

Advance care planning for health professionals: starting the conversation and understanding the law

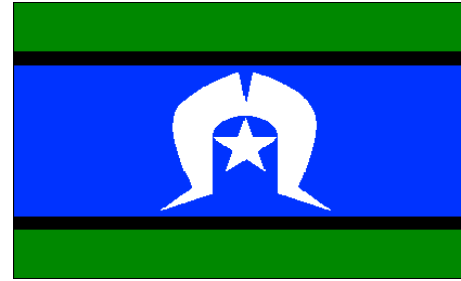
McCabe Centre for Law and Cancer

Cancer Council Victoria

Webinar 29 July 2015



Acknowledgement Of Country



Before we begin we would like to acknowledge the Traditional Owners of the Lands we are meeting on today.

We also pay our respects to Their Elders past and present and all Aboriginal People participating today.

Welcome

- Outline:
 - Background, introductions and scene-setting
 - Advance care planning
 - Starting the conversation – Sam Brean
 - Understanding the law – Claire McNamara
 - Panel discussion
 - Q & A

Cancer information and support



Your gateway to reliable information and relevant support services

Provided by experienced cancer nurses

Some background

- The McCabe Centre for Law and Cancer is a joint initiative of Cancer Council Victoria and the Union for International Cancer Control.
- Aims to contribute to the effective use of law for cancer control.
- Particular focus on tobacco control and regulation of other cancer risk factors.
- Intersection between law and cancer treatment.



Legal Services **BOARD**

Funded through the Legal Services Board Grants Program



Why a webinar on advance care planning?

- Earlier webinar for patients and carers
- Talking about dying can be challenging
- Legal framework and terminology complex
- Difficult for patients, carers, the community and health professionals to understand the law in this area and how it impacts on their decision-making.
- Evidence of knowledge gaps

Disclaimer

- The content in this webinar is general information only. The information is not intended to be legal advice, and should not be relied on as such.
- The legal information in this webinar is Victoria-specific. Please contact your local State or Territory Cancer Council for information about the laws and processes in your own region: 13 11 20



Advance Care Planning (ACP)

A guide for health professionals
how to have the conversation

Samantha (Sam) Brean
ACP Program Lead EH
July 2015

2013 & 2014 Premier's Health
Service of the Year



Why am I talking to you?

What you do everyday is important





Advance care planning is...



- Patient directed
- May include nominating a substitute decision maker
- Planning for when the patient can't communicate for themselves
- Describes patient's goals "what matters most to them"
- Guides the patient's medical management plan



Setting the scene

- Patients often wait for their doctor to initiate an ACP discussion
- Clinicians often wait for their patient or family members to initiate an ACP discussion
- General practitioners often wait for a signal from the patient's specialist before initiating an ACP discussion. (Scott, Mitchell et al)



What we know

People want to be involved in decisions about their care





“but it might upset them”

Research indicates that:

- Patients do not have distress or anxiety as a result of hearing the truth about their illness
- Patients want their doctor to talk to them about end of life issues, and they want the discussion to occur sooner rather than later
- Advance care planning reduces stress, anxiety and depression in surviving family members

(Gesme & Wiseman, 2011)



Why is ACP important?

- Increasing complexity of medical treatment and decisions
- Families have a significant chance of not knowing what the patient would want – may substitute their own wishes/values/needs/beliefs
- Health professionals “err” on the side of more treatment



- We manage acute situations well but most people (~ 85%) will die after chronic illness, not a sudden event



Over the next 40 years, the number of people aged 85 years and over is expected to increase four-fold². The disease pattern is shifting to the extent that approximately 85 per cent of people will die after a chronic illness, not after a sudden event. The

