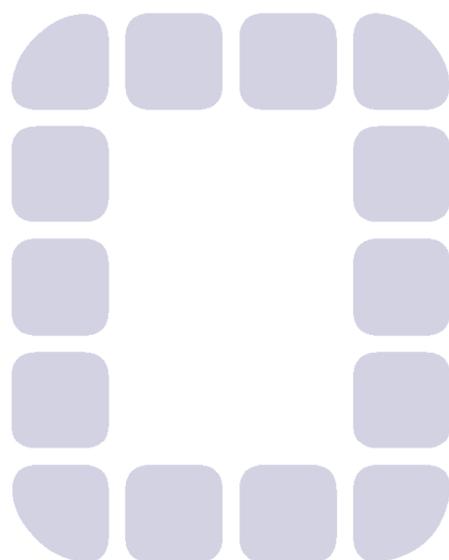
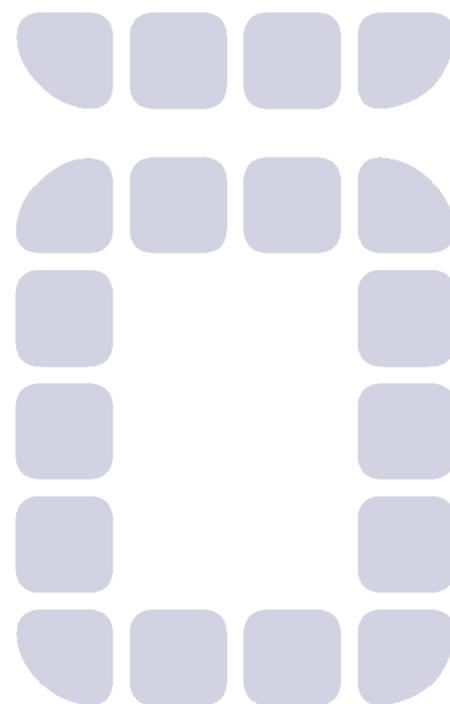
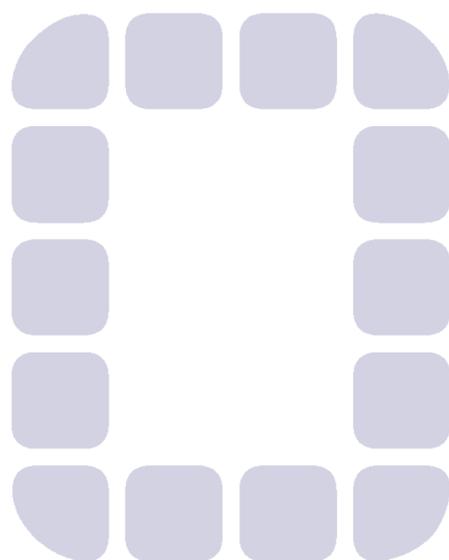
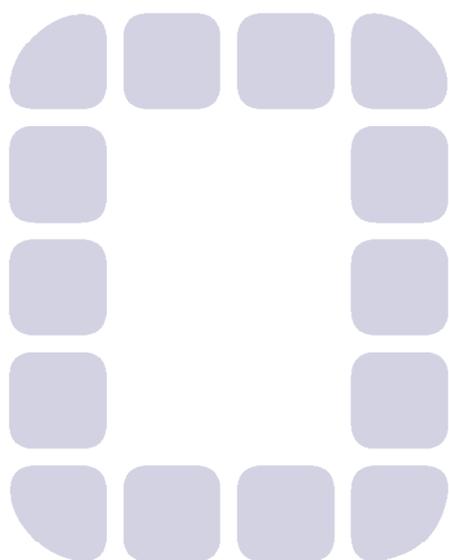


A Guide for Health Professionals to the *Acts Amendment (Consent to Medical Treatment) Act 2008*



Copies of this guide and the Advance Health Directive form can be downloaded from the Department of Health's website. Further information and advice can also be obtained by contacting the Department of Health.

The Department of Health (Office of the Chief Medical Officer)

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T: (08) 9222 2300

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For further information on Enduring Powers of Guardianship or for a copy of the booklet 'A Guide to Enduring Power of Guardianship Western Australia' contact the Office of the Public Advocate.

Office of the Public Advocate

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Introduction

The Western Australian Government supports community opinion which prioritises the right to self-determination in treatment, the primacy of quality of life over longevity and the principle of human dignity. However, when a person loses the ability to make or express their treatment wishes, a gap can arise between support for these ideals and actual delivery.

In recent decades average life expectancy and the likelihood of living with chronic disease for a longer period later in life have increased in Australia and all Western societies. Today, with advances in medical technology, the treatment of a serious illness often results in restoration of health and promotion of longevity. While many individuals now survive illnesses or traumatic injuries that would once have been fatal, survival is often accompanied by a state of dependence, indignity and reduced function, which may be considered an unacceptable quality of life for many.

A person may reach a point at which he or she wishes to forgo life-sustaining treatment. However, people may not be able to make or express their wishes when they are unwell. Furthermore prior to a diagnosis of advanced illness or a traumatic accident, it may not be possible to imagine what one might want in a future situation.

It is for these reasons that the *Acts Amendment (Consent to Medical Treatment) Act 2008* ("the Act") was prepared. The Act realises the State Government's commitment to law reform regarding consent for medical treatment for individuals who, at the time treatment is required, cannot make their own treatment decisions. The Act provides the instruments for people to plan in advance for future circumstances based on their values, beliefs, religion and culture, regardless of the view of their family or health professionals

Prior to this Act, Western Australia did not have any legislation that allowed people to plan for their future treatment.

The *Guide for Health Professionals to the Acts Amendment (Consent to Medical Treatment) Act 2008*, prepared by the Department of Health, is designed to educate health professionals about the Act.

How to use this Guide

This guide is divided into different sections

Section A: The New laws

This section provides information about the key legislative changes and an overview of the amendments to the *Guardianship and Administration Act 1990*, the *Civil Liability Act 2002* and the *Criminal Code*.

Section B: Advance Health Directives

This section describes and explains Advance Health Directives. The role of health professionals is also explained.

Section C: Enduring Powers of Guardianship

This section describes and explains Enduring Powers of Guardianship. The role of health professionals is also explained.

Section D: Consent for Treatment

This section provides an overview of the new process for seeking consent to treatment. The new Treatment Hierarchy is outlined and the position of Advance Health Directives, Enduring Guardians and other substitute decision makers in this hierarchy are described.

Section E: Advance Care Planning

This section describes advance care planning and how to use Advance Health Directives and Enduring Powers of Guardianship in clinical scenarios.

The New Laws

Learning outcomes

At the end of this module you will:

- Have a broad understanding of the *Acts Amendment (Consent to Medical Treatment) Act 2008* (“the Act”) which amended the *Guardianship and Administration Act 1990*, the *Civil Liability Act 2002* and the *Criminal Code*.
- Be able to describe the scope of the Act and explain the implications for clinical practice.
- Understand the Treatment Hierarchy.
- Be able to explain the terms Advance Health Directive and Enduring Power of Guardianship.

Overview of the Act

The Act amends three Acts, namely the *Guardianship and Administration Act 1990*, the *Civil Liability Act 2002* and the *Criminal Code*.

The key changes from the amending Act include:

- **Introduction of Advance Health Directives**

An adult with full-legal capacity¹ can now prepare an Advance Health Directive which contains treatment decisions. These treatment decisions will come into effect if at any time in the future the person is unable to make reasonable judgments in respect of a treatment decision at the time that the treatment decision is required to be made.

- **Introduction of Enduring Power of Guardianship**

An adult with full-legal capacity can now prepare an Enduring Power of Guardianship to appoint an Enduring Guardian to make personal, lifestyle and treatment decisions on their behalf. The Enduring Guardian may only make these decisions if the person is unable to make reasonable judgments in respect of the personal, lifestyle or treatment decision at the time that the decision is required to be made.

- **Legislative protection from criminal responsibility extended to withdrawal and withholding of medical treatment**

Providing that health professionals act in good faith, they will be protected by the Act if treatment is withdrawn or withheld in accordance with an Advance Health Directive or a decision of a substitute decision maker, even when death ensues.

Euthanasia and assisted suicide remain illegal in Western Australia. Patients and/or substitute decision makers cannot require that health professionals take active steps to unnaturally end life.

- **New hierarchy of substitute decision makers**

There is a new Treatment Hierarchy for health professionals to follow when seeking a treatment decision in relation to a patient who is unable to make reasonable judgements about a treatment decision at the time that the treatment decision is required to made.²

The Act does not alter the existing common law which supports the validity of “living wills” and other similar documents.³

¹ A person is said to have full legal capacity if they are at least 18 years of age and are capable of understanding the nature and effect of their AHD/Enduring Power of Guardianship. A person may lack full legal capacity if their decision-making is impaired, for example, by reason of illness, disease or injury, or the effects of medication, drugs or alcohol.

² Not including personal and lifestyle matters.

³ Common Law definition (judge made law).

Amendments to the *Guardianship and Administration Act 1990*

The amendments to the *Guardianship and Administration Act 1990* provide a legislative basis for people to plan for how personal, lifestyle and treatment decisions should be made on their behalf in the future if they are unable to make reasonable judgments about these matters for themselves. The amendments introduce two new legal concepts:

- Advance Health Directives; and
- Enduring Powers of Guardianship.

The amendments allow for consent to be given or refused by an individual or substitute decision maker.⁴

Advance Health Directive

An Advance Health Directive (AHD) is a legal document that is completed using a prescribed form which contains a person's decisions about future treatment in anticipation of a time when they may be unable to make reasonable judgments for him/herself. A valid AHD is legally binding and documents treatment decisions⁵ in which a person consents or refuses consent to future treatment according to specific circumstances.

Enduring Power of Guardianship

An Enduring Power of Guardianship (EPG) is a document in which a person nominates an Enduring Guardian to make personal, lifestyle and treatment decisions on their behalf in the event that they are unable to make reasonable judgments about these matters in the future. An EPG is different from an Enduring Power of Attorney (EPA)⁶, which relates to financial and property matters.

An Enduring Guardian is the person appointed under an EPG to make personal, lifestyle and treatment decisions on behalf of the appointor. They may have authority to make all decisions, or their authority may be limited to specific areas of decision-making. It is possible to appoint multiple Enduring Guardians for some or all decisions.

