Online Q&A following the McCabe Centre for Law and Cancer's webinar - *New advance care planning laws – implications for clinical practice* [Presented on 28 February 2017]

Q: I was just wanting to clarify, what are the obligations on a health practitioner to make sure a person has been appointed properly as a decision-maker?

A: There aren't any specific obligations in the legislation. However, if the Victorian Civil and Administrative Tribunal (VCAT) is satisfied that a person's intention was to appoint a medical treatment decision maker (even if they didn't properly appoint the person) then VCAT can make an order that the attempt to appoint someone was effective, despite it being technically non-compliant. A directive that doesn't comply with the legislation won't be valid unless VCAT makes a specific order - but the directive may still be taken into account as a statement of a person's preferences and values to be considered by the medical treatment decision maker.

Q: Is anyone in a position to comment on the interface between the new Medical Treatment Planning and Decisions Act and the Mental Health Act?

A: My understanding is both acts are independent but a person can choose to complete both an advance statement and an advance care plan. The Medical Treatment Planning and Decisions Act makes some changes to the Mental Health Act in relation to electroconvulsive treatment and other matters. For more information, see https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/recovery-and-supported-decision-making/advance-statements

Q: Earlier you stated that the Act says a medical practitioner can go against patient wishes if they have reasonable grounds to think the patient would make a different decision now. Does the Act specify what those reasonable grounds are? And how do you detect influence from other carers/family members?

A: That's a good question. The Act doesn't specify what reasonable grounds are, but 'reasonable' has a special meaning in law. The circumstances in which a practitioner may refuse to comply with an instructional directive are if they believe on 'reasonable grounds' that the circumstances have changed since the person gave the advance care directive, so that the practical effect would no longer be consistent with a person's preferences and values. There is a lot in that requirement - there have to be reasonable grounds for the belief that circumstances have changed, and a reasonable belief that they have changed such that the practical effect of the instructions would no longer be consistent with the person's preferences and values. This is a high threshold, and relates only to instructional directives. It emphasises the binding nature of these directives, compared with values directives.

With regards to the latter point, regarding influence I think the new legislation allows further protection as an independent person other than MTDM signs the values or instructional directive.

Q: Under the new legislation is capacity a Yes/No decision or is there a space for supported decisions?

A: There will be scope for supported decision-making under the new Act. The Act provides for the appointment of support persons to support the person to make, communicate and give effect to their medical treatment decisions. The support person will also represent the interests of the person in respect of their medical treatment, including when the person doesn't have decision-making capacity in relation to medical treatment decisions. However, the support person doesn't have the power to make medical treatment decisions on the patient's behalf.

Q: If a patient consents to a procedure like CAGS in an instructional directive, that now passes for consent. What if you are not sure they were completely, appropriately consented?

A: Thanks. If the person has completed the instructional directive without fully understanding what they were consenting to, then you would need to contact OPA for advice.

Q: An interesting recent German study of people who died on a stroke unit found that only half the ACDs were applicable to the person's situation. The main problem seemed to be people focusing on single medical procedures and not the context.

A: I think that the Doctor witnessing a Directive will need to take responsibility for ensuring understanding. I also think information about completing Instructional Directives will need to make this clear in very simple language. I think that study would have similar findings if held in Australia. I think it is multifactorial, and requires, education, awareness and understanding of the limitations of ACD if it is so specific.

Q: What do we need to do to educate people about how to make good directives that won't be found not to apply to their circumstance, particularly with chronic conditions?

A: Values directives, which focus on values, what matters most to that person, and treatment/outcomes that would be too burdensome should probably be the focus. I think that explaining the 'why' helps to guide when an instructional directive applies.

A community awareness strategy would be very helpful. The key is frequent discussions, to revisit ACP and clarify wishes.

Q: Under the new legislation is only the patient's doctor able to authorise the appointment of a medical treatment decision maker or is this open to all witnesses who are authorised to witness statutory declarations.?

A: Hi, appointments of medical treatment decision-makers will need to be signed and certified by two people, one of whom must be an 'authorised witness', which means either a registered medical practitioner or a person authorised to take affidavits. The category of people who can take an affidavit is smaller than the category of people who can witness statutory declarations - restricted to lawyers, senior police, Parliamentarians, judges etc.

Q: I am wondering if I can clarify something that was mentioned in the presentation: are value directives legally binding?

A: Health practitioners and medical treatment decision makers must consider a values directive in offering and administering treatment, and in medical treatment decision-making. That said, they're not legally binding decisions in the same way that an instructional directive is, which stands in the place of the person actually giving consent or refusing treatment. Values directives will usually require more interpretation to apply to the situation.