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| A guide to the Medical Treatment Planning and Decisions Act 2016For health practitioners2nd edition |
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# Introduction

The ***Medical Treatment Planning and Decisions Act 2016***provides a framework for medical treatment decision making for people who do not have the capacity to make their own decisions. This includes allowing people to make decisions in advance, through an advance care directive, about medical treatment they do or do not want in the future, if they do not have decision-making capacity. There is a presumption that people have the capacity to make their own decisions, and medical treatment decisions should only be made on someone else’s behalf when it is demonstrated they do not have the capacity to make those decisions.

The Act recognises that medical treatment should not be provided without informed consent, except in exceptional circumstances. If those unable to provide informed consent do not have a relevant instructional directive providing consent, a health practitioner must obtain informed consent from a medical treatment decision maker. This will help to ensure people obtain medical treatment that is consistent with their preferences and values.

The Act is part of a broader shift towards empowering people to make their own treatment decisions. This includes clear recognition that, wherever possible, people should be supported in making their own decisions.

The Act recognises that when decisions are made on behalf of a person, these decisions should be made in accordance with the person’s preferences and values. Decisions should no longer be made on someone’s behalf based on what is believed to be in the ‘best interests’ of the person. Instead, decisions must focus on what the person would want in the circumstances.

The Act includes a number of principles to help guide decision making.

* People have the right to make informed decisions about their own medical treatment and should be given–, in a sensitively communicated and clear and open manner, information about medical treatment options, including comfort and palliative care, to enable them to make informed decisions.
* A person’s informed decision should be respected and given effect to.
* A person has the right to be shown respect for their culture, beliefs, values and personal characteristics.
* A person’s preferences, values and personal and social wellbeing should direct decisions about the person’s medical treatment.
* A person should be supported to enable them to make decisions about their medical treatment.
	+ A person may exercise autonomy in regard to medical treatment by:
* making decisions
* setting out preferences and values in advance
* appointing a medical treatment decision maker
* appointing a support person
* making collaborative decisions with family or community.
	+ A partnership between a person and the person’s family and carers and health practitioners is important to achieve the best possible outcomes.

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# Medical treatment

The Act applies to ‘medical treatment’ and defines medical treatment as ‘any of the following treatments of a person by a health practitioner for the purposes of diagnosing a physical or mental condition, preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life –

* + 1. treatment with physical or surgical therapy
		2. treatment for mental illness
		3. treatment with –

prescription pharmaceuticals, or

an approved medicinal cannabis product within the meaning of the **Access to Medicinal Cannabis Act 2016**

* + 1. dental treatment
		2. palliative care –

but does not include a medical research procedure’.

Note: the provision of medical research procedures to people without decision making capacity is governed by the Act. This is addressed in the ‘Medical research’ section of this guide.

# Decision-making capacity

The Act provides a four-part test to determine if a person has decision-making capacity. Health practitioners are responsible for obtaining informed consent, and it is up to them to determine whether a person has capacity to make a decision about the medical treatment they are offering.

If a health practitioner cannot determine whether or not a person has capacity to make the decision, the person may be referred for a relevant specialist assessment. If the person does not have decision-making capacity, the health practitioner has not obtained informed consent. Providing medical treatment without informed consent may constitute unprofessional conduct and may be considered an assault.

To have decision-making capacity, a person must be able to:

* + - 1. understand the information relevant to the decision and the effect of the decision
			2. retain that information to the extent necessary to make the decision
			3. use or weigh that information as part of the process of making the decision, and
			4. communicate the decision and the person’s views and needs as to the decision in some way, including by speech, gestures or other means.

An adult is presumed to have decision-making capacity unless there is evidence to the contrary.

The Act recognises that decision-making capacity may vary depending on the decision and the circumstances and that people may have capacity to make some decisions, even if they do not have capacity to make others.

Efforts must also be made to ensure people are provided with practicable and appropriate support to make a decision. People will be deemed to have understood information relevant to the decision if they understand an explanation of the information given in a manner appropriate to their circumstances – for example, through modified language or visual aids.

If a health practitioner determines that a person does not have decision-making capacity, the person may seek a second opinion. An application may also be made to the Victorian Civil and Administrative Tribunal (VCAT) to challenge a finding that a person does or does not have decision-making capacity.

# Advance care directives

A person may only create an advance care directive if they have decision-making capacity in relation to each statement in their advance care directive. This means they must understand the nature and effect of the treatment about which they are making decisions. The advance care directive will only take effect at a time when the person does not have capacity to make a medical treatment decision that needs to be made. Until this time, the person will continue to make their own medical treatment decisions at the time treatment is offered.

There are two forms of statement a person may include in their advance care directive – an instructional directive and a values directive.

* In an instructional directive a person may either consent to or refuse a particular medical treatment. If the person subsequently does not have capacity to make a decision about that treatment, the instructional directive will apply as though the person has consented to or refused the treatment.
	+ In a values directive a person may make more general statements about their preferences and values and what matters to them. If there is not an instructional directive, then the health practitioner will need to obtain consent from a medical treatment decision maker to provide treatment. The medical treatment decision maker must consider a values directive.