Definition of Treatment

The Act has changed the definition of treatment in the *Guardianship and Administration Act 1990*. Treatment is now defined as any medical or surgical treatment (including a life sustaining measure and palliative care), dental treatment or other health care.

⁴ A substitute decision maker makes decisions on behalf of an adult who is unable to make reasonable judgments because of conditions such as dementia, an intellectual disability, psychiatric illness or an acquired brain injury. These include an Enduring Guardian, Guardian and others in the Treatment Hierarchy.

⁵ A treatment decision is defined as "a decision to consent or refuse consent to the commencement or continuation of any treatment of the person"

⁶ Enduring Power of Attorney (EPA) is a legal document in which an adult with full legal capacity (the appointor) gives authority to a trusted person or agency the right to make financial and/or property decisions on their behalf. This person is known as their Enduring Attorney.

Previously the *Guardianship and Administration Act 1990* did not refer to palliative care as treatment. Under this new definition it is clear that consent may be given or refused for palliative care and/or life sustaining treatment.⁷

Amendments to the *Criminal Code*

Amendments to the *Criminal Code* provide increased certainty for health professionals in the provision of end-of-life care. The amendments to the *Criminal Code* put beyond doubt the exemption from criminal responsibility for the administration, in good faith, of reasonable medical treatment (including palliative care) even when death ensues. They also put beyond doubt that it is lawful to withdraw or withhold treatment even where death ensues, if the non-provision or cessation of that treatment is done in good faith and is reasonable in all the circumstances of the case. It remains unlawful for any person to take any active steps to unnaturally end life.

Amendments to the *Civil Liability Act 2002*

The *Civil Liability Act 2002* has been amended to alter the definition of “health professional”. The definition currently includes twelve individual health professionals such as medical practitioners and nurses. It also lists as a final category “any other discipline or profession practising in the health area which applies a body of learning”.

Other relevant law

Common law

In addition to the *Guardianship and Administration Act 1990*, under the common law a person can also prepare a directive to express their future treatment wishes. Such directives have legal standing under common law and health professionals must comply with a valid common law directive, as they would an AHD.

Common law directives do not have a prescribed form, however they are often referred to as written documents such as a ‘living will’ or ‘advance care plan’. A number of different agencies have produced templates and forms for common law directives, such as the Respecting Patient Choices program, which has been implemented at Fremantle Hospital, Western Australia.

It is important to remember that despite the type of document used, under the common law any document produced by an individual that expresses future treatment wishes may constitute a common law directive.

Mental Health Act 1996

Other statutes, such as the *Mental Health Act 1996*, may interact with amendments introduced by the Act. For example, in relation to an involuntary patient under the *Mental Health Act 1996*, patient consent is not required for psychiatric treatment. As

⁷ Palliative care is defined as “a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure.

such, this treatment may be provided irrespective of the contents of any AHD or the decision of an Enduring Guardian (or other substitute decision maker). However, it may still be appropriate for the treating health professional to take these matters into account when formulating the treatment plan.

Advance Health Directives

Learning outcomes

At the end of the module you will:

- Be able to explain what an AHD is and the process of completing an AHD.
- Be able to lead, participate in discussions about, and provide guidance in developing an AHD and assist in completing an AHD document.
- Be able to identify an AHD form and discuss issues relating to safe storage and accessibility of the AHD.
- Understand the limitations of an AHD and the possibility of revocation and amendment of the AHD.
- Understand the role of State Administrative Tribunal (SAT) in relation to AHD's.
- Understand the process for resolving disagreements about the use/interpretation/validity of an AHD.

About Advance Health Directives

What is an Advance Health Directive

An AHD is a document which contains decisions about future treatment. An AHD only comes into effect if the person (the maker) is unable to make reasonable judgments about a treatment decision at the time that the treatment decision is required.

What can an Advance Health Directive do

An AHD is legally binding and allows the maker to consent or refuse consent to treatment.

An AHD cannot be used to:

- Require unlawful medical interventions such as euthanasia. An AHD cannot require or authorise a health professional to take active steps to unnaturally end life.
- Require specific interventions if they are not clinically indicated.
- Record wishes about organ and tissue donation. An AHD is ineffective after death. If a patient would like to donate their organs and tissues, they can register their wishes on the Australian Organ Donation Register by contacting their local Medicare Australia office or visiting www.medicareaustralia.com.au for further information.

Who can prepare an Advance Health Directive

It is possible to make an AHD if someone is at least 18 years of age and has full legal capacity.⁸

The maker must prepare their own AHD. It is not possible for one person to make an AHD on behalf of someone else. However, if a patient is incapable of writing and signing their AHD, they may direct another person to write and sign the AHD, in accordance with their direction, on their behalf. If another person signs the AHD, at the direction of the maker, then that person cannot be one of the witnesses.

⁸ A person will have full legal capacity if they are capable of understanding the nature and effect of their AHD. Someone may lack full legal capacity if their decision making is impaired by illness, disease or injury, or the effects of medication, drugs or alcohol.

If there is uncertainty as to whether the person seeking to make an AHD has full legal capacity, it is recommended that they be encouraged to seek the opinion of at least one medical practitioner qualified to assess capacity. The medical practitioner may be asked to write a written report stating whether or not the person has the full legal capacity required. It is further recommended that the medical practitioner who has assessed the person as having full legal capacity be one of the two witnesses to the person's signature on the AHD form. In many cases it will be the general practitioner who will be asked to assess whether the person has full legal capacity. See Appendix 2 for the Six Step Capacity Assessment tool developed by the Geriatric Research Group, McMaster University, 1999.

About the AHD form

How to identify an AHD form

An AHD is a statutory form that is part of the *Guardianship and Administration Regulations 2005* (www.slp.wa.gov.au).

An AHD must use the form that is part of the Regulations or a form that is substantially similar. The Department of Health has published an AHD form and a copy of this form is located in Appendix 1.

It is possible (but not recommended) for other organisations and individuals to publish their own AHD forms.

Health professionals may contact the Department of Health or the State Administrative Tribunal if they are uncertain about a particular AHD form.

Treatment Decisions

A treatment decision is a decision to consent or refuse consent to the commencement or continuation of any treatment. A treatment decision operates only in the circumstances that are specified in the AHD and only if the patient is unable to make reasonable judgements about the treatment decision at the time the treatment decision is required.

Treatment that the patient consents to can be provided to them. Treatment to which the patient refuses consent cannot be provided to them.

A treatment decision requires the patient to complete two sections on the AHD form; the treatment and the circumstance.

Patients should be encouraged to write down treatment decisions in their own words. However, health professional can provide advice to patients about treatment decisions they may wish to make.

Witnessing

An AHD must be signed in the presence of two witnesses.

The witnesses must sign in the patient's presence and in the presence of each other. The witnesses must each be at least 18 years of age. One of the witnesses must also be a person who is authorised to witness statutory declarations. The following people are authorised to witness statutory declarations:

- Academic (post-secondary institution)
- Accountant
- Architect
- Australian Consular Officer
- Australian Diplomatic Officer
- Bailiff
- Bank Manager
- Chartered Secretary
- Chemist
- Local Government CEO or Deputy CEO
- Local Government Councillor
- Loss Adjuster
- Marriage Celebrant
- Member of Parliament
- Minister of Religion
- Nurse
- Optometrist
- Patent Attorney

- Chiropractor
- Company Auditor or Liquidator
- Court Officer
- Defence Force Officer
- Dentist
- Doctor
- Electorate Officer of a Member of State Parliament
- Engineer
- Industrial Organisation Secretary
- Insurance Broker
- Justice of the Peace
- Landgate Officer
- Lawyer
- Physiotherapist
- Podiatrist
- Police Officer
- Post Office Manager
- Psychologist
- Public Notary
- Public Servant (Commonwealth or State)
- Real Estate Agent
- Settlement Agent
- Sheriff or Deputy Sheriff
- Surveyor
- Teacher
- Tribunal Officer
- Veterinary Surgeon

It is worth noting that all registered health professionals are included on this list.

Medical and legal advice

Patients should be encouraged, however are not required to seek medical and legal advice to make an AHD.

Health professionals can advise patients that it may be useful for them to seek assistance to reassure themselves and their families that all possible options have been considered in their best interests. Additionally, in the event that there is later uncertainty about their AHD, the person/s who provided advice may be able to provide assistance to ensure that the patient's treatment decisions are respected.

Storage

Currently no register exists for AHDs. Sections in the Act relating to the requirement to establish and maintain a register will not be proclaimed until the Department of Health has established an electronic patient health record.

In the interim, individuals who prepare an AHD will be encouraged to ensure that their AHD is kept in a safe place that it is easily accessible when it is required. People should inform their family of where they keep their AHD. It is advised that a copy of an AHD be kept within the patient's medical record and a copy be given to their treating health professionals, family members, Enduring Guardian or Guardian (if applicable), lawyer (if applicable), carers and nursing home (if applicable). People may choose to use a MedicAlert bracelet or a wallet card to alert health professionals to the existence of an AHD.

When seeking consent for a treatment decision, even in urgent situations, health professionals must consider whether the patient has an AHD. See Section D: Consent for Treatment for further information about the consent process.

Validity of treatment decisions

Are there any times when a treatment decision will be invalid?

A treatment decision contained in an AHD will be invalid (void) if:

- It was not made voluntarily. For example, if a patient was pressured by another person to make the treatment decision and the patient felt they had no choice but to do so.
- It was made as a result of inducement. For example, if a patient was told that a person close to them would receive some financial benefit if the patient agreed to make the treatment decision, and the patient made the treatment decision for this reason.
- It was made as a result of coercion. For example, if the patient was told that their family would only continue to care for them if they agreed to make a treatment decision, and the patient made the treatment decision for this reason.
- At the time that the patient made the AHD, they did not understand the treatment decision. For example, if the patient made a treatment decision which provided consent to receive a particular type of treatment, and the patient did not know what this treatment was, what it involved or what the risks of the treatment were.
- At the time that the patient made the AHD, they did not understand the consequences of making the treatment decision. For example, if the patient did not understand that the treatment they refused consent for was necessary to save their own life.

If there is any doubt about the validity of an AHD, an application can be made to the State Administrative Tribunal (SAT) for clarification.

Are there any times when a treatment decision will be inoperative?

A treatment decision contained in an AHD will be inoperative (not followed or of no effect) if:

- circumstances relevant to the treatment decision have changed since the patient made the treatment decision; and
- the patient could not have reasonably anticipated those changes at the time that they made the treatment decision; and
- a reasonable person with knowledge of the change of circumstances would now change their mind about the treatment decision.

