Advance Care Planning: Have the conversation

Results of a survey of doctor’s knowledge

Australian Medical Association Victoria and the Department of Health and Human Services Victoria
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Introduction

In December 2015 the Australian Medical Association Victoria and the Department of Health and Human Services commissioned a survey to gain a better understanding of doctor’s knowledge of current legislation relating to advance care planning and end of life decision making in Victoria.

Although the results from the survey are not statistically significant they provide valuable insight into the level of doctors’ knowledge of end of life care issues.

Profile of survey respondents

The survey was distributed to all Victorian doctors. Between 21 December 2015 and 25 January 2016 a total of 389 doctors completed the survey.

Doctors were asked three initial questions designed to gauge what type of medical practice they were predominantly involved in.

The majority of respondents were Non-General Practitioner Specialists (29.2%), Doctors in Training (24.81%) and Full time Salaried Specialists (24.55%). General Practitioners (15.25%) and Emergency Physicians (6.2%) made up the remainder of respondents.

The majority of doctors worked in the public system with 72.58% identifying this as their main area of work.

To more accurately gauge the reach of the survey across the medical profession respondents were asked to list the craft group (the type of medicine they practice) they belonged to. Respondents identified themselves as coming from the following craft groups:

- Emergency medicine
- Surgery – multiple types
- Palliative care
- Anaesthetics
- Trainees – multiple types
- Nephrology
- Pathology
- Obstetrics and Gynaecology
- Medical Administration
- Rehabilitation
- Endocrinology
- Psychiatry
- Oncology
- Haematology
- Physicians
- General Practice
- Cardiology
- Radiology
- Ear, Nose and Throat
- Ophthalmology
- Pain Specialists
- Neurology
- Geriatric medicine
- Urology
- Intensive care
- Rural medicine
- Gastroenterology
- Public Health
- Pathology

The broad scope of craft groups listed indicates substantial reach across the medical profession and that also indicates that doctors from all areas of practice have a role to play, and an interest in, advance care planning and end of life decision making.
Survey Responses

Self-assessment of knowledge

In Question 4 doctors were asked:

“How would you rate your knowledge of current Victorian legislation relating to consent and medical treatment decision making and end of life care?”

Figure 1: Question 4 responses

![Bar chart showing self-assessed knowledge responses]

Figure 1 shows an array of self-assessed knowledge with 35% of respondents believing they had only poor to basic knowledge and only 6.42% believing they had an excellent level of knowledge.

This indicates that there are substantial improvements to be made in the provision of education and information to doctors on the laws regulating this area of medicine.

Treatment scenarios

The survey then posed a series of ten questions which asked doctors to select which treatment path they would follow in the described scenario. Questions related to Refusal of Treatment Certificates, consent, the role of the enduring attorney (medical treatment), the legal status of advance care plans and the provision of palliative care.
Survey Question 5 posed the following scenario:

“An elderly person is brought into an emergency department unconscious and requiring CPR. The person was admitted to the hospital one week earlier and completed a valid Refusal of Treatment Certificate, stating that they would not want CPR in these circumstances. The person’s child travelled to the hospital with them and is demanding that CPR be performed. What is an appropriate course of action?”

(a) perform CPR, consistent with the demands of the child.
(b) not perform CPR, consistent with the refusal of treatment certificate.
(c) perform CPR but apply to the Victorian Civil and Administrative Tribunal, as there is a dispute that needs to be resolved for future decision making.
(d) not perform CPR and provide notice to the Office of the Public Advocate to advise them of this decision.

Answer:

Option B – not perform CPR consistent with the Refusal of Treatment Certificate.

Rationale

It is an offence of medical trespass to provide treatment knowing that a valid Refusal of Treatment Certificate applies.

Figure 2: Question 5 responses
Summary

There were 365 total responses with 24 respondents choosing to skip this question.

Of those that responded 61.4% correctly chose to not perform CPR, which is consistent with the current law in relation to Refusal of Treatment Certificates.

Those respondents who selected option A or Option C, to perform CPR, would have been committing medical trespass by ignoring the valid Refusal of Treatment Certificate.

Question 6

Survey Question 6 posed the following scenario:

* A patient is unconscious and treatment X is clinically indicated. The patient’s wife and son are present at the hospital. The wife states that she will not consent to the treatment on behalf of the patient. The son indicates that he will. Can treatment X be provided?

   (a) Yes, the treatment is clinically appropriate.

   (b) No, the wife has refused treatment.

   (c) Yes, the treatment can be provided because the son has consented.