An advance care directive cannot contain any statement that would require an unlawful act to be performed or a health practitioner to breach a code of conduct or professional standards. If an advance care directive contains such statements, these statements are void and have no effect, but the remainder of the advance care directive remains valid.

## Making an advance care directive

Any person with decision-making capacity may create an advance care directive, but it must comply with a number of formal requirements. There is no requirement that an advance care directive be in a prescribed form. The Department of Health and Human Services has developed a generic form that a person may use; this is available on the department’s website.

The person must understand the nature and effect of each statement in their advance care directive. This includes an understanding of any treatments referred to and the potential consequences of compliance with the advance care directive. The advance care directive must be witnessed by two adults, one of whom is a medical practitioner. The witnesses must certify that the person:

* appeared to have decision-making capacity in relation to each statement in their advance care directive
* appeared to freely and voluntarily sign the document
* signed the document in the presence of the two witnesses, and
	+ appeared to understand the nature and effect of each statement in their advance care directive.

The role of the medical practitioner in witnessing the document is not to make judgements about the reasonableness of a person’s decision. The medical practitioner’s role is to ensure the person understands the nature and effect of the statements in their advance care directive and the possible implications of including these statements in their advance care directive. The medical practitioner can also help ensure that the advance care directive is consistent and can be applied practically.

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| **Witnessing an advance care directive**An advance care directive must be witnessed by a medical practitioner. The medical practitioner must certify that the person appears to have decision-making capacity in relation to each statement in their advance care directive and that they appeared to understand the nature and effect of each statement. Medical practitioners are required to witness the document because of their professional skills and knowledge. Medical practitioners also have professional obligations to ensure their patients are properly informed. A medical practitioner witnessing an advance care directive should discuss the document with their patient and ensure they understand the implications of the statements made in the document and the potential outcomes if the advance care directive is enacted. |

The advance care directive must be in writing and in English. For clarity and ease of identification, it must include the person’s full name, date of birth and address.

There is no requirement to register an advance care directive, but a person should notify their medical treatment decision maker, family and relevant health practitioners. Health facilities also have an obligation to place a patient’s advance care directive on their medical record.

## Amending or revoking an advance care directive

A person may also amend or revoke their advance care directive. In order to amend or revoke an advance care directive, the person must have decision-making capacity to do so and must comply with the same formal requirements for making an advance care directive. To avoid inconsistency or confusion about versions, an amendment must be made on the face of the original document. A subsequent advance care directive will revoke a previous advance care directive, so a person can only have one valid advance care directive at any one time.

While people may feel the need to amend their advance care directive, an advance care directive will only have effect when the person does not have decision-making capacity. Those with decision-making capacity receiving medical treatment may make decisions that are contrary to their advance care directive and do not need to amend their advance care directive to do so. They may, however, wish to amend their advance care directive in case they subsequently lose decision-making capacity.

## Applying an advance care directive

A health practitioner should turn to an advance care directive only if a person does not have capacity to make a decision. If the person does have decision-making capacity, they must always make the medical treatment decision.

How an advance care directive is applied will depend on whether there is a relevant instructional directive or values directive. An instructional directive must be expressly identified as such. This means that it must contain a heading or some other reference using the words ‘instructional directive’. All other statements in an advance care directive are values directives. If it is unclear how an instructional directive would apply in the circumstances, but it is still indicative of a person’s preferences or values, it must be applied as a values directive.

If there is a relevant instructional directive consenting to the medical treatment, a health practitioner may provide clinically indicated treatment as though the person has capacity and has given informed consent. It is still up to the health practitioner to determine whether treatment is clinically indicated, and the practitioner is under no obligation to provide specific treatment just because a person has consented to it in their advance care directive.

If there is a relevant instructional directive refusing a medical treatment, a health practitioner cannot provide that treatment. A medical treatment decision maker cannot override an instructional directive.

If there is a values directive but no relevant instructional directive, a health practitioner will need to turn to a medical treatment decision maker to make a medical treatment decision before providing treatment. The health practitioner must consider the values directive, but ultimately it is the role of the medical treatment decision maker to interpret the values directive and make a decision.

# Appointed medical treatment decision maker

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## Appointing a medical treatment decision maker

The Act allows a person to appoint a medical treatment decision maker. A medical treatment decision maker will make medical treatment decisions on the person’s behalf if they do not have capacity to make the decision.

The appointment of a medical treatment decision maker must:

* be in writing and in English
* include the full name, date of birth and address of the person appointing the medical treatment decision maker, and
	+ include the full name, date of birth, address and contact details of the medical treatment decision maker.

The appointment must be witnessed by two people, one of whom is an authorised witness. The witnesses must certify that the person:

* appeared to have decision-making capacity in relation to the appointment
* appeared to freely and voluntarily sign the document, and
	+ signed the document in the presence of the two witnesses.

A person may appoint more than one medical treatment decision maker, but there will only ever be one medical treatment decision maker with authority to make a particular decision about a medical treatment. The person must list the medical treatment decision makers in the order in which they would like them to act; the first appointee who is available and willing will be the medical treatment decision maker.