For example, if a patient made a treatment decision thinking their illness would get severely worse, and a new treatment or cure became available after the time the patient made the treatment decision.

Validity outside Western Australia

Whether or not an AHD will be valid in another state or territory of Australia will depend on the laws applying in that jurisdiction.

Validity of an AHD created in another jurisdiction

An instrument created in another state or territory of Australia will only be enforceable as an AHD if SAT makes an order to this effect. SAT may make an order recognising an instrument created under a law of another jurisdiction as an AHD if it

is satisfied that the instrument corresponds sufficiently, in form and effect, to an AHD. If the person retains full legal capacity, it may be preferable for them to make an AHD.

In addition, an instrument created in another jurisdiction, even if it has not been formally recognised by SAT may be valid as a directive recognised under the common law.

Reviewing and changing an Advance Health Directive

Changing or revoking an AHD

While the patient has full legal capacity, they can change their wishes as stated in their AHD or completely revoke their AHD at any time. It is preferable for this revocation to occur in writing. Written notification of the revocation of the AHD should also be provided to all relevant persons and organisations, such as health professionals, family members and residential facilities.

Rather than amending an AHD, it is preferable that a patient revokes their existing AHD and completes a new AHD. Creating a new AHD will require the patient to comply with the witnessing requirements.

Reviewing an AHD

It is recommended that patients review their AHD at least every 2 years to ensure that it reflects their current wishes. Likewise, if the patient's medical condition alters significantly, they may wish to change their AHD (it is preferable that in this scenario a new AHD is created).

Copies of Advance Health Directives

If copies are made of AHDs it is recommended (but not legally required) that they are certified. A person who is authorised as a witness for statutory declarations under the *Oaths, Affidavits and Statutory Declarations Act 2005* may certify that the copy is a true copy of the original document.

A suggested wording for the certification is as follows:

"I certify that this is a true copy of the original produced to me on <date>.

Signature

Name

Qualification (eg JP, Pharmacist)"

What if a person does not make an Advance Health Directive?

Where a person does not have an AHD a treatment decision will be made on their behalf in the event that they are unable to make reasonable judgements about the treatment decision. The treatment decision will be made by either the patient's (in the following order of priority) Enduring Guardian (if one has been appointed one), Guardian (if one has been appointed for the patient), or by another person responsible (such as the patient's spouse, parent, child, sibling or unpaid carer). For more information refer to the Treatment Hierarchy in Section D: Consent for Treatment.

Role of the State Administrative Tribunal (SAT)

Amongst other things, SAT has responsibility for the resolution of issues arising under the *Guardianship and Administration Act 1990*, including issues relating to AHD's.

In relation to an AHD, SAT may:

- Declare an AHD or a treatment decision in an AHD to be valid or invalid.
- Declare that a person is unable to make reasonable judgments in respect of the treatment proposed to be provided.
- Give directions connected to a treatment decision in an AHD and/or construction of the terms of an AHD.
- Declare that a treatment decision in an AHD has been revoked.
- Make an order recognising an instrument created under a law of another jurisdiction as an AHD.

Exercises

1. Sam has made a treatment decision in his AHD to the effect that if he is unable to feed himself, he does not wish to be given artificial nutrition. Following a stroke, he is unable to feed himself.

Knowing that not feeding him will eventually result in death, should health professionals follow the treatment decision, and will this expose them to any criminal liability?

2. Sam's daughter disagrees with the treatment decision contained in his AHD and says that it is wrong not to feed her father.

What should the health professionals do? Sam's wife, doesn't wish to enter into the conflict.

3. Martin would like to ensure that he can donate his organs after his death? How should he identify this on his AHD?

4. Diane, a 55 year old woman whose mother has just died after a protracted illness would like to know how she can make sure that the same thing doesn't happen to her. In particular she wants to make sure that if she was unable to communicate with her family that she would not be artificially kept alive. She wants to know how she can legally make sure her wishes will be followed. What is your advice?

Advice and further assistance

Department of Health (Office of the Chief Medical Officer)

The Office of the Chief Medical Officer, Department of Health provides information on AHDs and is able to assist health professionals with issues relating to AHDs.

PO Box 8172, Perth Business Centre, WA 6849

T: (08) 9222 2300

E: chiefmedicalofficer@health.wa.gov.au

W: www.health.wa.gov.au/advancehealthdirective

State Administrative Tribunal

Information on how to make an application for resolution of issues arising under the Act, and relevant application forms, can be obtained from the State Administrative Tribunal website at www.sat.justice.wa.gov.au .

T: (08) 9219 3111

T: 1300 306 017 (Toll Free)

W: www.sat.justice.wa.gov.au

Enduring Powers of Guardianship

Learning Outcomes

At the end of the module you will:

- Be able to explain what an EPG is and the process of completing an EPG.
- Be able to lead, participate in discussions about, and provide guidance in completing an EPG.
- Be able to identify an EPG form, understand how to use an EPG, know when to refer to one and be able to discuss issues relating to safe storage and accessibility of the EPG.
- Understand the limitations of an EPG and the possibility of revocation and variation of the terms of the EPG.
- Understand the relationship between an EPG and an AHD.
- Understand the difference between an Enduring Guardian (appointed through an EPG) and a Guardian (appointed by SAT).
- Be able to recognise the legal authority of the Enduring Guardian.
- Be able to provide support to Enduring Guardians.
- Understand SAT's role in relation to EPG's.
- Understand the process for resolving disagreements about the use/interpretation/validity of an EPG.

About Enduring Power of Guardianship

What is an Enduring Power of Guardianship?

An EPG is a formal legal document that enables a person to give authority to another person(s) (the Enduring Guardian) to make personal, lifestyle and treatment decisions on their behalf if they are unable to do so in the future. It only comes into operation when a the person is unable to make reasonable judgments about these matters for themselves.

A person (also called the appointor) can give their Enduring Guardian(s) the authority to make all of their personal, lifestyle and treatment decisions or the appointor can limit their authority to specific functions.

Although SAT could appoint a Guardian on behalf of a person, there was not previously a mechanism for the person themselves to direct how and by whom personal, lifestyle and treatment decisions should be made on their behalf.

What can an Enduring Guardian do

An Enduring Guardian who is authorised to make all personal, lifestyle and treatment decisions would have the following authority:

- Deciding where a patient lives, whether permanently or temporarily.
- Deciding who the patient will live with.
- Deciding whether the patient will work and if so, any matters related to that work.
- Providing or refusing consent, on the patient's behalf, to any medical, surgical or dental treatment or other health care (including palliative care and life-sustaining measures such as assisted ventilation and cardiopulmonary resuscitation).
- Deciding what education and training the patient receives.
- Determining who the patient will associate with.
- Commence, defend, conduct or settle any legal proceedings on the patient's behalf, except proceedings that relate to property or estate
- Advocate for and make decisions about the support services that the patient will have access to.
- Seek and receive information on behalf of the patient.

An Enduring Guardian cannot make decisions for a patient on their property or financial matters. If a patient wishes to give someone the authority to make financial decisions on their behalf, they will need to make an Enduring Power of Attorney.⁹

The extent of an Enduring Guardian's powers depend on the instructions as set out in the EPG. The EPG may give the Enduring Guardian all powers, or they may have limited authority to make decisions.

⁹ Copies of the EPA form and a guide explaining how to complete an EPA are available from the Office of the Public Advocate's website at www.publicadvocate.wa.gov.au. Alternatively, copies can be purchased from the State Law Publisher, Ground Floor, 10 William St Perth, 6000, phone (08) 9321 7688 or fax (08) 9321 7536.

Who can execute an EPG?

Any person who is at least 18 years of age and who has full legal capacity can complete an EPG. A person will have full legal capacity if they are capable of understanding the nature and effect of the EPG.

If there is uncertainty as to whether the person seeking to make an EPG has full legal capacity, it is recommended that they be encouraged to seek the opinion of at least one medical practitioner qualified to assess capacity. The medical practitioner may be asked to write a written report stating whether or not the person has the full legal capacity required. It is further recommended that the medical practitioner who has assessed the person as having full legal capacity be one of the two witnesses to the person's signature on the EPG form.

In many cases it will be the general practitioner who will be asked to assess whether the person has full legal capacity.

Who can be appointed as an Enduring Guardian?

Substantive requirements

A person appointed as an Enduring Guardian must also be at least 18 years of age and have full legal capacity. People can choose whomever they wish but most commonly it will be the spouse, a relative or a friend who is selected.

A substitute Enduring Guardian can also be appointed in the event that the Enduring Guardian also loses full legal capacity, dies or is unable to continue in their role.

There is no requirement for the Enduring Guardian to reside in Western Australia, although they should be easily contactable to ensure they can be consulted quickly when any personal, lifestyle or treatment decision needs to be made.

Assisting someone to choose an Enduring Guardian

Health professionals may need to lead a discussion on appointing and choosing an Enduring Guardian. People should be advised to choose someone that they know well and trust to make decisions on their behalf later.

The following questions may be helpful for the person to consider:

- Is the person someone that they trust to consider their wishes, beliefs and values, to make the same decisions as they would be likely to make in the circumstances that apply at the time and always act in a manner that they consider is in their best interests?
- Will this Enduring Guardian have time to fulfil the role and be contactable when decisions are needed?
- Could this choice create any conflict within their family?
- If appointing joint Enduring Guardians, could these people work together to make unanimous decisions on their behalf?

While not essential, the person should be encouraged to discuss their preferences for future personal, lifestyle and treatment decisions with the people they propose to appoint as Enduring Guardian to ensure that their wishes are well understood. They should also be encouraged to consider informing family members and close friends

of their choice of Enduring Guardian to reduce the likelihood of questions later about what their intentions and wishes were.

The person designated should confirm that they are willing to make the types of personal, lifestyle and treatment decisions specified in the EPG as and when such decisions are required.

Accepting the role of Enduring Guardian

Being an Enduring Guardian is a voluntary position. Questions which may assist those who are considering the role include:

- Do you know the person well enough to make decisions that they would probably have made?
- Are you fully aware of the role and do you believe you can fulfil its responsibilities?
- Are other Enduring Guardians being appointed? If so, do you think you would be able to come to unanimous decisions with them?
- Will the EPG give you the power to make decisions about the person's treatment and, if so, has the person completed or are they intending to complete an AHD?