   (d) Yes, the treatment can be provided if the doctor gives notice to the Office of the Public Advocate.

Answer:

Option D – Yes, the treatment can be provided if the doctor gives notice to the Office of the Public Advocate.

Rationale

To provide treatment a medical professional must receive consent. If there is no appointed substitute decision maker, a medical professional must turn to a ‘person responsible’, who will be the first available and willing person listed in section 37 of the Guardianship and Administration Act 1986. In this case, the patient’s wife would be their ‘person responsible’. As the patient’s wife withheld consent, there is no consent and treatment cannot be provided. The Guardianship and Administration Act 1986 provides that treatment can be provided if a person responsible does not consent and the medical professional reasonably believes the treatment is in the patient’s best interests if the medical professional provides notice of their intention to proceed to the person responsible and the Public Advocate. Before providing treatment the medical professional must allow sufficient time for the person responsible to apply to the Victorian Civil and Administrative Tribunal.
Summary

There were 359 responses with 30 doctors choosing to skip this question.

Of those who responded only 31.2% correctly identified that the treatment could be provided if the doctor gives notice to the Office of the Public Advocate (OPA).

The low correct response indicates that, amongst survey respondents, there is a high level of uncertainty regarding consent when a patient is not capable of providing that consent themselves and there is no enduring attorney (medical treatment) appointed.

Question 7

Survey Question 7 posed the following scenario:

*A patient no longer has decision making capacity but previously appointed an enduring attorney (medical treatment). The patient now requires treatment Y. If treatment Y is not provided, the patient will die. The enduring attorney states that the patient would never have wanted treatment Y and so they do not think it should be provided. What is an appropriate course of action?*

(a) provide treatment Y, it is clinically appropriate and if the patient dies the doctor may be liable.

(b) not provide treatment Y, the enduring attorney (medical treatment) has refused treatment.

(c) seek consent to perform treatment Y from another member of the patient’s family.
(d) provide treatment Y and give notice to the Office of the Public Advocate that treatment was performed.

Answer:

Option B – Not provide treatment Y, the enduring attorney (medical treatment) has refused treatment.

Rationale

The Medical Treatment Act 1988 allows an enduring attorney (medical treatment) to refuse treatment if the medical treatment would cause unreasonable distress to the patient or there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.

Figure 4: Question 7 responses

Summary

There were 353 responses with 36 respondents choosing to skip this question.

Of those that responded 94.05% correctly chose to not provide treatment in accordance with the decision of the enduring attorney (medical treatment). This indicates that the respondents had a high level of knowledge regarding the role of the enduring attorney (medical treatment) where one has been appointed.
Question 8

Survey Question 8 posed the following scenario:

A patient who is no longer competent has prepared an advance care directive. The patient has also appointed an enduring attorney (medical treatment). The advance care directive describes the patient’s views and values and describes the circumstances in which the patient would not want further medical treatment. Under what circumstances should treatment be provided?

(a) a doctor may rely on the advance care directives and determine appropriate treatment in accordance with this.

(b) the advance care directive has no legal effect and should be disregarded, the enduring attorney must make treatment decisions.

(c) the doctor must consult with the enduring attorney, but ultimately must provide treatment that is consistent with the advance care directive.

(d) the enduring attorney must consider the wishes of the patient expressed in the advance care directive and the enduring attorney must consent to treatment.

Answer:

Option D – The enduring attorney must consider the wishes of the patient expressed in the advance care directive and the enduring attorney must consent to treatment.

Rationale

In Victoria the legal status of advance care directives is unclear. A medical professional must receive consent to provide treatment and if an enduring attorney (medical treatment) has been appointed, the medical professional must turn to them if the patient no longer has capacity. An enduring attorney must make decisions consistent with the wishes of the patient. Although the legal status of an advance care directive is unclear, it is clearly an expression of the patient’s wishes and should be considered by an enduring attorney.
Summary

There were 346 responses with 43 respondents choosing to skip the question.

Of those that responded only half correctly identified that the enduring attorney must consider the wishes of the patient expressed in the advance care directive and must consent to treatment.

The high number of incorrect responses, particularly those indicating that the advance care directive should be followed, indicates a lack of knowledge amongst respondents regarding the current legal status of advance care directives.

