Safer Care Victoria | Critical Care Clinical Network

Medical Treatment Planning and Decisions Act 2016: Recommended procedure for patients admitted to Victorian intensive care units

The Medical Treatment Planning and Decisions Act 2016 applies to medical treatment decision making for patients who lack decision making capacity.

This document has been developed by the Critical Care Clinical Network in conjunction with the Office of the Public Advocate to clarify expectations of intensive care units and critical care health professionals under the Act. The Australian and New Zealand Intensive Care Society and the Australian College of Critical Care Nursing have endorsed these recommendations.

Individual intensive care units should develop local policies and processes to comply with the Act in accordance with their own case-mix and scope of practice. Individual intensive care units should develop and implement processes for achieving this in a manner that suits their specific circumstances.

Medical Treatment Planning and Decisions Act 2016

The Act makes clear that doctors **cannot be compelled to provide futile or non-beneficial medical treatment**. It relates to decision making about clinically indicated treatment **offered** by the doctor.

The Act reflects a change away from 'best interests' determinations, instead decisions must focus on what the person would want (their preferences and values) in the circumstances.

RECOMMENDED PROCEDURE FOR VICTORIAN ICUs

When admitting a patient to the intensive care unit (ICU) who does not have decision making capacity (as is the case for most ICU admissions), the ICU doctor acts on behalf of the ICU team:

1. Healthcare practitioners are obliged to look for an advance care directive (ACD):
   (a) This would reasonably involve looking in the medical record and/or asking relatives.
   (b) In some cases it may be appropriate to call the patient's GP. In the future, patients may upload their ACD into MyHealthRecord, therefore doctors should be aware of this evolving resource.
   (c) It is important to document the search for an ACD in patient's medical record. A failure to look for an ACD may constitute unprofessional conduct.
   (d) Emergency treatment **should not be delayed** to search for an ACD, however a readily available ACD must be respected.
   (e) If the patient has a valid ACD it **must** be placed in the medical record.

2. An ACD may include instructional directives and/or values directives. A valid instructional directive must be followed. A medical treatment decision maker cannot overrule an instructional directive. If the doctor feels that there is good reason to override an instructional directive then VCAT should be contacted (www.vcat.vic.gov.au). Any values directive must be considered in treatment discussions with the medical treatment decision maker.
3. The medical treatment decision maker should be clearly identified in the medical record. This is the person formally appointed by the patient or, failing this, the most senior person in the hierarchy* who has a close and continuing relationship with the patient and is willing and able to act as a medical treatment decision maker.
4. The medical treatment decision maker should be informed of the type of treatment that admission to ICU involves (preferably provided in written form) and their consent to this 'package' of medical treatment should be documented in the medical record. The potential benefits and risks of ICU treatment should be presented within the context of the patient's critical illness.

*Medical treatment decision maker hierarchy

1. A formally appointed medical treatment decision maker
2. A guardian appointed by VCAT to make decisions about medical treatment for the patient
3. The first person in the list below who is in a close and continuing relationship with the patient:
   - spouse or domestic partner
   - primary carer (not a paid service provider)
   - adult child
   - parent
   - adult sibling.

If there are two or more relatives who are first on this list, it is the eldest person who is the **medical treatment decision maker.**

5. The medical treatment decision maker should be asked to provide specific consent whenever significant, higher risk treatments are required, unless these are deemed to be emergency treatment.
6. Should the medical treatment decision maker not be able to be contacted and delay is considered to be detrimental to the patient (but treatment is not emergency) then the next person in the medical treatment decision maker hierarchy should be approached for a medical treatment decision.
7. Where no medical treatment decision maker can be identified and the medical treatment is not emergency treatment and it is significant medical treatment (as defined by the Medical Treatment Planning and Decisions Act 2016), the Office of the Public Advocate (OPA) must be contacted using a Section 63 form. (www.publicadvocate.vic.gov.au)
8. Where there is concern about the medical treatment decision maker's decision making processes, or where an ACD is ambiguous, then VCAT may need to be involved. VCAT can decide the validity or meaning of an ACD, review a medical treatment decision or make orders about a medical treatment decision maker (which may involve replacing them as decision maker).

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9. Where a medical treatment decision maker refuses treatment but is not thought to know the preferences and values of the person or to not be acting in accordance with those wishes then the OPA must be contacted using a Section 62 form. (www.publicadvocate.vic.gov.au)

Note:

1. The OPA requires time to make a decision and so the section 63 form should be submitted as soon as possible
2. The OPA does not have a role in making a decision about emergency treatment, or what is/is not significant medical treatment, as these are clinical assessments by the health practitioner
3. The OPA can provide advice to health practitioners about how the Medical Treatment Planning and Decisions Act 2016 defines treatment types and the application processes to OPA or to VCAT.

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