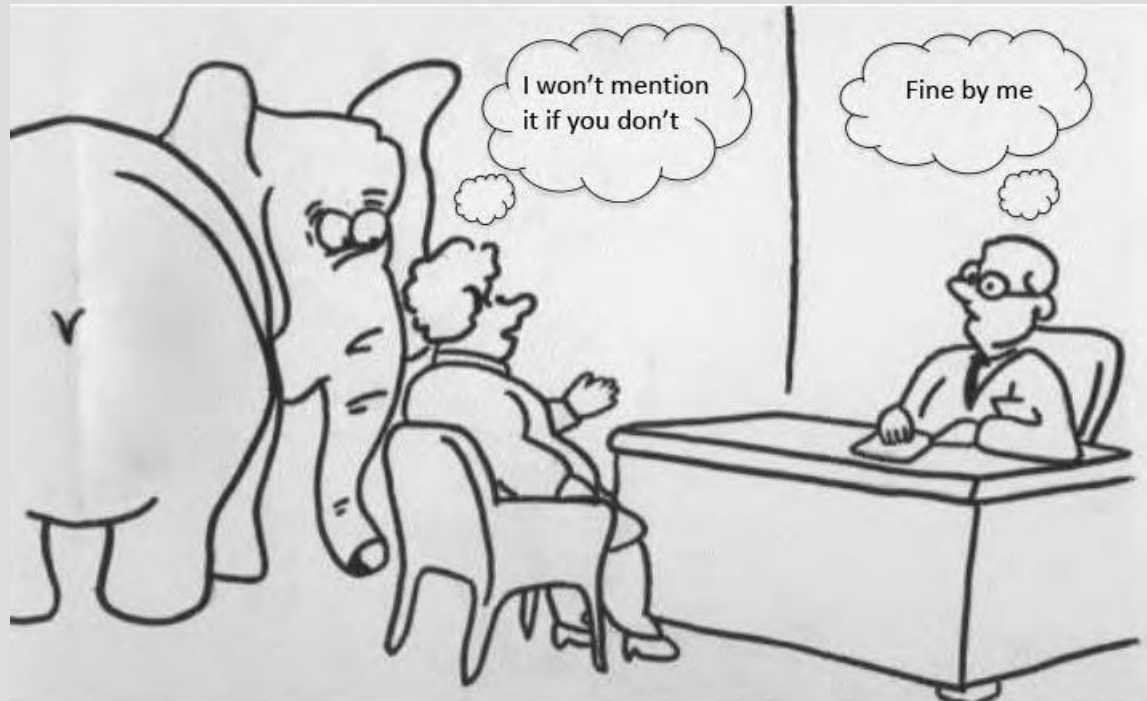


Chronic illness – discussing an uncertain future

- **Complexity and fragmentation of care. Care is episodic and reactive.** Crawford et al. unmet needs of people with end-stage COPD in Australia. IMJ 2013; 43(2): 183-190
- **Fear, denial and unrealistic expectations. Clinicians, patients may avoid discussing death and dying.** NSQHS essential statement: end of life care in acute hospitals a background paper Aug 2013
- **Unknown preferences for discussing the future.** Monmen et al. Discussing an uncertain future: end-of-life care conversations in chronic obstructive pulmonary disease. A systematic literature review and narrative synthesis. BMJ 2012



How to start the conversation some useful approaches





It's a team approach!

- If you introduce ACP to your patient it doesn't mean you have to assist them to complete the documents.....

Planting the seed is the key ... the patient will choose to discuss ACP at a time that is right for them



Introducing the topic – make ACP routine care

- *“we are talking to all of our patients about advance care planning, have you ever heard of it?”*

Remember people call it different things e.g. statement of choices, living will

- *“ we have xxx as your contact person, is this correct? Do you have a medical power of attorney?”*
- *“have you any powers of attorney, if so is it for medical decisions, what about an advanced care plan?”*



What to talk about?

- Quality of life
- Patients beliefs about life and death
- Preferred location of care
- Can be helpful to have family or significant other/s present – perhaps ask, “have you spoken to your family about your wishes”?