Question 9

Survey Question 9 asked the following question:

*If there is no appointed substitute decision maker, who can consent to treatment on a patient’s behalf?*

a) the patient’s next of kin

b) any family or friend at the hospital

c) the highest ranked person on the ‘Person Responsible’ list that is available and willing to make decisions

d) no one, an order would need to be sought from VCAT
Answer:

Option C – The highest ranked person on the ‘Person Responsible’ list that is available and willing to make decisions

Rationale

Section 37 of the Guardianship and Administration Act 1986 provides a list of potential ‘persons responsible’. A medical professional must receive the consent of the highest ranked person on the list who is available and willing to make a decision.

Figure 6: Question 9 responses

Summary

There were 345 responses with 44 doctors choosing to skip the question.

Of those that responded 55.65% correctly identified that in the absence of an appointed substitute decision maker the highest ranked person on the person responsible hierarchy can provide consent.

The low correct response rate indicates that there is uncertainty amongst respondents about who is able to make decisions for a patient and that the ‘next of kin’ may not be the most appropriate person.

Question 10

Survey Question 10 asked the following question:

Who can refuse treatment on behalf of a non-competent patient?

a) their Enduring Power of Attorney (Medical Treatment)
b) the ‘person responsible’ if there is no EPOA (Medical Treatment)

c) A referral would have to be made to VCAT

d) the patient’s doctor can refuse treatment on their behalf

Answer:

Option A – Their enduring Power of Attorney (Medical Treatment)

Rationale

The Medical Treatment Act 1988 provides that an enduring attorney (medical treatment) may refuse medical treatment. A ‘person responsible’ can withhold consent, but they cannot refuse treatment. As discussed above, medical treatment cannot be provided without consent unless the procedure in sections 42L and 42M of the Guardianship and Administration Act 1986 are complied with.

Figure 7: Question 10 responses

Summary

There were 344 responses with 45 doctors choosing to skip the question.

Of those that responded 82.56% correctly identified that only an enduring attorney (medical treatment) can refuse treatment on behalf of a non-competent patient.
Question 11

Survey Question 11 asked the following question:

*What legal status does an advance care directive have in Victoria?*

- a) an advance care directive has no legal status
- b) an advance care directive is a legal document that must be complied with
- c) an advance care directive is binding on enduring attorneys (medical treatment) and guardians
- d) the status of an advance care directive is unclear

**Answer:**

Option D – The status of an advance care directive is unclear

**Rationale**

No Victorian legislation recognises advance care directives. Despite this, some legislation requires substitute decision makers to consider the wishes of patients and advance care directives are a clear statement of a patient’s wishes. Further, the New South Wales Supreme Court found that advance care directives have legal effect and should be complied with. This decision does not apply in Victoria and the Victorian Supreme Court has not considered the matter, but may follow the New South Wales Supreme Court if the matter was considered.

**Figure 8: Question 11 responses**

![Bar chart showing responses]

**Summary**

There were 343 responses with 46 doctors choosing to skip the question.
Of those that responded 51.6% correctly identified that the status of an advance care directive is unclear.

The low correct response rate likely reflects a high level of uncertainty and confusion regarding the legal status of an advance care directive amongst respondents.

Question 12

Question 12 posed the following scenario:

An elderly man with end stage chronic obstructive pulmonary disease who has completed a valid refusal of treatment certificate for intubation collapses in the park. Paramedics are not aware of his refusal of treatment certificate and intubate him and take him to the emergency department. At the emergency department his refusal of treatment certificate is located. What should be done now?

a) extubate the man and assess his progress post-extubation
b) attempt to contact a family member to ask what to do
c) continue the current treatment
d) continue the treatment and provide notice to the Office of the Public Advocate

Answer:

Option A – Extubate the man and assess his progress post-extubation

Rationale

As discussed above, a valid refusal of treatment certificate must be complied with. A refusal of treatment certificate may require that treatment is withheld, but also that treatment be withdrawn.

Figure 9: Question 12 responses
Summary

There were 341 responses with 48 doctors choosing to skip the question.

Of those that responded only 51% correctly chose to extubate the man in accordance with his valid Refusal of Treatment Certificate. 35% of respondents elected to continue the treatment against the Refusal of Treatment Certificate which would be classified as medical trespass.

Question 13

Question 13 posed the following scenario:

A general practitioner is called to an aged care facility to assess a resident who is having trouble breathing. Whilst there, the resident collapses and requires CPR to stay alive. Staff at the facility indicate that they are not aware of the resident’s wishes. How should the doctor proceed?

a) attempt to contact someone to consent to medical treatment, CPR cannot be provided without consent

b) provide CPR if a staff member at the aged care facility consents

c) provide no treatment and wait for paramedics to arrive

d) proceed with life sustaining treatment even though there is no consent

Answer:

Option D – Proceed with life-sustaining treatment even though there is no consent.

