DecisionAssist
Palliative Care and Advance Care Planning for Aged Care

Advance Care Planning in general practice

Frequently Asked Questions for General Practice

What is advance care planning (ACP)?

A process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known so they can guide decision-making at a future time when the person cannot make or communicate their decisions.[1] ACP may benefit from the assistance of trained health professionals; however people can choose to discuss their advance care plans in an informal family setting.

Who needs to do advance care planning?

Everyone should consider ACP, regardless of their age or health. But, it is particularly important in the following patient scenarios:

- If the patient raises ACP with a member of the general practice team
- If the answer to "Would I be surprised if this patient died within the next 12 months?" is "No"
- Has an advanced chronic illness (e.g. COPD, heart failure)
- Has a life limiting illness (e.g. dementia or advanced cancer)
- Is aged 75 years or older, or 55 years or older if they are an Aboriginal and/or Torres Strait Islander person
- Is a resident of, or is about to enter, an aged care facility
- Is at risk of losing competence (e.g. has early dementia)
- Has a new significant diagnosis (e.g. metatastic disease, transient ischemic attack)
- Is at a key point in their illness trajectory (e.g. recent or repeated hospitalisation, commenced on home oxygen)
- Does not have anyone (e.g. family, caregiver, friend) who could act as substitute decision maker
- May anticipate decision-making conflict about their future healthcare
- If the patient has a carer

What is an advance care plan?

An ACP discussion will often result in an advance care plan which states preferences about health and personal care, and preferred health outcomes. It may be made on the behalf of a non competent person, and should be prepared from the person's perspective to guide decisions about care.

What is an advance care directive[1]

It is a type of written advance care plan recognised by common law or specific legislation that is completed and signed by a competent adult. It can record the person's preferences for future care, and appoint a substitute decision-maker to make decisions about health care and personal life management.

In some states, these are known as advance health directives. In Victoria the statutory advance care directive is called a refusal of treatment certificate. It can only apply to a condition that the patient has at the time of completing the certificate.

When is an advance care directive used?

These are only used if a patient is unable to make or communicate their decisions. The directive would then be used to guide the decisions made by the medical staff in consultation with the substitute decision maker if one has been nominated, and family.

Why is it helpful to make an advance care directive?

Completing an advance care directive often reassures people and their families as they have a clear idea of what is desired by the patient in the event of illness or injury.

Who can make an advance care directive?

Any person over 18 years of age can make an advance care directive, unless they are no longer able to make decisions about medical treatment due to a disability, illness or injury.

Is a lawyer required to complete an advance care directive?

No, the law does not require a lawyer to complete an advance care directive. The doctor or someone experienced in ACP can help to complete this document.

Is a doctor required to complete an advance care directive?

Ideally an advance care directive should be discussed with a doctor as this ensures that any decisions made will be made on the basis of correct information. It also ensures that the treating doctor is fully aware of the patient's wishes and therefore better able to provide medical care that takes these wishes into account.

Making decisions based on good medical information will help future doctors to follow a directive with confidence.

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Frequently Asked Questions for General Practice (cont.)

Who can the patient choose/nominate as a substitute decision maker?

A substitute decision maker (SDM) is expected to act in the patient's best interests and make the same decisions they believe the patient would have made. A SDM should be someone who:

- is over 18 years of age
- the patient trusts to listen carefully to their wishes for future medical treatment
- can faithfully make difficult decisions on behalf of the patient who no longer has capacity.

Often, these people are family members but they can be any person who the patient believes can fulfil this role.

What authority does a substitute decision maker have?

There are some differences between Australian states, but generally substitute decision makers can consent to medical treatment on the patient's behalf if they lose capacity. In some states, they can also legally refuse medical treatment if the patient has made their wishes. In Victoria the MEPOA (Medical Enduring Power of Attorney) can also refuse treatment on behalf of a patient who has lost capacity.

Can an advance care directive be changed or revoked?

Yes, it can be changed or revoked while the patient still has capacity. It is best to make a new directive and destroy any old ones.

Ensure that those who had a copy of the previous directive receive a copy of the new directive.

How does advance care planning differ from euthanasia?

Euthanasia is the deliberate action of causing the death of someone who otherwise would not die. This is completely different from the withdrawal of a treatment that is no longer of benefit to the patient. In this circumstance the patient is dying from the underlying illness from which they would have died if the extraordinary medical treatment had not been commenced. NOTE: In all Australian states and territories euthanasia is illegal.

Does an advance care directive still apply if the patient is interstate?

If a patient has discussed their wishes with a SDM and family, then they will be able to give information regarding the patient's wishes to the doctors who will contact them to discuss the situation if the patient loses the capacity.

The SDM and family will also be able to give the advance care directive to the treating doctors.

There is variation regarding interstate recognition of SDMs. Specifically, SDM interstate appointment documentation is recognised in ACT and QLD, recognised with some exceptions in NSW, NT and SA and not recognised in TAS or WA without case by case approval.

What happens in an emergency?

In an emergency medical decisions will be made by the doctors, taking into account the patient's wishes, whether they were expressed in an advance care directive or verbally to the substitute decision maker and family.

If the advance care directive is not immediately available, life-prolonging measures may be started until the treating doctors can hold discussions with the substitute decision maker/family regarding expressed wishes.

What happens if the patient does not have an advance care plan?

In the event of serious illness doctors will make treatment decisions based on best interests. This may include treatments that the patient would not want.

Does a patient have the right to refuse medical treatment?

Yes, a patient can legally refuse treatment before or after it has been commenced. In some states, nominated substitute decisions makers can also refuse treatment on behalf of the patient who has lost capacity.

How can a patient's competence to appoint a SDM or to make an ACD be assessed?

A person with capacity should know the decision facing them, understand the possible options and the possible outcomes of the options available and be able to understand and retain the information, use or weigh the information and communicate the decision.

It is not necessary to complete a mini mental state. A person's competence or capacity to make decisions is assessed in the process of the discussion.

1 Working Group of the Clinical Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council. A national framework for advance care directives. Adelaide: Australian Health Ministers' Advisory Council, 2011.