Preferences for care

- Exploring understanding and experience
 - *“What do you understand of your condition?”*
 - *“what was it like for you being in hospital?”*
- Speaking in the 3rd person
 - *“some people prefer this...others say that...”*
- Reassurance that there is no ‘wrong’ decision
 - *“there is no right or wrong answers, it’s what’s you prefer...”*
- Clarifying their hopes and fears
 - *“what is important to you at this stage in your life?”*
 - *“what is your greatest fear... ”*



What to talk about?

- Be disease - treatment specific if possible
- Resuscitation is a sub set of ACP

Remember the patient documents or discusses as much or as little as they wish



What to talk about?

- What would be important if dying?
 - We are all different and need to ask this question and be guided by the patient
- Messages to family and friends
 - highlights the individuality of the patients plan
- Care after death
 - organ and tissue donation, research, funeral arrangements may also be a concern to the patient



Conclusion

Advance Care planning discussions need to be.....

- Timely
- Embedded in routine care
- Part of everyone's responsibility
- Be treatment-specific (where possible)
- Documented well

... and the documents shared with family, GP and local hospital and other relevant health providers



Thank you

- Resources:
- www.publicadvocate.vic.gov.au
- www.vcat.vic.gov.au
- www.legislation.vic.gov.au
- www.health.vic.gov.au/acp/
- www.advancecareplanning.org.au
- Eastern Health ACP team: 03 9955 1276
acp@easternhealth.org.au



Office of the Public Advocate

Advance Care Planning - Legal Issues

Cancer Council Victoria/McCabe Centre for Law and Cancer

29 July 2015

Claire McNamara, Legal Officer



Outline

- Human Rights
- Legislation
- Common law
- Powers of Attorney
- Advance care planning – what is it, who can do it, who is informed by it
- Advance care directives – statutory, common law
- Decision-making capacity
- Medical treatment, palliative care
- **Substitute** decision-making (person responsible, agent, guardian, attorney)
- **Supported** decision-making
- **Clinical** decision-making



Human Rights

Patient autonomy and self-determination

“Every human being of **adult years** and **sound mind** has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”

Justice Cardoza in *Schloendorff v. Society of New York Hospital*, 1914

The Court found that the operation to which the plaintiff did not consent constituted medical battery.



Legislation

- Charter of Human Rights and Responsibilities Act 2006
- Guardianship and Administration Act 1986
- Medical Treatment Act 1988
- Powers of Attorney Act 2014 *
- Mental Health Act 2014
- Instruments Act 1958 *

* The Powers of Attorney Act 2014 will come into effect on 1 September 2015 and will replace the Instruments Act provisions relating to Enduring Powers of Attorney (Financial) and the Guardianship & Administration Act provisions relating to Enduring Powers of Guardianship



Charter of Human Rights and Responsibilities Act 2006

Section 10

A person must not be subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

A **public authority** must act compatibly with a person's human rights.

“Under section 38 of the Charter, it is unlawful for a public authority to act in a way that is incompatible with human rights, or to fail to give proper consideration to relevant human rights when making decisions. There are two parts to this obligation. Firstly, if public authorities act (or fail to act), in a way that is incompatible with human rights, their conduct will be unlawful. Secondly, the Charter imposes a procedural obligation in the way public authorities go about decision-making – they must take relevant human rights into account.” Fact sheet, Victorian Equal Opportunity and Human Rights Commission



Guardianship and Administration Act

- Defines **person responsible** – who can consent (or not consent) to medical and dental treatment for a patient who is incapable of consenting. The person responsible must make their decision based on what they consider to be in the patient's **best interests**. OPA has a flowchart titled ***Can your adult patient consent?***
- If the medical or dental practitioner considers the person responsible has not made a decision in the best interests of the patient then they can provide a statement to the person responsible, and OPA, pursuant to **s.42M**. If the person responsible does not apply to VCAT within 7 days, the medical or dental practitioner can provide the treatment. s.42M notices are rare.
- If there is no person responsible then the medical practitioner can provide a notice to OPA pursuant to **s.42K** and provided the legislative requirements are met, the treatment can proceed.