Rationale

In an emergency, a medical professional can provide treatment without consent if this is necessary as a matter of urgency to save the patient’s life.
Summary

There were 339 responses with 50 doctors choosing to skip the question. Of those that responded 97% correctly chose to proceed with life sustaining treatment despite not being able to get consent.

Question 14

Question 14 posed the following scenario:

*A patient is suffering from bowel cancer and further treatment for the cancer would be futile. The patient is no longer competent and the patient’s spouse withholds consent to palliative care. Can palliative care be provided?*

- a) yes, pain relieving treatment is necessary and the patient should not be denied this
- b) no, the person responsible has refused treatment
- c) yes, palliative care is not medical treatment and consent is not required
- d) yes, the doctor can proceed with treatment if they provide notice to the Office of the Public Advocate.
Answer:
Option D – Yes, the doctor can proceed with treatment if they provide notice to the Office of the Public Advocate.

Rationale
The Medical Treatment Act 1988 excludes palliative care from the definition of medical treatment, and so palliative care cannot be refused under that Act. Palliative care is not excluded from the definition of medical treatment under the Guardianship and Administration Act 1986 though. Although palliative care cannot be refused for a patient who is not competent, consent is still required to provide palliative care. If consent is not provided by a person responsible, a medical professional may proceed if notice is given to the Public Advocate and the person responsible does not appeal to the Victorian Civil and Administrative Tribunal.

Figure 11: Question 14 responses

Summary
There were 338 responses with 51 doctors choosing to skip the question.

Of those that responded 76.92% chose to provide pain relieving treatment. However, only 22.19% correctly identified that, due to the patient’s spouse refusing treatment, they must provide notice to the Office of the Public Advocate.

The significant variation in responses reflects the uncertainty of respondents as to the definition of medical treatment due to inconsistent definitions across the two Acts.
Summary/Conclusions

The survey reflects a basic level of knowledge on advance care directives and end of life decision making amongst respondents highlighting some significant gaps in knowledge.

The responses showed that where the situation was clear-cut, such as when there is an enduring attorney (medical treatment) appointed, respondents tended to choose the correct treatment path.

The low correct response rate for many questions, particularly in more complex situations, suggests a significant lack of certainty amongst respondents regarding the current laws relating to advance care directives and end of life decision making.

That no respondents were able to correctly answer all 10 questions indicates a lack of clarity in the law and highlights the need for new legislation that will simplify and clarify the laws regulating this area.
Appendix – Further data analysis
Appendix 1: Correct responses

Table 1 summarises the number of respondents who selected the correct response to questions 5 to 14.

Table 2 lays out the average correct response by profession alongside the lowest (Lower) score and highest (Upper) score. The Upper limit of each profession shows that there were no respondents who were able to correctly answer all ten questions.

Figure 12 provides a visual representation of the data provided in Table 2.

Table 1: Number of Correct Responses to Survey Questions 5 to 14 by profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total no. completing survey</th>
<th>Question 5</th>
<th>Question 6</th>
<th>Question 7</th>
<th>Question 8</th>
<th>Question 9</th>
<th>Question 10</th>
<th>Question 11</th>
<th>Question 12</th>
<th>Question 13</th>
<th>Question 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>59</td>
<td>28</td>
<td>20</td>
<td>46</td>
<td>17</td>
<td>18</td>
<td>44</td>
<td>25</td>
<td>23</td>
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<td>10</td>
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<tr>
<td>Non GP Specialist</td>
<td>113</td>
<td>63</td>
<td>36</td>
<td>98</td>
<td>50</td>
<td>53</td>
<td>93</td>
<td>59</td>
<td>54</td>
<td>100</td>
<td>26</td>
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<tr>
<td>Full Time Salaried Specialist</td>
<td>95</td>
<td>63</td>
<td>20</td>
<td>85</td>
<td>41</td>
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<td>65</td>
<td>47</td>
<td>47</td>
<td>83</td>
<td>12</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>24</td>
<td>16</td>
<td>5</td>
<td>21</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>11</td>
<td>9</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>96</td>
<td>53</td>
<td>31</td>
<td>82</td>
<td>54</td>
<td>61</td>
<td>69</td>
<td>35</td>
<td>41</td>
<td>81</td>
<td>22</td>
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Table 2: Average Correct Responses to Survey Questions 5 to 14

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<th></th>
<th>All respondents</th>
<th>GPs</th>
<th>Non GP Specialist</th>
<th>Full Time Salaried Specialist</th>
<th>Emergency Physicians</th>
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<tbody>
<tr>
<td>Mean (average) correct responses</td>
<td>6</td>
<td>5</td>
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<td>5</td>
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</tr>
<tr>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Upper</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
Figure 12: Average correct response compared to upper and lower range, by profession.
Appendix 2: Self-rated knowledge – all respondents

Table 3 outlines the number and percentage of respondents, by profession, by their level of self-rated knowledge with Figure 13 providing a visual representation of this data.