Each appointee must accept their appointment in writing on the same document. This acceptance must include a statement that the appointee:

* understands the obligations of an appointed medical treatment decision maker
* undertakes to act in accordance with any known preferences and values of the person making the appointment
* undertakes to promote the personal and social wellbeing of the person making the appointment, having regard to the person’s individuality, and
* has read and understands any advance care directive that the person has given before, or at the same time as, their appointment.

## Role of a medical treatment decision maker

The role of a medical treatment decision maker is to make medical treatment decisions on behalf of a person who does not have decision-making capacity in relation to a treatment decision that needs to be made. Until this time, an appointed medical treatment decision maker(s) has no role or status. A decision by a medical treatment decision maker has the same effect as if the person had capacity and made the decision themselves.

Once a medical treatment decision maker is required to make a decision, they may access necessary medical records to make a properly informed decision. This is the only circumstance in which a medical treatment decision maker may access a person’s medical records.

# Support person

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## Appointing a support person

The Act introduces the process for formally appointing a support person. The role of a support person is to help a person who has decision-making capacity to make their own decisions. The role will vary depending on the type of support that is required. It is important to note that the formal appointment of a support person will not preclude others from supporting people informally.

Appointing a support person will give the support person automatic access to the person’s medical information. This will allow the support person to compile information or help interpret information.

The appointment of a support person must:

* be in writing and in English
* include the full name, date of birth and address of the person making it, and
	+ include the full name, date of birth, address and contact details of the support person.

The appointment must be witnessed by two adults, one of whom is an authorised witness. The witnesses must certify that the person:

* appeared to have decision-making capacity in relation to the appointment
* appeared to freely and voluntarily sign the document, and
* signed the document in the presence of the two witnesses.

## Role of a support person

The support person’s role is to support a person to make their own decisions and to help ensure these decisions are enacted. What this requires will vary depending on the needs of the person. Some people may simply need information from a range of sources to be collated, while others may need the information to be presented in a way they can understand and may need help communicating their decision.

It is important the support person understands that it is not their role to make medical treatment decisions, but to help ensure the person can make their own decisions. The support person should not try to influence these decisions. If the person does not have decision-making capacity, their medical treatment decision maker must decide.

The support person may play a role in medical treatment decisions if the person does not have decision-making capacity. In these circumstances, the support person’s role will be to advocate for the person and to ensure treatment is provided in accordance with the person’s preferences and values. The support person may also help to coordinate medical treatment. The support person may also continue to collect and collate information to help inform other medical treatment decisions that the person may need to make. The support person and medical treatment decision maker may be the same person.

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| **Support person in practice**The Act is not prescriptive about the role of a support person, and in practice the role may include providing whatever support is needed. A support person may help coordinate care. People often see a range of specialists at different locations and receive different information from each. When a person is unwell, this may be overwhelming. A support person may provide a clear point of contact for specialists and may follow up with specialists to help coordinate care. The medical practitioners can feel comfortable disclosing information because the support person is authorised to access the person’s health information. A support person may also help to present medical information in a way that the person can understand to allow them to continue to make their own decisions. This may include collecting information over a period that the person is particularly unwell and providing it to them at a time when they can fully consider the implications. A support person may help to ensure the person is able to make their own decisions for longer. |

# Medical treatment decision making

A health practitioner must obtain a medical treatment decision before providing medical treatment. If a person has decision-making capacity, they must make the decision. If the person does not have decision-making capacity, the Act provides a process for medical treatment decision making.

If a person does not have decision-making capacity, a health practitioner proposing to administer medical treatment (other than emergency medical treatment) must make reasonable efforts in the circumstances to locate an advance care directive and/or a medical treatment decision maker. The extent of any searches will vary in every situation, but it would be unreasonable to cause delays in treatment that would have a detrimental effect on a person’s health in order to conduct extensive searches. A failure to undertake reasonable searches will constitute unprofessional conduct. This means that a relevant health practitioner board may take disciplinary action against the health practitioner. The appropriate action will be a matter for the board.

## Emergency medical treatment

A health practitioner may administer medical treatment to a person who does not have decision-making capacity without consent if the medical treatment is necessary to:

* save a person’s life
* prevent serious damage to the person’s health, or
	+ prevent the person from suffering or continuing to suffer significant pain or distress.

This recognises that there are times when it would not be possible to obtain consent in time and that the preference in these circumstances is to proceed with treatment.

The Act also recognises, however, that an emergency situation does not justify overriding a person’s known preferences and values. If a person has validly refused treatment, a health practitioner must respect this refusal. A health practitioner should never delay emergency treatment to search for an advance care directive but must comply with an advance care directive that is readily available.

## Medical treatment decisions

A medical treatment decision is a decision to either consent to or refuse medical treatment. The Act establishes a process for medical treatment decision making if a person does not have decision-making capacity. If a person does not have decision-making capacity, but is likely to recover this capacity within a reasonable time, the health practitioner should only proceed through this process if further delay in treatment would cause significant deterioration of the person’s condition. This recognises that, wherever possible, people should make their own medical treatment decisions.

Once a health practitioner determines that a person they are proposing to treat does not have decision-making capacity, they must make reasonable efforts in the circumstances to locate an advance care directive and a medical treatment decision maker. The amount of time spent attempting to locate an advance care directive and/or medical treatment decision maker will depend on how urgently treatment is required.