Guardianship and Administration Act

- VCAT can appoint a **guardian** with powers and duties to make decisions concerning medical and dental treatment and other health care:
 - A VCAT appointed guardian is in the hierarchical list of the person responsible, and so can consent (or not consent) to medical or dental treatment
 - A VCAT appointed guardian with these powers also has powers under the Medical Treatment Act to refuse treatment
- A person can appoint an **enduring guardian** with powers to make decisions concerning **healthcare**:
 - An enduring guardian is in the hierarchical list of person responsible, and so can consent (or not consent) to medical or dental treatment
 - An enduring guardian does **not** have the powers under the Medical Treatment Act to refuse treatment
 - It is possible to make such appointment until 1/9/15 – and these appointments post 1/9/15 will continue to have effect



Person responsible

1. enduring power of attorney (medical treatment)
2. person appointed by VCAT
3. a guardian appointed by VCAT
4. an enduring guardian *
5. a person appointed by the patient in writing
6. the patient's spouse or domestic partner
7. the patient's primary carer
8. the patient's nearest relative:
 1. Son/daughter
 2. Father/mother
 3. Brother/sister
 4. Grandfather/grandmother
 5. Grandson/granddaughter
 6. Uncle/aunt
 7. Niece/nephew

* Powers of Attorney Act which comes into effect on 1/9/15 repeals provisions in GAA relating to enduring guardians. Instead in an enduring power of attorney a principal will be able to appoint an attorney for personal matters and/or financial matters. Attorney for personal matters will be at point 4



Medical Treatment Act

- A person can appoint a **medical agent** by completing an Enduring Power of Attorney (Medical Treatment)
- A person with capacity can **refuse** medical treatment for a current condition by completing a **Refusal of Treatment Certificate**
- A guardian or agent for a person without capacity to make such decision can **refuse** medical treatment for a current condition by completing a **Refusal of Treatment Certificate Agent or Guardian of Incompetent Person**
- RTCs made under the MTA are **statutory advance care directives** – and are binding. There is an **offence** of medical trespass if a registered medical practitioner provides treatment to which the RTC applies.
- It is only possible to make a RTC for a current condition



Powers of Attorney Act

- A person can appoint an **attorney(s) for personal and/or financial matters**
- An attorney for personal matters who can make decisions concerning health care will be in the hierarchical list of the person responsible, and so can consent (or not consent) to medical or dental treatment
- An attorney for personal matters will not have the powers under the Medical Treatment Act to refuse treatment
- It is not possible to make such appointment until 1/9/15
- A person can appoint someone to be their **supportive attorney** – this operates only during such times as a person has decision-making capacity



Mental Health Act 2014

- There is a different hierarchy of substitute decision-makers for a patient (that is, someone who is subject to a compulsory treatment order under the MHA) who lacks capacity to consent to medical treatment
- A person can complete an **advance statement** in relation to (psychiatric) treatment in the event that they become a patient subject to compulsory treatment. The authorised psychiatrist must take this into account – but is not bound by it



Change in Powers of Attorney Legislation

Law prior to 1/9/15	Law from 1/9/15
<p data-bbox="170 544 479 578">Instruments Act</p> <ul data-bbox="170 606 850 706" style="list-style-type: none">• general power of attorney• enduring power of attorney (financial)	<p data-bbox="966 544 1406 578">Powers of Attorney Act</p> <ul data-bbox="966 606 1696 821" style="list-style-type: none">• general, non-enduring power of attorney• enduring power of attorney for personal and or financial matters• appointment of supportive attorney
<p data-bbox="170 853 884 888">Guardianship and Administration Act</p> <ul data-bbox="170 916 753 951" style="list-style-type: none">• enduring power of guardianship	
<p data-bbox="170 1039 598 1073">Medical Treatment Act</p> <ul data-bbox="170 1102 830 1188" style="list-style-type: none">• enduring power of attorney (medical treatment)	<p data-bbox="966 1031 1391 1065">Medical Treatment Act</p> <ul data-bbox="966 1093 1622 1179" style="list-style-type: none">• enduring power of attorney (medical treatment)



Next of kin

Next of kin is not defined in any of the relevant legislation

Whoever is 'next of kin' does not necessarily have the legal authority to provide consent (or not consent) or to refuse medical treatment

For example:

John is married to Mary. Mary is John's next of kin and John is Mary's next of kin. However, both Mary and John appointed their son, Martin, to be their medical agent. Therefore, Martin as agent is the first listed in the person responsible hierarchy.