These graphs show that the spread of self-rated knowledge between each profession is generally consistent with the majority of respondents selecting “basic”, “good” or “very good”.

Table 3 also shows the average score (Av. Scr.) achieved by each profession and by self-rated knowledge.

This data is further analysed in the following sections.

Table 3: Self rated knowledge by profession

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Total respondents</td>
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<td>4.13</td>
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<td>135</td>
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<td>22.22</td>
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<td>24</td>
<td>6.20</td>
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<td>GP</td>
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<td>Non GP Specialist</td>
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<td>Full Time Salaried Specialist</td>
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<td>11.98</td>
<td>7</td>
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<tr>
<td>Emergency Physicians</td>
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<td>4</td>
<td>36</td>
<td>36.46</td>
<td>6</td>
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<td>2</td>
<td>2.08</td>
<td>7</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>4</td>
<td>4.17</td>
<td>6</td>
<td>35</td>
<td>36.46</td>
<td>6</td>
<td>35</td>
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<td>16.67</td>
<td>6</td>
<td>2</td>
<td>2.08</td>
<td>7</td>
</tr>
</tbody>
</table>

Figure 13: % of Self-rated level of knowledge by profession
Table 4 (represented graphically in Figure 14) shows that while many GPs rated their knowledge as Good (38.98%) or Very Good (20.34%) the average score across the Basic, Good and Very Good categories was the same, being 5 out of 10.

Table 4 also shows that those who rated their knowledge as Poor or Excellent had the same average score of 3 out of 10 correct answers.

This indicates that amongst the general practitioner respondents the self-assessed level of knowledge is not an accurate reflection of actual level of knowledge.
Appendix 4: Non-General Practitioner Specialist respondents

Table 5 and Figure 15 show that the majority of non-general practitioner specialists rate their knowledge as Basic (32.74%), Good (27.43%) or Very Good (23.89%).

The average score for those assessing their knowledge as Poor or Basic was 5 out of 10. The average score for those assessing their knowledge as Good, Very Good or Excellent was 6 out of 10.

The low average score and small difference between the lower knowledge level and high knowledge level categories indicates that the self-assessed level of knowledge amongst non-general practitioner specialist respondents is not an accurate reflection of their actual level of knowledge.

Table 5: Self rated knowledge of Non General Practitioner Specialists and average score

<table>
<thead>
<tr>
<th>Self-Rated Knowledge -Non General Practitioner Specialists</th>
<th>Poor</th>
<th>Basic</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Unrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>5.31%</td>
<td>5</td>
<td>37</td>
<td>32.74%</td>
<td>5</td>
<td>31</td>
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</tbody>
</table>

Figure 15: Self rated knowledge of Non General Practitioner Specialists and average score
Appendix 5: Full Time Salaried Specialist

Table 6 and Figure 16 show that the majority of Full Time Salaried Specialists who responded to the survey assessed their knowledge as Good (36.84%) or Very Good (27.37%).

The average scores of full time salaried specialist’s respondents tended to increase with a higher knowledge rating. The average score of those in the Poor category was 4 out of 10, the Basic and Good categories was 5 out of 10, the Very Good category was 6 out of 10 and the Excellent category was 7 out of 10.

These scores do not accurately reflect the self-assessed level of knowledge by full time salaried specialist respondents but, the higher correlation between the assessed level of knowledge and average score do show that this group of respondents had a better understanding of their level of knowledge.

Table 6: Self rated knowledge of Full Time Salaried Specialists and average score

<table>
<thead>
<tr>
<th>Self-Rated Knowledge - Full Time Salaried Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
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<td>3</td>
</tr>
</tbody>
</table>

Figure 16: Self rated knowledge of Full Time Salaried Specialists and average score
Appendix 6: Emergency Physician Respondents

Table 7 and Figure 17 show that the majority of emergency physician respondents rated their level of knowledge as Good (45.83%), Basic (25%) or Very Good (20.83%).

