?

For more information

- The Medical Treatment Planning and Decisions Act page of www.health.vic.gov.au

- The Office of the Public Advocate
  www.publicadvocate.vic.gov.au

This presentation was developed by the Office of the Public Advocate and the Department of Health and Human Services. It is intended as a general guide only.



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