Since an AHD takes precedence in the Treatment Hierarchy it is advisable that the Enduring Guardian be aware of the existence of an AHD. Enduring Guardians should also make themselves familiar with the general health and preferences of the person.

Health professionals as Enduring Guardians

Occasionally a health professional may be approached to be an Enduring Guardian. The health professional should consider the commitment required to act as an Enduring Guardian, in addition to any potential conflict between their role as the treating health professional and the role of the Enduring Guardian.

When does an EPG become operational?

The Enduring Guardian is authorised to act only if and when the person is unable to make reasonable judgments and only in accordance with the matters specified by the appointor. If the person is unable to make reasonable judgements about the matter required, any decisions made by the Enduring Guardian will have the same legal status as a decision made by the person themselves. The treating health professional is obliged to provide the Enduring Guardian with information and support to make an informed decision.

The ability to make reasonable judgments may fluctuate, may be uncertain, or may be permanently impaired. A person may be unable to make reasonable judgments about some matters, but may still be able to make reasonable judgments about others. This may depend on the type of decision to be made. It is important to ensure that the Enduring Guardian only acts at times when the person is unable to make reasonable judgments for themselves.

The ability to make reasonable judgments can be considered to be:

- Global (either able or unable to make reasonable judgments in all spheres)
- Domain-specific (able to make reasonable judgments in one domain but not in others, e.g. accommodation, but not finances)
- Decision-specific (able to make reasonable judgments but not all within a domain,

e.g. in healthcare able to make simple but not complex decisions).

About the EPG Form

How to identify an EPG form

An EPG is a statutory form that is part of the *Guardianship and Administration Regulations 2005* (available at www.slp.wa.gov.au). A person must use the form that is part of the Regulations or a form that is substantially compliant.

The Office of the Public Advocate has published an EPG form and a copy of this form is located at www.publicadvocate.wa.gov.au. It is possible (but not recommended) for other organisations and individuals to publish their own EPG forms.

Health professionals may contact the Office of the Public Advocate or SAT if they are uncertain about a particular EPG form.

Witnessing

The EPG must be signed by the person and witnessed in the presence of two other people who are at least 18 years of age and who have full legal capacity, one of whom is a person authorised to witness statutory declarations (link to list of who can witness).

The Enduring Guardian must also sign the EPG form and have their signature witnessed by two other people who are at least 18 years of age and who have full legal capacity, one of whom is a person authorised to witness statutory declarations.

The witnesses for the person and the Enduring Guardian do not have to be the same and the Enduring Guardian does not need to be present when the person signs the form. However, the EPG does not come into effect until the form is signed by the Enduring Guardian and appropriately witnessed.

If the person is incapable of writing or signing the EPG, another person may sign it at their direction and in their presence (this person cannot be a witness).

Storage

There is no registration process for an EPG. Therefore, it is essential that both the person and the Enduring Guardian know where the original EPG is kept.

A person who has prepared an EPG should be encouraged to ensure that their EPG is kept in a safe place that it is easily accessible when it is required. People should inform their family of where they keep their EPG. It is advised that a copy of an EPG is be kept within the patient's medical record and a copy be given to their treating health professionals, family members, substitute Enduring Guardian or Guardian (if applicable), lawyer (if applicable), carers and nursing home (if applicable). People may choose to use a MedicAlert bracelet or a wallet card to alert health professionals to the existence of an EPG.

Validity outside Western Australia

Whether or not an EPG is valid in another state or territory of Australia will depend on the laws applying in that jurisdiction.

Validity of an EPG created in another jurisdiction

An instrument created in another state or territory of Australia will only be enforceable as an EPG if SAT makes an order to this effect. SAT may make an order recognising an instrument created under a law of another jurisdiction as an EPG if it is satisfied that the instrument corresponds sufficiently, in form and effect, to an EPG. If the person retains full legal capacity, it may be preferable for them to make an EPG.

Relationship between EPG and Enduring Power of Attorney (EPA)

EPG's and EPA's are two arrangements which complement each other, although there is no requirement to execute both. It is possible for the same person to be appointed as an Enduring Guardian and as an Enduring Attorney if this is desired. There are some differences between EPA and a EPG as illustrated below.

Table 1B: Comparison of EPA and EPG

	Enduring Power of Attorney	Enduring Power of Guardianship
Matters which decisions relate to:	Financial and property matters	Personal, lifestyle and treatment matters
Person appointed:	Enduring Attorney	Enduring Guardian
Relationship between capacity and authority to act:	Can operate while the person has capacity to make decisions	Only operates when the person is unable to make reasonable judgements in respect of that matter

An EPA and EPG must be executed according to the legal requirements set out in the *Guardianship and Administration Act 1990* and the correct form should be used in each case. Copies of the EPA form and a guide explaining how to complete an EPA are available from the Office of the Public Advocate's website at www.publicadvocate.wa.gov.au. Alternatively, copies can be purchased from the State Law Publisher, Ground Floor, 10 William St Perth, 6000, phone (08) 9321 7688 or fax (08) 9321 7536.

Reviewing and changing an EPG

Changing or revoking an EPG

While the patient has full legal capacity, they can change their wishes as stated in their EPG or completely revoke their EPG at any time. It is preferable for this revocation to occur in writing. This should include writing to the Enduring Guardians to notify them of the intention to revoke the EPG and requesting that any copies of the EPG be returned. Written notification of the revocation of the EPG should also be provided to all relevant persons and organisations, such as health professionals, family members and residential facilities.

Rather than amending an EPG, it is preferable that a patient completes a new EPG. Creating a new EPG will require the witnessing requirements to be met.

Reviewing an EPG

It is recommended that patients review their EPG at least every 2 years to ensure that it reflects their current wishes.

Enduring Guardian ceasing to act

Anyone can refuse a request to be an Enduring Guardian if they do not think they are able to, or do not wish to, carry out the role. In addition, once appointed, an Enduring Guardian can decide that they no longer wish to continue in the role at any time. This decision should be communicated to the person in writing. If however the person has no longer has full legal capacity, it is necessary for the Enduring Guardian to apply to SAT for revocation of their appointment.

What if a person does not make an Enduring Power of Guardianship?

If anyone chooses not to make an EPG, a treatment decision will be made on their behalf in the event that they are unable to make a treatment decision. The treatment decision will be made by either the person's (in the following order of priority) Guardian (if one has been appointed for the person), or by another person responsible (such as the person's spouse, parent, child, sibling or unpaid carer. For more information refer to the Treatment Hierarchy in Section D: Consent for Treatment.

Role of State Administrative Tribunal (SAT)

Resolution of Issues

Amongst other things, SAT has responsibility for the resolution of issues arising under the *Guardianship and Administration Act 1990*, including issues relating to EPG's.

In relation to EPG's, the State Administrative Tribunal may:

- Declare an EPG to be valid or invalid.
- Declare that the Enduring Guardian is unable to make reasonable judgments in respect of matters relating to the appointor.
- Give directions connected with the exercise of and/or construction of the terms of an EPG.
- Revoke an EPG if the Enduring Guardian wishes to be discharged, is guilty of neglect or misconduct which renders the person unfit to continue as Enduring Guardian or appears to be incapable of carrying out their duties.
- Make an order recognising an instrument created under a law of another jurisdiction as an EPG.

Any person considered by SAT to have a proper interest may apply to SAT for a decision.

Appointing a Guardian

A Guardian may be appointed by SAT when a person lacks the capacity to make decisions for themselves. Guardians are appointed to safeguard the best interests of people with decision-making disabilities such as intellectual disability, mental illness, acquired brain injury and dementia. This is usually considered when there are legal problems, unresolved conflicts between family members or care providers, or risks of neglect, exploitation or abuse. A Guardian may be a close friend or family member of the represented person or, when there is no other suitable option available, the Public Advocate may be appointed.

When informal arrangements can ensure the best interests of the person with a decision-making disability are protected, then the appointment of a Guardian may not be necessary.

Exercises

1. When should an EPG be considered and what are the benefits of appointing an Enduring Guardian?
2. What if an Enduring Guardian wants to change his/her mind about accepting the role?
3. What if there are concerns about an abuse of power by the Enduring Guardian or that the Enduring Guardian does not have the capacity to fulfil his or her role?
4. What if there are concerns about the validity of the EPG and whether the person had full legal capacity at the time that an EPG was made?

Advice and further assistance

Office of the Public Advocate

For further information on Enduring Powers of Guardianship or for a copy of the booklet 'A Guide to Enduring Power of Guardianship Western Australia' contact the Office of the Public Advocate.

Level 1, 30 Terrace Road, EAST PERTH WA 6004

T: 1300 858 455 TTY: 1300 859 955

F: (08) 9278 7333

E: opa@justice.wa.gov.au

W: www.publicadvocate.wa.gov.au

State Administrative Tribunal

Information on how to make an application for resolution of issues arising under the Act, and relevant application forms, can be obtained from the State Administrative Tribunal website at www.sat.justice.wa.gov.au .

T: (08) 9219 3111

T: 1300 306 017 (Toll Free)

W: www.sat.justice.wa.gov.au

Consent for Treatment

Learning Outcomes

At the end of the module you will:

- Be able to distinguish between urgent treatment and non-urgent treatment.
- Understand the Treatment Hierarchy and how it applies to non-urgent medical treatment.
- Be able to understand the relationship between AHD's, common law directives, EPG's and other substitute decision makers in the consent for treatment process.

Consent to Treatment

When a patient is unable to make reasonable judgments about a treatment decision at the time that the treatment decision is required, who can make the treatment decision on their behalf depends on whether the treatment is “urgent” or “non-urgent”.

Urgent Treatment

Urgent treatment is treatment that is urgently required to:

- save the patient’s life;
- prevent serious damage to the patient’s health; or
- prevent the patient from suffering or continuing to suffer significant pain or distress.

Where urgent treatment is required, the health professional may make the treatment decision unless either:

- it is practical to ascertain whether the patient has made an AHD;
- it is practical to consult with a person who can make the treatment decision on behalf of the patient (this is explained further below as being the Enduring Guardian, Guardian or “person responsible” for the patient).

Even where it is practical to ascertain if there is an AHD or to consult with a person who can make the treatment decision on behalf of the patient, if the health professional reasonably believes that the patient has attempted to commit suicide, and that the patient needs the urgent treatment as a consequence, the health professional can make the treatment decision on behalf of the patient.