The average score in each knowledge category for emergency physician respondents tended to decrease with a higher knowledge category across the Basic, Good and Very Good Categories. Those rating their level of knowledge as Basic or Excellent had the same average score of 6 out 10.

These figures indicate that the self-assessed level of knowledge among emergency physician respondents is not an accurate reflection of the actual level of knowledge.

Table 7: Self rated knowledge of Emergency Physicians and average score

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Basic</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Unrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>0</td>
<td>6</td>
<td>11</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>%</td>
<td>0.00%</td>
<td>25.00%</td>
<td>45.83%</td>
<td>20.83%</td>
<td>8.33%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Average Score</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 17: Self rated knowledge of Emergency Physicians and average score
Appendix 7: Doctors in Training respondents

Table 8 and Figure 18 show that the majority of Doctors in Training assessed their level of knowledge as Basic (36.46%) or Good (36.46%).

The average score was consistent across all levels of knowledge with the exception of the Excellent group. The average score in the Poor to Very Good groups was 6, with the Average Score in the Excellent group 7 out of 10.

As outlined in Table 3, this group of doctors also had the most consistent and highest average score of all the professions who responded to the survey.

These responses indicates that among the Doctors in Training respondents the self-assessed level of knowledge was more reflective of the average level of actual level knowledge than in other groups.

**Table 8: Self rated knowledge of Doctors in Training and average score**

<table>
<thead>
<tr>
<th>Self-Rated Knowledge - Doctors in Training</th>
<th>Poor</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>4</td>
<td>4.17%</td>
<td>6</td>
<td>35</td>
<td>36.46%</td>
<td>6</td>
<td>35</td>
<td>36.46%</td>
<td>6</td>
<td>16</td>
<td>16.67%</td>
<td>6</td>
</tr>
<tr>
<td>Basic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 18: Self rated knowledge of Doctors in Training and average score**
Appendix 8: Incorrect Responses
Survey Question 5 posed the following scenario:

"An elderly person is brought into an emergency department unconscious and requiring CPR. The person was admitted to the hospital one week earlier and completed a valid Refusal of Treatment Certificate, stating that they would not want CPR in these circumstances. The person’s child travelled to the hospital with them and is demanding that CPR be performed. What is an appropriate course of action?"

Table 9: Number and percentage of answers to Question 5, by profession

<table>
<thead>
<tr>
<th>Question 5</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>GP</td>
<td>3</td>
<td>5.08%</td>
<td>28</td>
<td>47.46%</td>
<td>8</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>7</td>
<td>6.19%</td>
<td>65</td>
<td>57.52%</td>
<td>17</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>1</td>
<td>1.05%</td>
<td>63</td>
<td>66.32%</td>
<td>12</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>0.00%</td>
<td>16</td>
<td>66.67%</td>
<td>3</td>
<td>12.50%</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>5</td>
<td>5.21%</td>
<td>53</td>
<td>55.21%</td>
<td>15</td>
</tr>
</tbody>
</table>

Figure 19: Percentage of Question 5 answer options by profession
Question 6

Survey Question 6 posed the following scenario:

*A patient is unconscious and treatment X is clinically indicated. The patient’s wife and son are present at the hospital. The wife states that she will not consent to the treatment on behalf of the patient. The son indicates that he will. Can treatment X be provided?*

Table 10: Number and percentage of answers to Question 6, by profession

<table>
<thead>
<tr>
<th>Question 6</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, the treatment is clinically appropriate.</td>
<td>No, the wife has refused treatment.</td>
<td>Yes, the treatment can be provided because the son has consented.</td>
<td>Yes, the treatment can be provided if the doctor gives notice to the Office of the Public Advocate.</td>
<td>No Answer</td>
</tr>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>GP</td>
<td>16</td>
<td>27.12%</td>
<td>13</td>
<td>22.03%</td>
<td>2</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>37</td>
<td>32.74%</td>
<td>25</td>
<td>22.12%</td>
<td>8</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>35</td>
<td>36.84%</td>
<td>30</td>
<td>31.58%</td>
<td>4</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>9</td>
<td>37.50%</td>
<td>9</td>
<td>37.50%</td>
<td>0</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>23</td>
<td>23.96%</td>
<td>32</td>
<td>33.33%</td>
<td>4</td>
</tr>
</tbody>
</table>

Figure 20: Percentage of Question 6 answer options by profession
Question 7

Survey Question 7 posed the following scenario:

*A patient no longer has decision making capacity but previously appointed an enduring attorney (medical treatment). The patient now requires treatment Y. If treatment Y is not provided, the patient will die. The enduring attorney states that the patient would never have wanted treatment Y and so they do not think it should be provided. What is an appropriate course of action?*

Table 11: Number and percentage of answers to Question 7, by profession

<table>
<thead>
<tr>
<th>Question 7</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>GP</td>
<td>0 0.00%</td>
<td>46 77.97%</td>
<td>0 0.00%</td>
<td>3 5.08%</td>
<td>10 16.95%</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>0 0.00%</td>
<td>98 86.73%</td>
<td>2 1.77%</td>
<td>5 4.42%</td>
<td>8 7.08%</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>0 0.00%</td>
<td>85 89.47%</td>
<td>0 0.00%</td>
<td>4 4.21%</td>
<td>6 6.32%</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>0 0.00%</td>
<td>21 87.50%</td>
<td>0 0.00%</td>
<td>1 4.17%</td>
<td>2 8.33%</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>0 0.00%</td>
<td>82 85.42%</td>
<td>0 0.00%</td>
<td>6 6.25%</td>
<td>8 8.33%</td>
</tr>
</tbody>
</table>

Figure 21: Percentage of Question 7 answer options by profession
Survey Question 8 posed the following scenario:

*A patient who is no longer competent has prepared an advance care directive. The patient has also appointed an enduring attorney (medical treatment). The advance care directive describes the patient’s views and values and describes the circumstances in which the patient would not want further medical treatment. Under what circumstances should treatment be provided?*

Table 12: Number and percentage of answers to Question 8, by profession

<table>
<thead>
<tr>
<th>Question 8</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>GP</td>
<td>6</td>
<td>10.17%</td>
<td>10</td>
<td>16.95%</td>
<td>18</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>9</td>
<td>7.96%</td>
<td>8</td>
<td>7.08%</td>
<td>37</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>6</td>
<td>6.32%</td>
<td>6</td>
<td>6.32%</td>
<td>32</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>1</td>
<td>4.17%</td>
<td>0</td>
<td>0.00%</td>
<td>8</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>4</td>
<td>4.17%</td>
<td>10</td>
<td>10.42%</td>
<td>17</td>
</tr>
</tbody>
</table>

Figure 22: Percentage of Question 8 answer options by profession
Survey Question 9 asked the following question:

*If there is no appointed substitute decision maker, who can consent to treatment on a patient’s behalf?*

Table 13: Number and percentage of answers to Question 9, by profession

<table>
<thead>
<tr>
<th>Question 9</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>the patient’s next of kin</td>
<td>25</td>
<td>1</td>
<td>18</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>any family or friend at the hospital</td>
<td>1</td>
<td>0</td>
<td>53</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>the highest ranked person on the ‘Person Responsible’ list that is available and willing to make decisions</td>
<td></td>
<td></td>
<td>49</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>no one, an order would need to be sought from VCAT</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>25</td>
<td>42.37%</td>
<td>1</td>
<td>1.69%</td>
<td>18</td>
<td>30.51%</td>
<td>6</td>
<td>10.17%</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>44</td>
<td>38.94%</td>
<td>0</td>
<td>0.00%</td>
<td>53</td>
<td>46.90%</td>
<td>8</td>
<td>7.08%</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>31</td>
<td>32.63%</td>
<td>0</td>
<td>0.00%</td>
<td>49</td>
<td>51.58%</td>
<td>6</td>
<td>6.32%</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>7</td>
<td>29.17%</td>
<td>0</td>
<td>0.00%</td>
<td>11</td>
<td>45.83%</td>
<td>1</td>
<td>4.17%</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>20</td>
<td>20.83%</td>
<td>0</td>
<td>0.00%</td>
<td>61</td>
<td>63.54%</td>
<td>4</td>
<td>4.17%</td>
</tr>
</tbody>
</table>

Figure 23: Percentage of Question 9 answer options by profession
Question 10

Survey Question 10 asked the following question:

*Who can refuse treatment on behalf of a non-competent patient?*

Table 14: Number and percentage of answers to Question 5, by profession

<table>
<thead>
<tr>
<th>Question 10</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>their Enduring Power of Attorney (Medical Treatment)</td>
<td>the person responsible (Medical Treatment)</td>
<td>A referral would have to be made to VCAT</td>
<td>the patient’s doctor can refuse treatment on their behalf</td>
<td>No Answer</td>
</tr>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>GP</td>
<td>44</td>
<td>74.58%</td>
<td>0</td>
<td>0.00%</td>
<td>4</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>93</td>
<td>82.30%</td>
<td>7</td>
<td>6.19%</td>
<td>1</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>65</td>
<td>68.42%</td>
<td>16</td>
<td>16.84%</td>
<td>2</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>13</td>
<td>54.17%</td>
<td>2</td>
<td>8.33%</td>
<td>2</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>69</td>
<td>71.88%</td>
<td>8</td>
<td>8.33%</td>
<td>5</td>
</tr>
</tbody>
</table>