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| **Reasonable efforts in the circumstances**A health practitioner will be required to make reasonable efforts in the circumstances to locate an advance care directive and medical treatment decision maker. What this requires will depend on the circumstances. It may be reasonable for a health practitioner to:check a patient’s clinical recordask any family or friends presentcontact a medical treatment decision makercontact a next of kin or emergency contact on the patient’s medical recordcontact the person’s GP, orcontact any residential care facility or other health facility the person may have attended. It would never be reasonable to delay medical treatment to locate an advance care directive if this would cause the person’s health to significantly deteriorate. |

If a valid advance care directive is located, a health practitioner must determine whether it contains an instructional directive, a values directive, or both. An instructional directive must be expressly identified as an instructional directive. This means there must be a heading or another statement that a section is intended to apply as an instructional directive. Anything not expressly identified as an instructional directive will be a values directive.

If there is an instructional directive that is relevant to the medical treatment, this may be relied upon as though the person had capacity and was making the decision. This means that:

* If the instructional directive consents to the relevant treatment, the health practitioner may provide clinically indicated treatment.
* If the instructional directive refuses the relevant treatment, the health practitioner must not provide that treatment.

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| **Circumstances have changed**A health practitioner may decide not to comply with an advance care directive if they believe, on reasonable grounds, that circumstances have changed since the person gave the advance care directive and that the practical effect would no longer be consistent with the preferences and values. A health practitioner may make this decision without making an application to VCAT if the person’s condition would deteriorate significantly as a result of the delay an application to VCAT would cause.Some people might make their advance care directive years before it is actually used. It might be that developments in medical technology mean there is a new treatment available for the person’s condition that would not be significantly less onerous than the treatments that existed at the time the person decided to refuse further treatments. It may also apply where the person’s diagnosis or prognosis has changed substantially from the time they made their advance care directive.  |

If there is only a values directive (or the instructional directive is not directly relevant), the health practitioner must turn to the person’s medical treatment decision maker to obtain consent.

At any one time, there will only ever be one medical treatment decision maker. This ensures it is clear who is responsible for making the medical treatment decisions. There is a hierarchy for determining the person’s medical treatment decision maker; the first available and willing person from the list below will be the medical treatment decision maker.

* an appointed medical treatment decision maker
* a guardian appointed by VCAT
* the first of the following with a close and continuing relationship with the person:
	+ - 1. the spouse or domestic partner
			2. the primary carer of the person
			3. the first of the following and, if more than one person fits the description, the oldest of those persons:

an adult child of the person

a parent of the person

an adult sibling of the person.

If a medical treatment decision maker consents to treatment, a health practitioner may proceed with that treatment. If the medical treatment decision maker refuses treatment, a health practitioner cannot provide that treatment.

A medical treatment decision maker may also refuse treatment at any time after it has begun. If the medical treatment decision maker refuses treatment, a health practitioner must withdraw the treatment.

Informed consent from a medical treatment decision maker is required for any new treatment proposed for a person who does not have decision-making capacity. However, this does not mean that a health practitioner must obtain consent separately for every element of a course of treatment. If the health practitioner can explain the nature and effect of the course of treatment and the medical treatment decision maker understands the likely consequences, they can consent to a course of treatment at the beginning of the course. For example, if a medical treatment decision maker consents to a course of antibiotics, they would not need to consent to each dose of the course.

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| **Conflict among family members**Conflict is inevitable in the stressful and upsetting circumstances in which medical treatment decisions often need to be made. No laws will ever fix this. The Act seeks to make unambiguous legal obligations so it is at least clear who has authority to make decisions. The Act recognises that if a person takes time to make an instructional directive and this is relevant, it should be respected even if family members might disagree with the decision. Indeed, many might make an instructional directive chiefly because they recognise that their family will not implement their preferences and values. While previous laws allowed the appointment of multiple substitute decision makers, the Act allows only one medical treatment decision maker for each decision. The medical treatment decision maker should still consult with other family members, but ultimately they are responsible for making the decision and their decision should be respected unless there is some evidence they are acting contrary to the person’s preferences and values. |

## Process for medical treatment decision makers to make decisions

The Act requires a medical treatment decision maker to make the decision they reasonably believe the person would have made if the person had decision-making capacity. The Act includes a process for determining the decision the person would have made, stating that the medical treatment decision maker must:

* first consider any valid and relevant values directive
* next consider any other relevant preferences that the person has expressed and the circumstances in which the preferences were expressed
* in a case where the medical treatment decision maker is unable to identify any relevant preferences, consider the person’s values, whether expressed by the person or inferred from the person’s life.

In making a decision, the medical treatment decision maker must also consider the likely effects and consequences of the medical treatment, including the likely effectiveness, and whether these are consistent with the person’s preferences and values. The medical treatment decision maker must also consider alternative treatment options, including not providing treatment. Given the medical treatment decision maker must either be appointed or have a close and continuing relationship with the person, it is expected they will have an understanding of the person and their values.