The Human Tissue Act 1982 does define senior next of kin for the purposes of who can consent to the removal of tissue after death



ACP and ACD

- **Advance Care Planning (ACP)** involves
 - Appointing a substitute decision-maker
 - Communicating wishes for future treatment to assist a substitute decision-maker and clinicians in the event of lack of decision-making capacity
 - Completing an ACD – statutory or common law – directing that particular treatment not be provided
- **Advance Care Directive (ACD)**
 - Statutory ACD – Refusal of Treatment Certificate (Medical Treatment Act) – in relation to a current condition. There is an offence of medical trespass for providing medical treatment to which a RTC applies.
 - Common law ACD – status of common law advance care directives is not fully settled in Victoria



ACP is a process

- ACP is not about one conversation, or a conversation with a single professional or potential substitute decision-maker
- People's views and wishes undergo constant evolution and are informed by their experience, observations, changed life circumstances, etc
- Medical, health, legal, financial professionals need to work collaboratively to ensure that people make sure their wishes are known, preferably documented, and accessible when decisions might need to be made for them
- It should be normative to discuss wishes, plans – and the topic not just be introduced because a person is elderly or suddenly confronted with a diagnosis of a terminal or chronic disease.



Decision-Making Capacity

- Capacity should be presumed. Evidence of incapacity can rebut the presumption; that is, you need to prove incapacity, not capacity.
- A person's capacity to give informed consent is specific to the decision that the person is to make, it is not a global assessment
- A person's capacity to give informed consent may change over time
- It should not be assumed that a person does not have capacity to give informed consent based only on his or her age, appearance, condition or an aspect of his or her behaviour
- A determination that a person does not have capacity to give informed consent should not be made because the person makes a decision that could be considered unwise
- When assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in which the person's capacity to give informed consent can be assessed most accurately



Decision-Making Capacity

A person has decision-making capacity if the person is able to –

- Understand the information relevant to the decision and the effect of the decision; and
- Retain that information to the extent necessary to make the decision; and
- Use or weight that information as part of the process of making that decision; and
- Communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means



Decision-Making Capacity for

- Capacity to appoint a medical agent
 - Capacity to appoint an attorney for financial and/or personal matters
 - Capacity to consent to a particular medical decision or medical research procedure
 - Capacity to complete a Refusal of Treatment Certificate
 - Capacity to appoint a supportive attorney
 - Capacity to manage one's own property, estate, financial, legal affairs
 - Capacity to make lifestyle decisions such as where to live
 - Capacity to engage in any aspect of advance care planning
 - Capacity to make a Will
-
- If you are asked to provide a medical assessment of capacity you must know the decision which is in question and the relevant legal test



Decision-Making (In)Capacity – Medical Treatment

- The Guardianship and Administration Act sets out the legal test for when a person is **incapable** of providing consent to treatment (s.36)
 - A patient is a person with a **disability*** who is incapable of giving consent to the carrying out of a **special procedure**, a **medical research procedure** or **medical or dental treatment** if the person –
 - is incapable of understanding the general nature and effect of the proposed procedure or treatment; or
 - is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment
- * intellectual impairment, mental disorder, brain injury, physical disability or dementia