Non Urgent Treatment

Non urgent treatment is planned or routine medical, surgical or dental treatment or other health care.

In relation to non-urgent treatment, treatment decisions should be made in accordance with the Treatment Hierarchy, which is outlined in Figure 1D. The Treatment Hierarchy sets out the order of consultation to obtain a treatment decision by or on behalf of the patient.

Health professionals should consult the person who is in the highest position on the hierarchy in relation to a treatment decision. This person can make the treatment decision if they are:

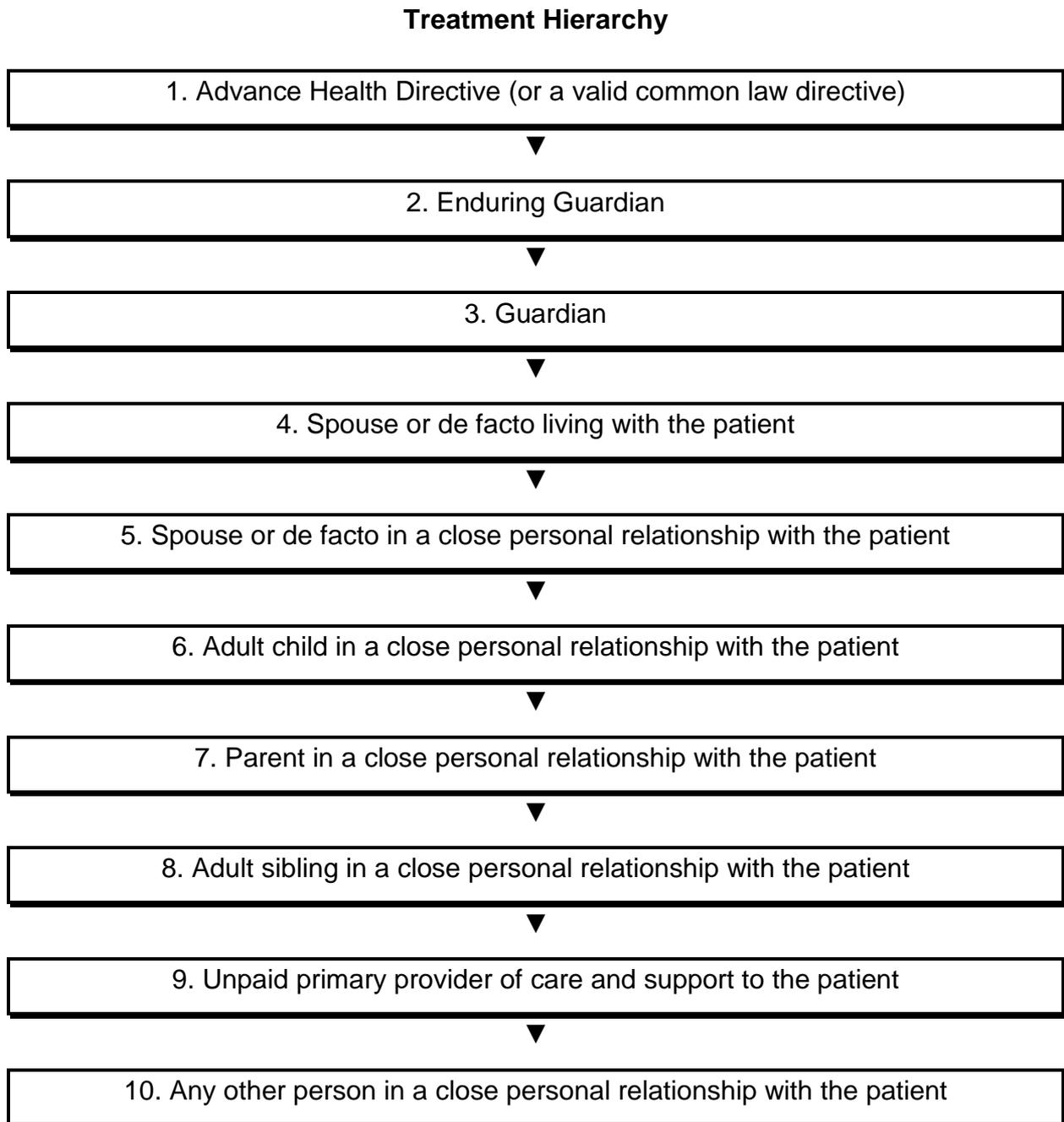
- of full legal capacity;
- reasonably available; and
- willing to make the treatment decision.

If the first (or any subsequent) person in the hierarchy does not meet these criteria, the next person should be consulted until the treatment decision can be made.

Treatment Hierarchy

The figure below outlines the Treatment Hierarchy. The hierarchy includes the two new instruments of the Act followed by a list of substitute decision makers.

Figure 1D: Treatment Hierarchy



Each level of the Treatment Hierarchy is explained below:

1. Advance Health Directive (or common law directive)

As an expression of the person's own wishes, an AHD or common law directive sits at the top of the Treatment Hierarchy and should be the first avenue for obtaining a treatment decision.

Except where there is doubt about the validity or operation of the AHD or common law directive, a treatment decisions contained in the AHD or common law directive must be followed (for more information see Section B: Advance Health Directives – Validity of treatment decisions).

2. Enduring Guardian

As an Enduring Guardian is personally appointed by the patient, they are the first person who should be consulted where a treatment decision is required on behalf of a patient.

As it is possible for the power of an Enduring Guardian to be limited (and to exclude the power to make treatment decisions), it is important to confirm the scope of the Enduring Guardian's powers in a particular case by referring to the EPG form.

Where a patient has appointed more than one Enduring Guardian, they must be consulted and must make all treatment decisions jointly.

An Enduring Guardian must act according to his or her opinion as to the best interests of the person, and in a manner consistent with any specific directions imposed by the person in the EPG form.

3. Guardian

A Guardian is a person appointed by the State Administrative Tribunal to make decisions on behalf of the patient.

As it is possible for the power of a Guardian to be limited (and to exclude the power to make treatment decisions), it is important to confirm the scope of the Guardian's powers in a particular case by referring to the order of the State Administrative Tribunal.

Where more than one Guardian has been appointed by the State Administrative Tribunal, they must be consulted and must make all treatment decisions jointly.

A Guardian must act according to his or her opinion as to the best interests of the person.

4. Spouse or de facto living with the patient

A "spouse" is a person who is lawfully married to the patient.

A "de facto" is a person who is in a "marriage-like relationship" with the patient, and who is at least 18 years of age. This includes same-sex relationships.

"Living with the patient" is likely to mean sharing the same primary residence.

5. Spouse or de facto in a close personal relationship with the patient

A "spouse" is a person who is lawfully married to the patient.

A "de facto" is a person who is in a "marriage-like relationship" with the patient, and who is at least 18 years of age. This includes same-sex relationships.

A spouse or de facto will be in a close personal relationship with the patient if they have frequent contact with the patient of a personal nature, and they take a genuine interest in the patient's welfare.

6. Adult child in a close personal relationship with the patient

"Child" means the biological or adopted child of the patient. For the sake of clarity, reference is made to the "adult child".

An adult child of the patient will be in a close personal relationship with the patient if they have frequent contact with the patient of a personal nature, and they take a genuine interest in the patient's welfare.

Any adult child who maintains a close personal relationship with the patient can make treatment decisions. If there is more than one adult child there is no hierarchy by age or otherwise to give authority of one child over another to make the treatment decision.

Valid consent can be obtained from any adult child and health professionals are not required to obtain consent from all adult children. If difficulties arise, that cannot be resolved by health professionals, then an application may be made to SAT to determine what treatment decision should be made in the best interests of the patient.

7. Parent in a close personal relationship with the patient

"Parent" means the biological or adoptive parent of the patient. "Parent" does not include a step-parent.

A parent of the patient will be in a close personal relationship with the patient if they have frequent contact with the patient of a personal nature, and they take a genuine interest in the patient's welfare.

8. Adult sibling in a close personal relationship with the patient

"Sibling" means the biological or adoptive sibling of the patient. For the sake of clarity, reference is made to the "adult sibling".

A sibling of the patient will be in a close personal relationship with the patient if they have frequent contact with the patient of a personal nature, and they take a genuine interest in the patient's welfare.

9. Unpaid primary provider of care and support to the patient

"Care and support" includes emotional support, but does not include care and support for which the provider is remunerated. A provider is not considered to be remunerated merely because they receive a carer payment or other benefit from the government for providing home care for the patient.

10. Any other person in a close personal relationship with the patient

A person will be in a close personal relationship with the patient if they have frequent contact with the patient of a personal nature, and they take a genuine interest in the patient's welfare.

Relationship between AHD, EPG and common law directive in a non-urgent situation

AHDs, EPGs and common law directives are ideally executed together but can be executed independently of each other. The following table outlines the process of obtaining consent for treatment where an AHD, EPG and/or common law directive may exist.

Table 1D: Decision-making in the presence/absence of AHD, EPG and/or common law directive for non-urgent treatment

Instrument(s) present			Consent for treatment process
AHD*	EPG	Common law directive	
✓	✓	✗	Decisions made on the basis of the AHD (where specified). The Enduring Guardian can make decisions (where not specified in the AHD) according to the best interests of the patient.
✓	✗	✗	Decisions made on the basis of AHD where specified. If the treatment decision to be made is not specified in the AHD then consent must be obtained from a substitute decision maker in the Treatment Hierarchy.
✗	✓	✗	If the Enduring Guardian has authority to make treatment decisions then they must make the treatment decision according to the patient's best interest. If the Enduring Guardian does not have authority to make treatment decisions, then consent must be obtained from a substitute decision maker in the Treatment Hierarchy.
✓	✓	✓	Decisions made on the basis of AHD (where specified) and the common law directive. If there is uncertainty, for example the treatment decisions described in a common law directive do not correspond to the AHD, then SAT can make a determination. If the treatment decision to be made is not referred to in the common law directive or the AHD, then the Enduring Guardian (with authority to make treatment decisions) must make a treatment decision according to the patient's best interest.