If the person’s preferences and values cannot be ascertained, the medical treatment decision maker must make a decision that promotes the person’s personal and social wellbeing, ensuring they respect the person’s individuality. In making this decision, the medical treatment decision maker must also consider the likely effects and consequences of the medical treatment, including the likely effectiveness, and whether these would promote the person’s personal and social wellbeing. The medical treatment decision maker must also consider alternative treatment options, including not providing treatment.

This prescriptive process is designed to help people understand what it means to make a substituted decision. The medical treatment decision maker should not base their decision on what they would want or what they think is best in the circumstances. Their role is to make the decision they believe the person would make. This also requires the medical treatment decision maker to consult with anyone they believe the person would want consulted. The people consulted will not have any power to make decisions, but will help to inform the decisions of the medical treatment decision maker.

If a medical treatment decision maker refuses clinically indicated treatment in circumstances where the person’s preferences and values are not known, the health practitioner must notify the Public Advocate, who will review the reasonableness of this decision. This will only occur in limited circumstances. It is rare that nothing can be discerned about a person’s preferences and values, and in these cases, it would be unusual for a medical treatment decision maker to refuse clinically indicated medical treatment. This safeguard is designed to ensure that, in these unusual circumstances, there is some independent review to protect vulnerable people.

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| **Preferences, values and personal and social wellbeing**The Act requires medical treatment decisions to be made based on what the person would have wanted in the circumstances. This is identified through the new preferences, values and personal and social wellbeing test, which replaces the ‘best interests’ test. While the ‘best interests’ test required a substitute decision maker to consider the person’s wishes, a range of other factors, such as the views of family members, also needed to be considered The preferences, values and personal and social wellbeing test requires that a decision be made based on the person’s preferences and values. If the person’s preferences and values are not known, the medical treatment decision maker must make a decision that will promote the person’s personal and social wellbeing.This new approach focuses on respecting people as individuals and enacting their preferences and values, rather than allowing others to impose their values or understanding of what is best for someone else. |

## Process if there is no advance care directive and no medical treatment decision maker

If a health practitioner makes reasonable efforts in the circumstances to locate an advance care directive and/or a medical treatment decision maker, but is unable to locate either, the Act provides a process for proceeding.

First, a health practitioner must determine whether medical treatment is routine or significant. Significant treatment is any medical treatment that involves any of the following:

* + - 1. a significant degree of bodily intrusion
			2. a significant risk to the person
			3. significant side effects
			4. significant distress to the person.

Routine treatment is any treatment that is not significant treatment. If the medical treatment is routine, a health practitioner may proceed to provide the treatment without consent, noting this decision in the clinical record.

If the treatment is significant treatment, the health practitioner will need to obtain consent from the Public Advocate. The Public Advocate will be required to make a decision through the same process as a medical treatment decision maker.

It should be noted that a health practitioner may proceed with emergency treatment without consent and that this includes treatment that is urgently required to prevent a person from suffering or continuing to suffer significant pain or distress. If a person is suffering pain that is not significant, it is unlikely that the treatment will be significant. In practical terms this means that the health practitioner may provide pain-relieving treatment without consent if there is no medical treatment decision maker or advance care directive available. A health practitioner would, therefore, not usually be required to wait for a decision by the Public Advocate to provide pain-relieving medication.

## Palliative care

The Act defines palliative care as reasonable medical treatment for the relief of pain, suffering and discomfort, and the reasonable provision of food and water. This does not include providing artificial nutrition and hydration via percutaneous endoscopic gastronomy (PEG feeding), which is legally considered to be medical treatment.

The Act provides that a person cannot refuse palliative care in an instructional directive and that a medical treatment decision maker cannot refuse palliative care. A person can, however, include statements about palliative care in their values directive. Health practitioners providing palliative care must ensure the palliative care is consistent with the person’s preferences and values. For example, a person may state in their values directive that at the end of their life it is more important for them to remain lucid than completely pain-free. The medical practitioner would be required to consider appropriate medications and dosages to ensure minimal pain and that the person was able to engage with family and friends as much as possible.

# Dispute resolution

Medical treatment decisions are generally made through a process of consultation with health practitioners, family and friends. However, it is important to note that informed consent to treatment is legally required to come from the person who will receive the treatment or their legally recognised substitute decision maker. If the person receiving treatment has decision-making capacity, they will always be responsible for making this decision. If the person does not have decision-making capacity, their medical treatment decision maker will be responsible for making this decision. This does not mean that others should not provide advice; ultimately, though, there is only one person who will make the decision to consent to or refuse medical treatment.

Through this process of consultation there may be disagreements and, ideally, these will be resolved through ongoing discussions. It is important to note the Act provides that if a person does not have decision-making capacity, the medical treatment decision maker has authority to make a medical treatment decision. If a health practitioner reasonably believes that the medical treatment decision maker is acting in accordance with the person’s preferences, values and personal and social wellbeing, the health practitioner must accept the medical treatment decision maker’s decision. A health practitioner acting in good faith and without negligence will not be liable for a medical treatment decision maker’s decision. A health practitioner may apply to VCAT for an order limiting the authority of a medical treatment decision maker or an order that the person is not the medical treatment decision maker.