Supported Decision Making

- A person (with a disability) may, with support, have capacity to make decisions
- On occasions, it may be necessary to make a reasonable adjustment so that a person with a disability is supported to make decisions:
 - allow more time *
 - permit a support worker
 - use communication aids
- The Powers of Attorney Act which comes into effect on 1/9/15 permits a principal to appoint a supportive attorney – in this situation the principal has capacity to make a decision and any decision made is that of the principal but they may have the supportive attorney assist with obtaining information or with communication

* BreastScreen Victoria allow more time for appointments for women with intellectual disabilities



Wishes of patient

- If an adult person has capacity then their wishes prevail – and the person has an absolute right to refuse medical treatment of any kind (unless they are a patient under the Mental Health Act subject to a compulsory treatment order)
- If a person does not have capacity to make a particular decision about their medical treatment, nonetheless their wishes are important and wherever possible should be given effect to by their substitute decision-maker



What is medical treatment?

Guardianship and Administration Act

- Consent is only required for what is defined as medical treatment
- Medical treatment means medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by, or under, the supervision of a registered medical practitioner
- It does not include a special procedure* as the consent of VCAT is required for these
- It does not include non-intrusive examination, first aid treatment, administration of a pharmaceutical drug

* removal of tissue for transplantation, termination of pregnancy, procedure likely to lead to permanent infertility



What is medical treatment?

Medical Treatment Act

- Medical treatment means the carrying out of –
 - An operation;
 - The administration of a drug or other like substance; or
 - But does not include **palliative care**



Palliative care

Medical Treatment Act

- Palliative care is the provision of reasonable medical procedures for the relief of pain, suffering or discomfort or the reasonable provision of food and water
- A person with decision-making capacity can refuse palliative care
- It is not possible for any substitute decision-maker, for a patient who is not capable of providing consent, to refuse palliative care
- The provision of artificial nutrition and hydration is medical treatment, not palliative care, and therefore can be refused by a guardian or agent, provided one of the two specified criteria in the MTA apply
 - 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



Refuse treatment, withhold consent – what is the difference?

Guardianship and Administration Act

Person responsible can consent (or not consent) to treatment

Medical Treatment Act

Medical agent or VCAT appointed guardian can refuse treatment



Decision Options

Patient who currently has capacity for the decision

Patient consents to treatment – the treatment can proceed.

The patient does not consent to treatment – the treatment cannot proceed.

Patient who is not currently capable of providing consent to treatment but previously, when competent, completed an advance care directive refusing the treatment

If it was a Refusal of Treatment Certificate – then treatment cannot proceed, and it would be a medical trespass to provide it.

If it was a common law advance care directive – then query if the treatment can proceed. Advice should be sought.

Patient who currently lacks capacity to make decision

If the person responsible consents to the treatment – then the treatment can proceed

If the person responsible does not consent to the treatment – the treatment cannot proceed *

If a VCAT appointed guardian or a medical agent completes a Refusal of Treatment Certificate – treatment cannot proceed, and it would be a medical trespass to provide it. *

* The decision can be challenged – the processes are different



Grounds for refusing treatment

Medical Treatment Act

An agent or guardian may only **refuse** medical treatment on behalf of a patient 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 wellbeing, would consider that the medical treatment is unwarranted.
- ACP can involve appointing a medical agent to have this power and discussing views and preferences with the agent so that the agent is clear when and how to exercise such powers



Scenario 1 – no treatment

Decision of a patient with decision-making capacity not to accept treatment

Mabel is 83 years old with a number of health issues. She has been diagnosed with stage 1 breast cancer and is offered chemotherapy. Mabel considers her options and declines to accept the treatment. Mabel is capable of making the decision. Her decision is respected. She does not have the treatment.



Scenario 2 – no treatment

Patient not capable of consenting to treatment, decision of person responsible not to consent to treatment

Mavis is 53 years old and has an intellectual disability. She has been diagnosed with stage 1 breast cancer and is offered chemotherapy. Her only relation is her brother, who is her 'person responsible'. Her brother does not consent to the chemotherapy. The doctor is concerned that the brother is not making a decision in Mavis' best interests and contacts OPA to discuss submitting a s.42M form and/or applying for a guardian.