Instrument(s) present			Consent for treatment process
AHD*	EPG	Common law directive	
✓	✗	✓	<p>Decisions made on the basis of AHD (where specified) and the common law directive. If there is uncertainty, for example the treatment decisions described in a common law directive do not correspond to the AHD, then SAT can make a determination.</p> <p>If the treatment decision to be made is not referred to in the common law directive or the AHD, then consent must be obtained from a substitute decision maker in the Treatment Hierarchy.</p>
✗	✓	✓	<p>Decisions made on the basis of the common law directive where specified. If not specified in the common law directive, the Enduring Guardian (with authority to make treatment decisions) must make a treatment decision according to the patient's best interest.</p>
✗	✗	✗	<p>Decision made by obtaining consent from a substitute decision maker in the Treatment Hierarchy.</p>

* In the above table the AHD is assumed to be both valid and operative.

Exercises

1. As a health professional you may find yourself in a situation where you are asked to assist a person to end his/her life. What is the impact of the *Acts Amendment (Consent to Medical Treatment) 2008* on the actions you may legally and ethically take?
2. As a health professional you may find yourself in a situation where you may disagree with a person's legal choice to refuse treatment (including nutrition and hydration). What are your ethical obligations?

Advice and further assistance

Department of Health (Office of the Chief Medical Officer)

PO Box 8172, Perth Business Centre, WA 6849

T: (08) 9222 2300

E: chiefmedicalofficer@health.wa.gov.au

W: www.health.wa.gov.au/advancehealthdirective

Department of Health (Office of Safety and Quality in Health Care)

2nd Floor, B Block, 189 Royal Street, East Perth 6004

T: (08) 9222 4080

F: (08) 9222 2032

E: safetyandquality@health.wa.gov.au

W: www.safetyandquality.health.wa.gov.au

Office of the Public Advocate

Level 1, 30 Terrace Road, EAST PERTH WA 6004

T: 1300 858 455 TTY: 1300 859 955

F: (08) 9278 7333

E: opa@justice.wa.gov.au

W: www.publicadvocate.wa.gov.au

Advance Care Planning

Learning outcomes

At the end of this module you will:

- Be able to explain the concepts of Advance Care Planning.
- Be able to lead, participate in discussions about, and provide guidance and assistance to patients, family and relevant others for Advance Care Planning.
- Be able to document discussions relating to plans and be aware of the importance of recording, storing and regularly updating plans on the patient's file.
- Understand the changing trajectory of disease and the implications for medical treatment decisions in the years preceding the end of life.
- Understand what people and families want in planning for the end of life.
- Be aware of clinical practice guidelines for communicating prognosis at the end of life.
- Be able to explain the concepts and legal implications of Advance Care Plans.
- Be familiar with some of the common Advance Care Planning templates.

Background

What is Advance Care Planning?

Advance care planning is a dynamic, ongoing process of communication between an individual, their health professionals and those close to them about future care, focusing on information sharing, reflection, discussion and review. It aims to achieve a shared understanding of the person's current state of health, the expected course of the disease, their goals for care, and their values and preferences for future treatment and the designation of a decision-maker should they no longer be able to be involved in their own medical decision-making.

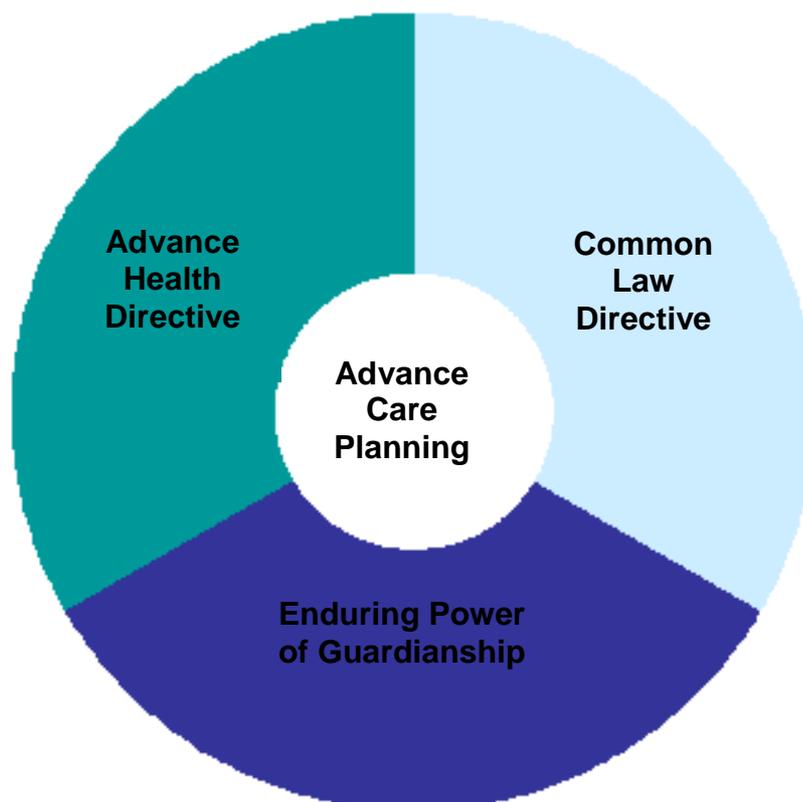
What are advance care plans?

An advance care plan is the outcome of the advance care planning process and refers to a repository of documents, text, records, and other relevant information documenting the wishes and preferences of the individual in their medical record and in a form provided to the patient themselves for their own records.

Advance care planning in context of *Guardianship and Administration Act 1990*

Advance care planning in accordance with the *Guardianship and Administration Act 1990* can include the development of a number of instruments by the patient. These instruments include an AHD and the appointment of an Enduring Guardian via an Enduring Power of Guardianship form. Under common law it is also possible to prepare a common law directive.

Figure 1E: Advance care planning model



Current evidence

The uptake of advance health directives

AHDs in which a patient directs future treatment decisions have been legal in other parts of the world for many years. Despite this Australian and international research indicates the uptake of AHD has generally been low outside of specific advance care planning programs. The literature suggests that most people would prefer to have their wishes for end of life care known but few want to 'micromanage' their own death by completing a formal, legal AHD. Experience in the USA shows completion rates of AHDs of 10-45%, but these rates vary dramatically among patient populations and health care settings. Even when AHDs are completed, most health professionals are not aware of them and care is inconsistent with specific directives written in medical records at least half the time.

The uptake of advance care planning

In contrast to AHDs, the ACP process has proven far more successful in other parts of the world. In Australia, where advance care planning is relatively new, it has been estimated that less than 1 percent of residential aged care facility residents had an advance care plan in 2000, in contrast with more than 70 percent in nursing homes and up to 94 percent in hospices in the USA. Acutely ill individuals complete AHDs only slightly more often than the healthy population. Only 1 in 3 chronically ill individuals in the community have completed AHDs (e.g., 35% in dialysis patients; 32% in COPD patients). Furthermore the comprehensiveness and applicability of AHDs vary substantially.

ACP is a continuous communication process which reviews the patient's situation, the risks and benefits surrounding current available treatments (including offering palliative or hospice care), and eliciting patient preferences and wishes that occurs between the patient, those close to them and their healthcare providers. ACP ideally includes the Enduring Guardian, thereby providing an opportunity to communicate preferences to those who will be left to make decisions for them if capacity is lost.

What people want from ACP

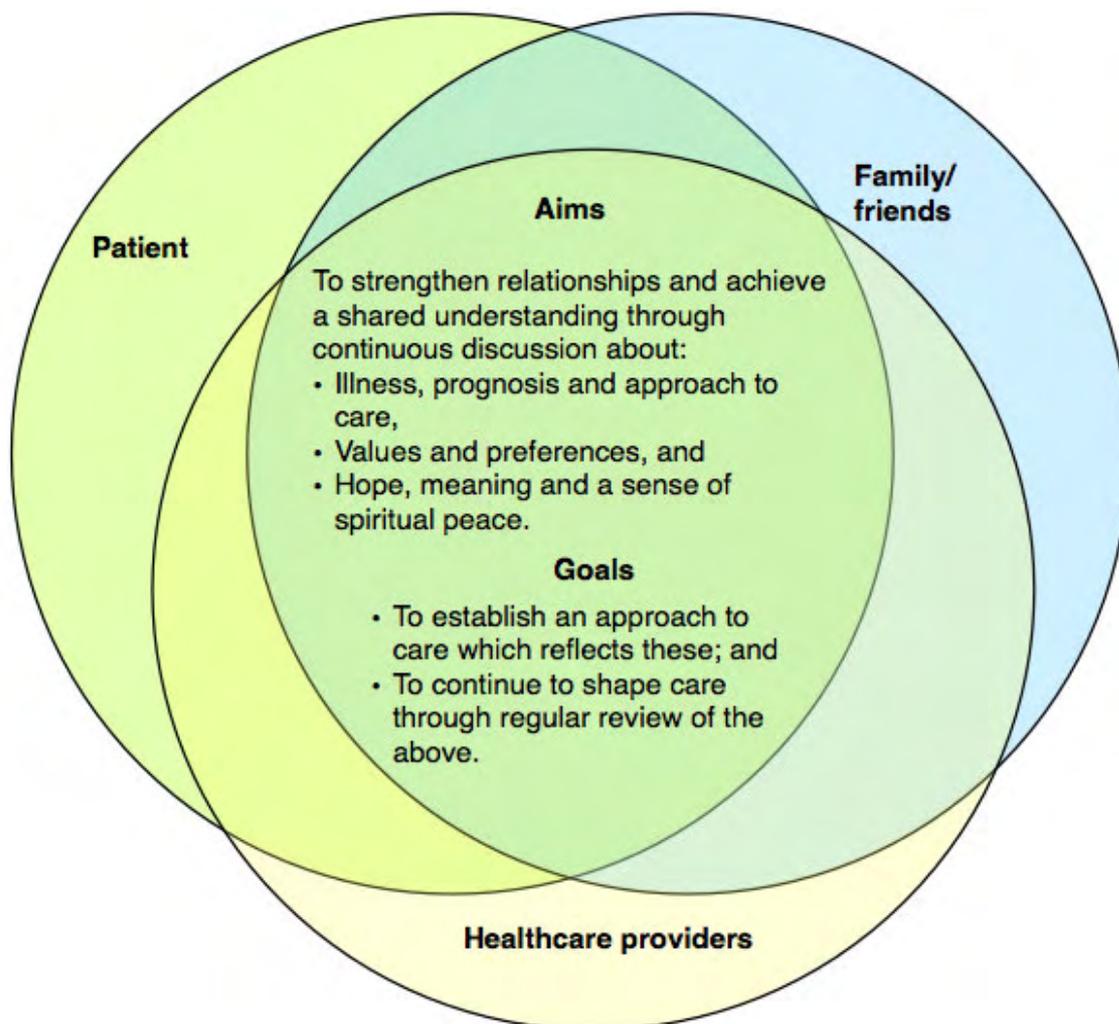
Most patients and families want and expect their healthcare providers to initiate end-of-life discussions and to ask them about their personal values and goals for care. Rather than selecting or rejecting specific treatment options, many individuals prefer to base treatment decisions on these discussions and by setting more broad treatment goals. Patients place a high value on these discussions and this involves providing honest information early in the illness trajectory about prognosis, treatment options (including hospice and palliative care) and the likely course of their disease. Issues that are consistently identified as important to guide medical decision-making at the end of life include cognitive function, independence, and dying with dignity.