If a health practitioner, another family member or friend would like to challenge the decision of the medical treatment decision maker, they may challenge their decision through VCAT. The Act allows an eligible applicant to apply to VCAT. An eligible applicant is any of the following:

* + - 1. a health practitioner who has the care of, or is providing medical treatment to, a person
			2. the medical treatment decision maker of a person
			3. a person’s support person
			4. the Public Advocate, or
			5. any other person whom VCAT is satisfied has a special interest in the affairs of the person concerned.

The decision of a medical treatment decision maker cannot be challenged simply on the basis that another person disagrees with it. There are a number of grounds on which a medical treatment decision maker may be challenged:

* that the person is not actually the medical treatment decision maker (because they have not been properly appointed or because they are not the first person in the list with a close and continuing relationship with the person)
* that the medical treatment decision maker has not appropriately considered a valid advance care directive, or
	+ that the medical treatment decision is not consistent with the person’s preferences, values and personal and social wellbeing.

VCAT may conduct a hearing and receive evidence. VCAT may determine the medical treatment decision maker has not made a decision consistent with the legislative requirements and may set aside the decision. VCAT may also declare that the person is not the medical treatment decision maker. VCAT may then appoint a guardian. If a guardian is not appointed, the next person listed with a close and continuing relationship with the person receiving treatment, who is available and willing, will be the medical treatment decision maker.

# Medical research

The Act also provides a process for obtaining consent to medical research procedures for people without decision-making capacity. The Act does not affect medical research procedures provided to people with decision-making capacity.

A ‘medical research procedure’ that requires consent in accordance with the Act is a procedure carried out for the purposes of medical research, including as part of a clinical trial, the administration of pharmaceuticals or the use of equipment or a device. A medical research procedure does not include:

* any non-intrusive examination including:
* a visual examination of the mouth, throat, nasal cavity, eyes or ears, or
* the measuring of a person’s height, weight or vision
* observing a person’s activities
* undertaking a survey
* collecting or using information, including either of the following:
* personal information within the meaning of the Privacy and Data Protection Act 2014
* health information.

The Act only allows a ‘medical research practitioner’ to perform or supervise a medical research procedure on a person who does not have decision-making capacity. A medical research practitioner must either be a registered medical practitioner or a registered dentist under the Health Practitioner Regulation National Law.

The Act includes a number of requirements for conducting research on people who do not have capacity to consent to participate in the research.

Capacity to consent must be considered in the context of the person’s condition and treatment, as well as the nature of the research project. If the person is likely to recover capacity in a reasonable time to make the decision about whether to consent to the medical research procedure, the medical research practitioner must wait to allow the person to make their own decision.

## Ethics committee approval

A medical research procedure cannot be administered to a person who does not have decision-making capacity in relation to the procedure unless the research project has been approved by the relevant human research ethics committee. Ethics committee approval for medical research is best practice for any medical research. This requirement should not create any additional burden, but in providing approval for the research project, the human research ethics committee must have been aware that the medical research procedure may be performed on people without their consent or the consent of the medical treatment decision maker.

## Consent to a medical research procedure

A medical research practitioner must not administer a medical research procedure to a person who does not have decision-making capacity in relation to the procedure unless consent has been obtained. Consent may be obtained through an instructional directive or from the person’s medical treatment decision maker. The only exceptions to this are:

* in an emergency, or
* if there is:
* no relevant instructional directive, and
* no willing and available medical treatment decision maker.

A medical research practitioner must make reasonable efforts in the circumstances to locate an advance care directive and/or a medical treatment decision maker before administering a medical research procedure to a person without decision-making capacity (unless it is an emergency). What this requires in practice will depend on the circumstances.

If a person has consented to a medical research procedure in an instructional directive, this may constitute consent to the medical research procedure. This is only likely to be applicable in limited circumstances, where the person was informed about the medical research procedure when making the advance care directive. This means the person will need to have been informed about the medical research, and this is likely to be possible only for ongoing research when participants are aware of their potential loss of capacity.

If there is not a relevant instructional directive, a medical research practitioner must turn to the person’s medical treatment decision maker for a decision. The medical treatment decision maker may consent to the administration of a medical research procedure if they reasonably believe the person would have consented to the procedure if they had decision-making capacity.

The Act includes a process for determining the decision the person would have made. The medical treatment decision maker must:

* first, consider any valid and relevant values directive
* next, consider any other relevant preferences that the person has expressed and the circumstances in which the preferences were expressed
	+ also consider if the medical treatment decision maker is unable to identify any relevant preferences, the person’s values, whether expressed by the person, or inferred from the person’s life.

In making a decision, the medical treatment decision maker must also consider the likely effects and consequences of the medical research procedure, including the likely effectiveness, and whether these are consistent with the person’s preferences and values. The medical treatment decision maker must also consider alternative options, including not providing the procedure.

If the person’s preferences and values cannot be ascertained, the medical treatment decision maker must make a decision that promotes the person’s personal and social wellbeing, respecting the person’s individuality. In making this decision, the medical treatment decision maker must also consider the likely effects and consequences of the medical treatment, including the likely effectiveness, and whether these would promote the person’s personal and social wellbeing.