Scenario 3 – no treatment

Patient has decision-making capacity and a current condition and completes RTC

Mattie is 65 years old. She previously had treatment for breast cancer and now the cancer has metastasised to her brain. Mattie indicates she no longer wants treatment and completes a Refusal of Treatment Certificate, knowing it is likely that she will lose decision-making capacity as the disease progresses. The treatment she refuses is not provided whilst she has decision-making capacity, nor provided when she loses capacity.



Scenario 4 – no treatment

Patient lacks decision-making capacity and medical agent does not consent to treatment **or refuses treatment**

Marnie is 65 years old. She previously had treatment for breast cancer and now the cancer has metastasised to her brain. Marnie indicates she no longer wants treatment, appoints her son **Morrie** as her agent and speaks with him about her treatment preferences. Marnie subsequently loses decision-making capacity. The doctor asks Morrie to consent to treatment.

- Morrie could complete a Refusal of Treatment Certificate (as agent under MTA). If the doctor had concerns about this decision she/he could apply to VCAT for orders in relation to the EPA and the RTC. Otherwise, the treatment could not proceed; or
- Morrie could withhold consent (as person responsible under GAA) – if the doctor thought this decision was not in Marnie’s best interests then the doctor could submit a s.42M or apply for guardianship. Otherwise, the treatment could not proceed.



Common law advance care directive

- The person must be competent at the time of making the ACD
- The person must not have been subject to undue influence
- The directive must be current
- It must apply to the presenting clinical circumstances
- It must be clear and unambiguous

- An example of a common law advance care directive is a no blood card carried by a person who adheres to the faith of the Jehovah's Witnesses

- If the person has a current condition then the person should consider completing a Refusal of Treatment Certificate



Distinguishing Advance Care Planning and Substitute Decision-Making

- There is a clear link between advance care planning and substitute decision-making but they are different concepts
- Advance planning is something that:
 - a person with capacity can do for themselves
 - a person who has a disability can do with support from others:
 - » if they have decision-making capacity
 - » if they do not have decision-making capacity they may still be able to express their wishes which would inform a future substitute decision-maker
- Substitute decision-makers:
 - can be involved in planning with the person – to inform any future decision-making
 - can rely upon the person's plans to inform their decision-making
 - do **not** do advance planning for another person



Clinical Decision-Making

- NFR, DNR, Goals of Care, Limitation of Care Orders
- A clinician may determine not to provide a specific treatment as it is considered to be futile (eg, resuscitation for elderly, frail, cognitively impaired patients)
- Doctors are not required to provide *futile and burdensome* treatment – so if they deem it so (eg resuscitation) there is no need to seek consent (whether from the competent patient or from the person responsible) not to provide such treatment. You need an **offer** of treatment in order to provide consent ... doctors should not be asking patients and persons responsible to be endorsing their clinical judgement not to provide treatment. They should be explaining their decision and taking responsibility for it.



Quality of life

- In determining whether to offer treatment, doctors need to focus on whether the **treatment** is worthwhile
- Considerations of **quality of life** belong with the competent patient or the incompetent patient's substitute decision-maker

“We emphasise this point especially: the question is never whether the patient's life is worthwhile but whether the treatment is worthwhile.” BWV [2003] VCAT 121 (28 February 2003)



Family members and advocates

- Family members or advocates may demand that doctors provide treatment or object to treatment or threaten to complain or take legal action.
- It is the patient's wishes, autonomy, well-being and best interests which is relevant to decision-making (by a doctor to offer treatment or by the patient, or their substitute decision-maker, to accept treatment).
- Communication with those who will be affected by the consequences of treatment been provided, or not provided, is critical. It should be clear to patients and family members and substitute decision-makers when a doctor has determined that specific treatment is not being offered and why
- If the patient or family members disagree with the decision for particular treatment not to be offered, they should be encouraged to seek a second opinion
- Any family member purporting to have authority to be acting as a substitute decision-maker can be asked to provide the evidence for this.