Most patients do not want to have to make treatment decisions on their own. Rather, they want a trusted individual and their healthcare team significantly involved in helping them determine the best course of action.

Important elements of the Advance Care Planning Process

Advance care planning involves communication about the individual's illness and prognosis, risks and benefits of treatment options (including palliative care), preferences in future health care and quality-of-life, reflection by the patient and family on the information provided, determination and documentation of treatment decisions and goals, and periodic review to reflect the person's current situation and available treatments that could influence prior decisions. Advance care planning ideally should become part of routine contact within the health services.

Figure 2E: The aims and goals of ACP



Who can instigate and who to involve?

Research has shown that most people want a say in their future care but are reluctant to initiate advance care planning discussions. Other research indicates that most people want their health professional to start such discussions. Therefore, Advance care planning should be instigated by a health care professional, such as a medical practitioner, a nurse, a social worker or other relevant health professional. Most successful advance care planning programs use a team approach.

The ACP planning process occurs between the individual, their healthcare providers and those close to them. This may include the guardian, spouse, other members of the family, close friends, carers and other healthcare providers.

Why do Advance Care Planning

Greater use of advance care planning is likely to help the community to recognise the limits of modern medicine and engender a considered conversation regarding one's expectations about the outcomes of medical interventions and desired quality of life. The emerging evidence on advance care planning suggests it has been far more successful than AHDs alone in enhancing patient/provider communication and reduces unnecessary hospitalisations, aggressive treatments at the end-of-life, and results more often in care that is consistent with the patient's goals.

ACP is a more than documenting life-sustaining treatment choices or identifying a surrogate decision-maker. The process of ACP can bring many benefits to the individual, those who are close to and those who care for the individual. ACP can enhance patient autonomy by providing the opportunity to express and document desired treatment wishes. It empowers patients to become partners with the healthcare team in the management of their own care. The process helps all involved to converge on a unified plan that gives voice to the person's preferences for medical care within the spectrum of reasonable clinical options.

The primary aims and goals of ACP are (outlined in the Figure 2E) adapted from the work of many authors. Continuous discussion and review with the patient, those who are close to the patient and health professionals about the illness, priorities, values and preferences strengthens relationships and creates a shared understanding of care preferences and wishes from which priorities and the approach to care can be shaped. Comprehensive advance care planning includes the communication of these wishes and decisions to the individual's family/friends and to other healthcare team members.

When is a person ready for advance care planning?

Each person will be at different stages in relation to their readiness to consider ACP and end-of-life decisions, depending on a variety of factors, including health or disease state, type and stage of disease, educational and socio-economic status, etc. Health professionals with ongoing therapeutic relationships with patients have multiple opportunities to raise ACP issues when appropriate.

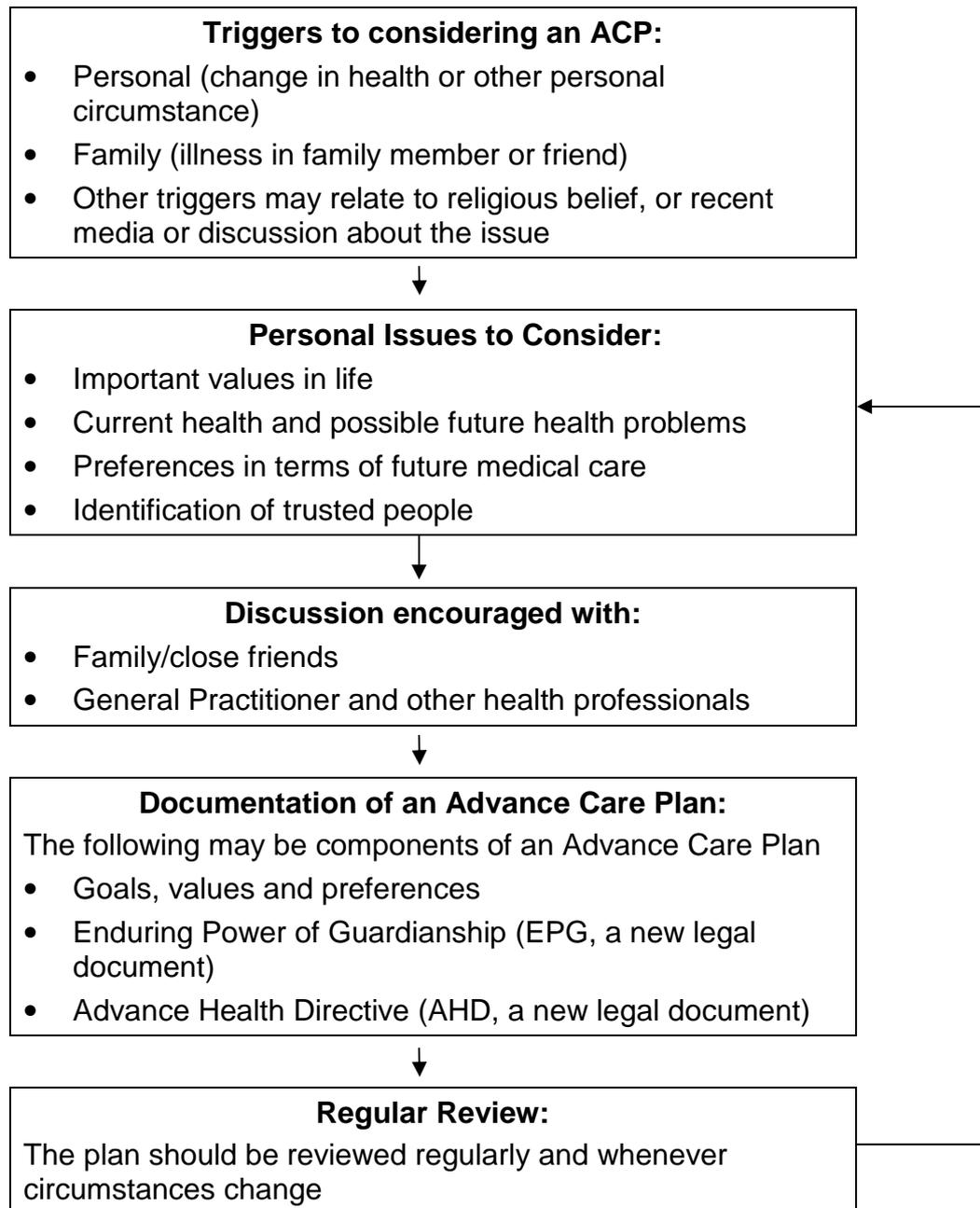
A variety of triggers may influence someone to participate in advance care planning: hearing something on the media, a personal experience of disease, change in personal circumstance such as retirement, or a family member/close friend at the end of life. The commonest reason for a person to initiate ACP is the experience of disability and reduced quality of life.

Suggesting that patients reflect on their situation, what is important to them and their family and using resources such as pamphlets or standardised ACP discussion guides can be helpful in achieving a shared understanding of their preferences.

The advance care planning process

Advance care planning may be triggered by many events in life and the diagram below summarises the steps in developing the plan.

Figure 3E: Advance Care Planning Process



What to discuss?

Topics which may be relevant to the ACP process include the following:

- Understanding of the illness and its prognosis, the likely progression of disease potential future symptoms and other relevant medical issues.
- The risks and benefits of current treatment options.
- Life goals, spiritual and religious values and beliefs, cultural values and how these should influence medical decision-making, existential and/or psycho-social issues.

- Determination of treatment goals, preferences and care wishes.
- The process of dying and preferences for place of death (when appropriate).
- Financial, caregiver, family and/or other practical issues and tasks that need action.

Who should consider advance care planning?

Most people think it is a good idea to define how treatment decisions should be made for them in the future. However it is difficult for the majority of people to make and document clear decisions relating to a future situation. It is not possible to know with certainty how one will feel about a future situation that can only be imagined. Compared with the experience of people living with disease, most healthy people asked to imagine being in the same situation report lower levels of happiness and quality of life. For example, those who are well may imagine having a colostomy to be a terrible outcome, but studies show no difference in quality of life between patients with rectal cancer with and without a colostomy. Thus, quality of life is a relative concept and assumptions cannot be made as to what conditions an individual would or would not consider acceptable. Some people with life-limiting illness may perceive themselves to be well and for ACP and AHDs to be irrelevant.

Therefore the nature of the ACP process will vary depending on the disease stage and expectations and prognosis of the patient.

The table below shows three broad groups for whom ACP may have a different purpose.

Table 1E: Targeting ACP

	Healthy	Life-limiting illness	Expected deterioration and impending death
Characteristics	No life-limiting illness or has early stage disease only	Living with chronic life-limiting illness which impacts on daily activities	Expecting to die soon or entering a high-care residential aged care facility
Expected life duration	Normal	At least 3-10 years	1-2 years
Common issues	Without experience of disease it is difficult for most people to define clear preferences. However most will desire aggressive rescue treatment in the event of a serious accident.	Decisions need to be based upon expectations of the disease trajectory. Not all clinical situations and outcomes can be anticipated.	Decisions need to be based upon the expected outcomes and preferences, both of which may be clearer for this group. The role of palliative care may be important.
Resources	Offer pamphlets or website information for people to read.	Offer pamphlets or website information for people to read.	Consider palliative care services.