This prescriptive process is designed to help people understand what it means to make a substituted decision. The medical treatment decision maker should not base their decision on what they would want or what they think is best in the circumstances; their role is to make the decision the person would make. This also requires the medical treatment decision maker to consult with anyone they believe the person would want consulted. These people will not have any power to make decisions but will help to inform the decisions of the medical treatment decision maker.

A medical research practitioner must record in writing on the person’s clinical records that the person did not have decision-making capacity in relation to the research procedure and that the person was not likely to recover capacity within a reasonable time, and the reasons for being so satisfied.

## Medical research procedures without consent

If a person without decision-making capacity does not have an advance care directive or a medical treatment decision maker, a medical research practitioner may still administer a medical research procedure, if they comply with the process in the Act. The medical research practitioner must believe, on reasonable grounds, that inclusion in the research project and being the subject of the proposed procedure would not be contrary to:

* any other relevant preferences that the person has expressed, having regard to the circumstances in which those preferences were expressed
* the person’s values, whether expressed by way of a values directive or otherwise, or inferred from the person’s life, and
	+ the personal and social wellbeing of the person, respecting the person’s individuality.

The medical research practitioner must also believe, on reasonable grounds, that the relevant human research ethics committee approved the research project with the knowledge that a person may participate without prior consent of that person or their medical treatment decision maker.

The medical research procedure must also fulfil a number of requirements. The medical research practitioner must believe, on reasonable grounds, that one of the purposes of the research project is to assess the effectiveness of the procedure and that the medical research procedure poses no more of a risk to the person than the risk that is inherent in the person’s condition and alternative medical treatments. The medical research practitioner must also believe, on reasonable grounds, that the research project is based on valid scientific hypotheses that support a reasonable possibility of benefit for the person compared with standard medical treatment.

If the medical research procedure is ongoing, the medical research practitioner must continue to take reasonable steps to identify and contact the person’s medical treatment decision maker and seek consent to continuing the procedure.

A medical research practitioner must sign a certificate before, or as soon as practical, after administering a medical research procedure in accordance with this process. The certificate must certify that the person did not have decision-making capacity in respect of the procedure, that a medical treatment decision maker could not be identified, and that each of the other requirements described above have been met. It must also certify that the person’s medical treatment decision maker will be informed of the procedure if one is subsequently identified, or that if the person recovers decision-making capacity they will be informed of the procedure. The medical research practitioner must forward a copy of the certificate to the Public Advocate and the relevant human research ethics committee within two business days after administering the procedure. If the procedure lasts longer than 30 days, the medical research practitioner must sign a certificate every 30 days and forward a copy of each certificate to the Public Advocate and the relevant human research ethics committee at intervals of no longer than 30 days.

It is an offence for medical research practitioners to sign a certificate they know to be false.

It is also an offence for medical research practitioners to administer a medical research procedure to a person who does not have decision-making capacity to make a decision about the procedure if it has not been approved by the relevant human research ethics committee.

It is also an offence for a medical research practitioner to administer a medical research procedure to a person who does not have decision-making capacity without consent or authorisation under the Act, unless it is an emergency.

## Medical research procedures in an emergency

In the case of an emergency, a medical research procedure may be administered to a person who does not have decision-making capacity without that person’s consent. The medical research practitioner must believe, on reasonable grounds, that the medical research procedure is necessary, as a matter of urgency, to:

* + - 1. save the person’s life
			2. prevent serious damage to the person’s health, or
			3. prevent the person from suffering or continuing to suffer significant pain or distress.

A medical research practitioner cannot provide a medical research procedure just because it is an emergency, if they are aware that the person has refused the particular medical research procedure in an instructional directive or through another legally valid and informed refusal of treatment.

The relevant research project under which the medical research practitioner is providing the emergency medical research procedure must have received prior approval from the relevant human research ethics committee.

It is not intended that the emergency medical research procedure provisions will be widely used. Instead, they are aimed at medical research into the efficacy of emergency treatments, when it would not ordinarily be possible to obtain consent to the necessary treatments. For example, research may be conducted to compare two emergency medical treatments when there is believed to be clinical equipoise. Once the procedures are randomised, they will become medical research procedures but will still be necessary, as a matter of urgency, to save the person’s life. In this case, the medical research procedure could be provided without consent, as long as the person had not previously refused the particular procedure.

# Previous appointments and documents

If a person has appointed a medical enduring power of attorney before the Act commenced on 12 March 2018, this appointment is still recognised under the Act. There is no need to re-do any legal documents appointing a medical enduring power of attorney made before 12 March 2018. The Act also recognises supportive attorney appointments made prior to 12 March 2018.

# Interstate appointments and documents

The Act recognises that advance care directives (or the equivalent document) validly made in another Australian state or territory should be recognised in Victoria. An interstate advance care directive will be taken to be a values directive and must be given effect in the same way as a values directive in Victoria.

Interstate advance care directives are limited to values directives because of the different laws and requirements in other jurisdictions. Some jurisdictions limit what a person may include in (the equivalent of) an instructional directive, and it would not be appropriate to require health practitioners to have an understanding of the laws in each jurisdiction and the intended effect of an advance care directive from another jurisdiction. Recognising interstate advance care directives as values directives ensures medical treatment decisions will always be made in accordance with the person’s preferences and values, without giving the advance care directive greater legal effect than the person intended.