Communicate, communicate, communicate

- The stakes are high for:
 - the patient (life, death),
 - their families (grief, anger, loss),
 - medical professionals (reputation, litigation/complaints, coronial processes)
- Communicate clearly
- Know the law
- Consult with professional peers
- Seek advice
- Document thoroughly



Checklist

1. Is medical treatment clinically indicated and being offered?
2. Is the patient capable of providing consent?
3. Has the patient, when competent, completed a RTC?
4. Has a guardian or medical agent completed a RTC for an incompetent patient?
5. Did the patient, when competent, complete a common law advance care directive?
6. Who is the person responsible?
7. Is the person responsible making a decision in the best interests of the patient?
8. Do you have a valid consent to proceed with providing treating?



OPA Resources

- Take Control – a kit for completing EPAs
- You Decide Who Decides – a web based activity to assist people with planning – going beyond an approach which is about completing a legal instrument (EPAs) and to think more broadly about a values base which informs future decision-making
- Securing Their Future – issues for people with children with disability to consider in planning for their children
- Fact sheets
- Practice guideline on ‘Advocacy and Decision-Making in Relation to Medical and Dental Treatment and other Healthcare’



OPA Advice Service

Who should contact OPA in relation to ACP and medical decisions?

- people wanting to engage in planning, including making EPAs and documenting wishes
- people concerned about impaired decision-making capacity of family and friends
- substitute decision-makers
- health professionals

1300 309 337

www.publicadvocate.vic.gov.au

Panel Discussion

- **Sonia Brockington**, McCabe Centre for Law and Cancer
- **Dr Deborah Lawson**, McCabe Centre for Law and Cancer
- **Sam Brean**, Eastern Health
- **Claire McNamara**, Office of the Public Advocate
- **Dr Anna Ugalde**, Cancer Council Victoria / Deakin Uni

Q:

What needs to happen to better integrate advance care planning into standard practice?

Q:

Are advance care directives legally binding? They are legal documents but are they legally binding?

Q:

We all strive to be more culturally aware and sensitive.

In a practical sense, how are cultural factors taken in consideration during advance care planning?

Q:

There seems to be some concern that the culture of oncology has become 'treat to the end' - do you think that's mostly due to a medical culture that views dying/death as 'failure'? Or do liability concerns also play a role?

Q:

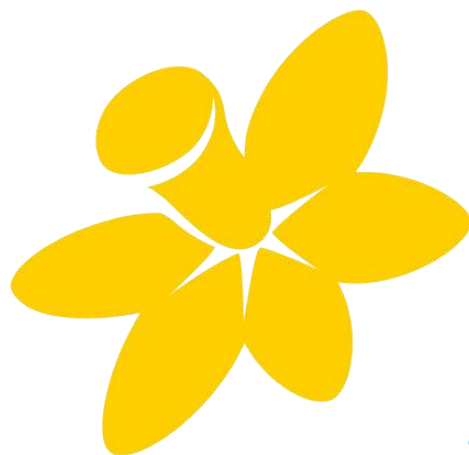
What actual language is important to use in the documents?

Moving to Q&A

- To open 'Q&A' – click the button on the top right of your screen
- To ask a question – type in the box at the bottom right on your screen and click 'send'

A screenshot of a Q&A interface. It features a dropdown menu labeled 'Ask:' with 'All Panelists' selected. Below the dropdown is a large, empty text input box. To the right of the input box is a 'Send' button.

Cancer information and support



**Cancer
Council**
Victoria
13 11 20

**Your gateway to reliable information and relevant
support services**

Provided by experienced cancer nurses

THANK YOU

- Q & A to follow
- Earlier webinar on CCV's YouTube channel and <http://www.mccabecentre.org/events/adv-care-event.html>
- Key resources will be made available within the next week.
- If you would like further information consider:
 - Calling 13 11 20
 - Visiting www.publicadvocate.vic.gov.au
- Please complete the exit survey.