Figure 24: Percentage of Question 5 answer options by profession

---

34
Question 11

Survey Question 11 asked the following question:

*What legal status does an advance care directive have in Victoria?*

Table 15: Number and percentage of answers to Question 11, by profession

<table>
<thead>
<tr>
<th>Question 11</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>GP</td>
<td>12</td>
<td>20.34%</td>
<td>9</td>
<td>15.25%</td>
<td>3</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>16</td>
<td>14.16%</td>
<td>14</td>
<td>12.39%</td>
<td>15</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>13</td>
<td>13.68%</td>
<td>16</td>
<td>16.84%</td>
<td>9</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>3</td>
<td>12.50%</td>
<td>4</td>
<td>16.67%</td>
<td>2</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>24</td>
<td>25.00%</td>
<td>16</td>
<td>16.67%</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 25: Percentage of Question 11 answer options by profession
Question 12

Question 12 posed the following scenario:

An elderly man with end stage chronic obstructive pulmonary disease who has completed a valid refusal of treatment certificate for intubation collapses in the park. Paramedics are not aware of his refusal of treatment certificate and intubate him and take him to the emergency department. At the emergency department his refusal of treatment certificate is located. What should be done now?

Table 16: Number and percentage of answers to Question 12, by profession

<table>
<thead>
<tr>
<th>Question 12</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>GP</td>
<td>23</td>
<td>38.98%</td>
<td>8</td>
<td>13.56%</td>
<td>5</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>54</td>
<td>47.79%</td>
<td>13</td>
<td>11.50%</td>
<td>6</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>47</td>
<td>49.47%</td>
<td>9</td>
<td>9.47%</td>
<td>6</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>9</td>
<td>37.50%</td>
<td>6</td>
<td>25.00%</td>
<td>2</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>41</td>
<td>42.71%</td>
<td>20</td>
<td>20.83%</td>
<td>3</td>
</tr>
</tbody>
</table>

Figure 26: Percentage of Question 12 answer options by profession
Question 13

Question 13 posed the following scenario:

A general practitioner is called to an aged care facility to assess a resident who is having trouble breathing. Whilst there, the resident collapses and requires CPR to stay alive. Staff at the facility indicate that they are not aware of the resident’s wishes. How should the doctor proceed?

Table 17: Number and percentage of answers to Question 13, by profession

<table>
<thead>
<tr>
<th>Question 13</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>GP</td>
<td>1</td>
<td>1.69</td>
<td>4</td>
<td>6.78</td>
<td>0</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>1</td>
<td>0.88</td>
<td>1</td>
<td>0.88</td>
<td>0</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>1</td>
<td>1.05</td>
<td>1</td>
<td>1.05</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>1</td>
<td>1.04</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 27: Percentage of Question 13 answer options by profession
Question 14

Question 14 posed the following scenario:

* A patient is suffering from bowel cancer and further treatment for the cancer would be futile. The patient is no longer competent and the patient’s spouse withholds consent to palliative care. Can palliative care be provided?

Table 18: Number and percentage of answers to Question 14, by profession

<table>
<thead>
<tr>
<th>Question 14</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>GP</td>
<td>23</td>
<td>38.98%</td>
<td>9</td>
<td>15.25%</td>
<td>7</td>
</tr>
<tr>
<td>Non GP Specialist</td>
<td>52</td>
<td>46.02%</td>
<td>6</td>
<td>5.31%</td>
<td>19</td>
</tr>
<tr>
<td>Full Time Salaried Specialist</td>
<td>51</td>
<td>53.68%</td>
<td>5</td>
<td>5.26%</td>
<td>16</td>
</tr>
<tr>
<td>Emergency Physicians</td>
<td>12</td>
<td>50.00%</td>
<td>0</td>
<td>0.00%</td>
<td>3</td>
</tr>
<tr>
<td>Doctors in Training</td>
<td>47</td>
<td>48.96%</td>
<td>3</td>
<td>3.13%</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 28: Percentage of Question 14 answer options by profession