Valid interstate appointments of substitute decision makers for medical treatment decisions will be recognised as appointed medical treatment decision makers.

# Criminal offences

The Act creates a number of criminal offences to protect people who may be vulnerable to abuse.

The creation of an advance care directive may have serious consequences, including death. Pushing or inducing a person to make an advance care directive will be a serious offence.

An advance care directive that is created as a result of dishonesty or undue influence will be void and of no effect.

A person must not, by dishonesty or undue influence, induce another person to create an advance care directive.

A person also must not knowingly make a false or misleading statement in relation to another person’s advance care directive or make a false or misleading statement about another person attempting to give an advance care directive.

Advance care directives may be open to interpretation, and an unscrupulous person may deliberately encourage others to misinterpret an advance care directive and act contrary to the preferences and values of the person receiving treatment. The offence will only apply to those who make knowingly false or misleading statements. A person must not purport to act as an appointed medical treatment decision maker or a support person.

A medical treatment decision maker will have the power to make extremely important decisions about a person’s medical treatment, and both a medical treatment decision maker and support person will have access to private medical records. These offences will only apply to those who deliberately purport to act as a medical treatment decision maker or support person, and not those who make an honest and reasonable mistake.

A person must not, by dishonesty or undue influence, induce another person to appoint a medical treatment decision maker.

A medical treatment decision maker will have significant powers, and pushing or inducing someone to appoint another could have very serious consequences. An appointment that is created as a result of dishonesty or undue influence will be void and of no effect.

All of these offences carry a maximum penalty of 600 penalty units or five years’ imprisonment, or both.

# Interaction with the Mental Health Act 2014

The *Mental Health Act 2014* provides for the assessment and treatment of mental illness. Treatment for mental illness is a form of medical treatment, and the vast majority of people receive treatment for their mental illness under the same laws as any other medical treatment. The Medical Treatment Planning and Decisions Actapplies to any treatment for a mental illness for a person without decision-making capacity, who is not receiving treatment under the Mental Health Act. Those receiving treatment under the Mental Health Act will be able to make an advance statement and appoint a nominated person in relation to the treatment they receive under that Act. For any other treatment not provided under the Mental Health Act, including other treatment for a mental illness, people will be able to make an advance care directive and appoint a medical treatment decision maker and support person.

# Electroconvulsive treatment

The Medical Treatment Planning and Decisions Act amends the Mental Health Actto clarify the process for consenting to electroconvulsive treatment for a person, who is not a patient within the meaning of the Mental Health Act and who does not have decision-making capacity. Electroconvulsive treatment may only be provided to a person without capacity, if this has been approved by the Mental Health Tribunal. (The requirements for consent regarding a *patient* within the meaning of the Mental Health Act are slightly different – it is not possible for a medical treatment decision maker to consent to electroconvulsive treatment on behalf of a *patient* who does not have capacity.)

A psychiatrist may apply to the Mental Health Tribunal to provide electroconvulsive treatment to a person who does not have decision-making capacity in relation to that treatment. In order to make an application, the psychiatrist must be satisfied that in the circumstances there is no less restrictive way for the person to be treated and either:

* the person has an instructional directive giving informed consent to electroconvulsive treatment, or
	+ if the person does not have a relevant instructional directive, the person’s medical treatment decision maker gives informed consent in writing to the electroconvulsive treatment.

In determining whether there is no less restrictive way for the person to be treated, the psychiatrist must, to the extent that it is reasonable in the circumstances, respect:

* the views and preferences of the person in relation to electroconvulsive treatment and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes the person would like to achieve
* any values directive of the person
* the views of the person’s medical treatment decision maker or support person (if any)
* the views of a person’s carer, if the psychiatrist is satisfied that the decision to perform a course of electroconvulsive treatment will directly affect the carer and the care relationship
* the likely consequences for the person, if the electroconvulsive treatment is not performed
	+ any psychiatric opinion given by another psychiatrist that has been given to the psychiatrist making the application.

The Mental Health Tribunal must grant the application if they are satisfied that:

* the person does not have decision-making capacity to give informed consent to the performance of electroconvulsive treatment
* there is no less restrictive way for the person to be treated, and
	+ either the person has given informed consent in their instructional directive or the person’s medical treatment decision maker has given informed consent in writing.

If the Mental Health Tribunal is not satisfied that any one of these criteria is fulfilled, it must refuse to grant the application.

Even if the Mental Health Tribunal approves the treatment, electroconvulsive treatment cannot be performed if, at any time before or during the course of electroconvulsive treatment, the person develops capacity to give informed consent and does not consent to the treatment. The person’s medical treatment decision maker, who originally gave consent, may also withdraw consent at any time.

# More information

A copy of the Act is available on the [Victorian Legislation and Parliamentary Documents](http://www.legislation.vic.gov.au/) website <http://www.legislation.vic.gov.au/>.

A summary of the information in this guide is available on the [health.vic website](http://www.health.vic.gov.au/acp) <http://www.health.vic.gov.au/acp>.

Notes

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