How to tailor ACP to the individual's situation

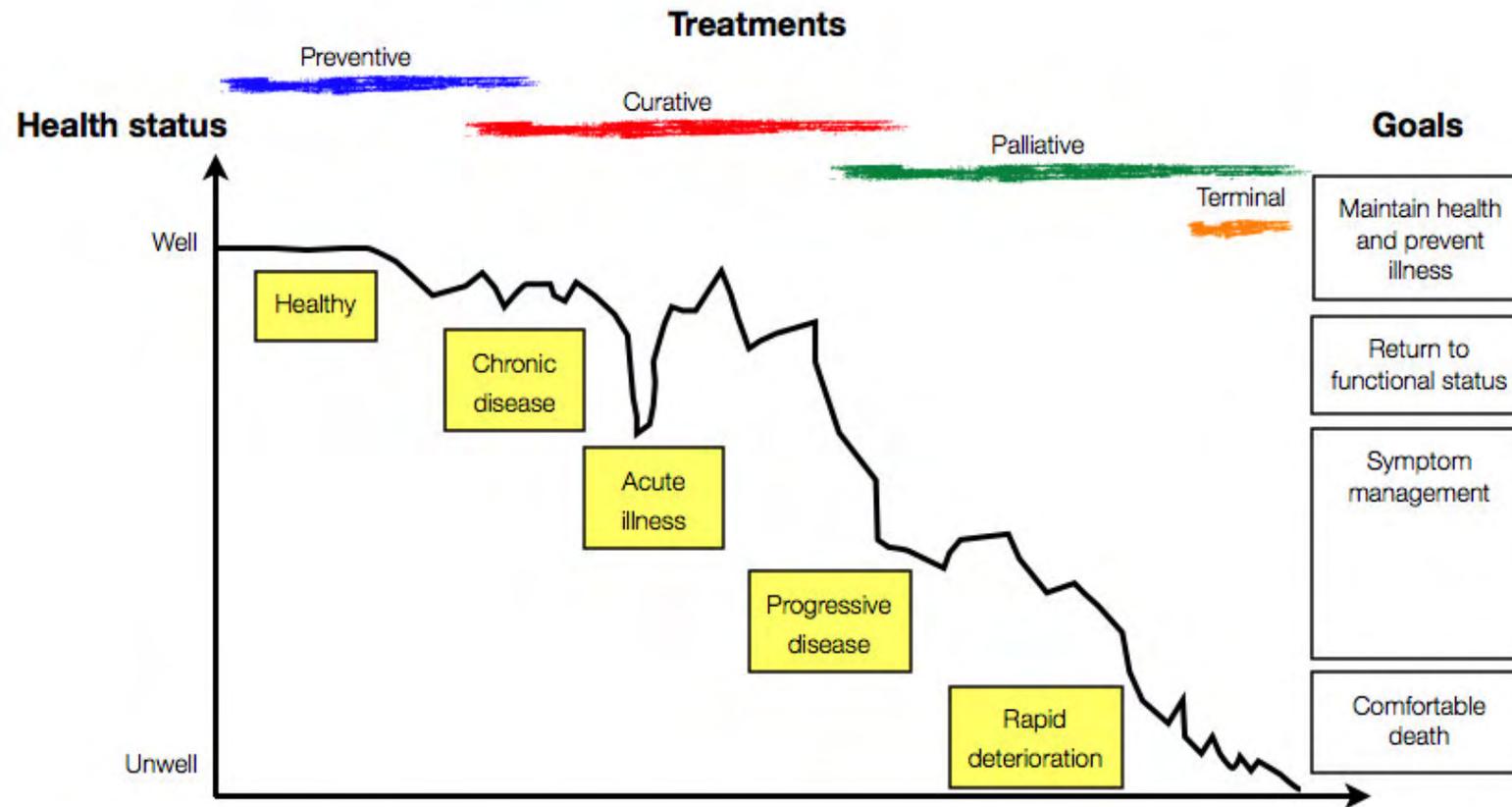
ACP efforts should be tailored to the individual patient's health status, social circumstances, beliefs and preferences.

Different diseases will follow different trajectories of longevity. The course of the individual's illness, or illness trajectory, will play a significant role in shaping the patient's experience and decision-making. As the patient's health status changes, the clinical team discusses and plans with the person, the family and decision makers. ACP in this sense is a very dynamic process. While it may not be possible to anticipate every potential clinical situation for every person, the majority of situations, such as symptom exacerbations of advanced chronic disease or potential hospitalisations, can be anticipated and planned for in the context of advance care planning. Preparing the person and family for these events and making contingency plans for them (e.g., the patient does not want to go to the hospital anymore or does not want cardiopulmonary resuscitation should his/her heart fail) can be incorporated in the plan. Good ACP ensures that individuals and families are 'not surprised' by the course of their disease.

In addition, many patients may not be ready to make end-of-life decisions and would rather take time to consider the issues while others may simply want to rely on their family/Enduring Guardian and health care professional to make decisions for them and not 'micro-manage' their own death. With ACP, general treatment preferences can be discussed so that everyone will be comfortable that they have a general understanding of what the individual would want. It is important to raise patient's awareness of the current situation and to reassess the patient's willingness to be actively involved in advance care planning.

Figure 4E demonstrates how ACP can be targeted and tailored to people at different points of the illness trajectory. Note that the goals and treatments are different for different stages of disease and health status. The discussion (the advance care planning process) and the EPG are relevant to all stages while the AHD and specific directives are more relevant to the later stages of the illness trajectory.

Figure 4E: The illness trajectory and ACP



Advance care planning

Advance care planning can include an EPG and an AHD. These and other components of the plan may have more relevance for different stages of the illness trajectory.

EPG An enduring power of guardianship can be considered in all cases, and discussion with enduring guardian is encouraged about values and broad preferences.

AHD An Advance Health Directive should be considered, with discussion about the illness, prognosis, treatment options, goals and preferences. Where appropriate, include directives relating to specific situations.

Review plan The plan should be reviewed regularly and whenever the situation changes. Consider specific directions relating to specific situations.

Facilitating Advance Care Planning

Some helpful hints on how to facilitate ACP in the clinical setting are presented in the following tables and are organised around the following patient populations:

- Healthy.
- With a life-limiting disease.
- With a life-threatening illness and the imminently dying.

Health professionals can take the lead to start the discussion on ACP:

- Plan your discussion, ensuring privacy and allowing sufficient time for discussion and reflection over one or more consultations, encourage having a close person present at the consultation(s) if appropriate.
- Use your existing therapeutic relationship and convey empathy using words, posture and appropriate touch.
- Avoid medical jargon and provide realistic information on prognosis and treatment options with an emphasis on how you expect their illness will impact daily living and function.
- Use positive language, e.g. "As things change, we can work on the options and come up with a plan together."
- Determine goals of care and identify any specific desires for how information should be shared with family members.

Some opening questions may include:

For healthy person:

You may be aware that in Western Australia new laws have been introduced allowing people to define who will make decisions for them and how this will happen if they are ever too unwell to be able to make their own decisions. Is that something you are interested in finding out about?

For someone with life-limiting illness:

This is a long-term condition and there are going to be periods when you are well and periods when you will not be well. Would you like to discuss how we should approach your care during the times when things are worse? What's important to you? Who would you like me to involve?

Someone with expected deterioration or impending death:

We've discussed what I think is likely to happen in the future. I'd like to know more about how you think we should approach your care from here. What's important to you? Who would you like me to involve? Have you been thinking much about what happens?

The following sections illustrate how ACP can be targeted to the person.

ACP for the healthy person

Most healthy individuals will desire aggressive for life threatening illnesses and may only want to name an Enduring Guardian and perhaps make life-sustaining treatment decisions for extreme situations. The focus of ACP should be on naming a substitute

decision-maker, stating preferences about undesirable outcome states such as persistent vegetative state, and noting special preferences. This discussion should be revisited if the individual's circumstances change.

ACP and the healthy person

	ACP Process for the Health Professional
Aim: Patient to consider and/or appoint an Enduring Guardian	<p>Content of discussion:</p> <ul style="list-style-type: none"> • Designation of Enduring Guardian and the degree of flexibility desired in decision-making by the Enduring Guardian and healthcare team.
	<p>Action items:</p> <ul style="list-style-type: none"> • Assist the person to identify the potential Enduring Guardian/s and facilitate communication with and inclusion of the potential Enduring Guardian/s in the ACP discussion if possible. Assist to complete an EPG. • Documentation of the discussion, designation of Enduring Guardian, any decisions regarding treatment preferences, and other relevant individual patient information, values or wishes into the medical record. • Provide a written copy of discussion and decisions to the patient for their records & to share with other treating health professionals.
	<p>Communication examples:</p> <ul style="list-style-type: none"> • If you become too sick to tell me what you want, who would you like me to speak with? Have you talked to ___ about this? Would you like to have them included in this discussion?

	ACP Process for the Health Professional
Aim: Patient to consider preparing an AHD and/or a common law directive	<p>Content of discussion:</p> <ul style="list-style-type: none"> • Potential outcome states from serious illness or traumatic accidents, such as coma, other serious neurological disabilities; general treatment preferences; and general treatment options, such as cardiopulmonary resuscitation, antibiotics, ventilation, and artificial nutrition/hydration. • The person's beliefs, preferences, religious or spiritual values (e.g. Jehovah's Witness) and how this should guide care.
	<p>Action items:</p> <ul style="list-style-type: none"> • Assist to consider an AHD if there is a desire to document specific treatment preferences. • Documentation of the discussion, designation of Enduring Guardian, any decisions regarding treatment preferences, and other relevant individual patient information, values or wishes into the medical record. • Provide a written copy of discussion and decisions to the patient for their records & to share with other treating health professionals.

ACP Process for the Health Professional	
	<p>Communication examples:</p> <ul style="list-style-type: none"> • Do you have any specific concerns about certain types of treatment? • In Western Australia, one of the ways to make sure that your treatment decisions will be followed in the future is to make an AHD. Is an AHD something you'd like to consider doing? • Do you have any personal or religious beliefs about medical treatment that I should know about?

ACP for the person with a life-limiting illness

The next level of ACP is warranted for those individuals diagnosed with a serious illness that affects lifestyle and will eventually worsen and may lead to death (3-10 years), such as cancer, respiratory diseases like emphysema, heart disease (e.g., myocardial infarction or congestive heart failure), or cerebrovascular accident or degenerative neurological disease. ACP discussions for these patients should be tailored to the specifics of the patient's disease(s), current treatment options, likely outcomes and prognosis. Research has shown that these patients may be more concerned with how various illnesses and treatment might affect their valued life activities rather than specifying interventions to be used.

ACP Process for the Health Professional	
<p>Aims Patient to consider and/or appoint an Enduring Guardian</p> <p>If an EPG exists the patient should consider reviewing their document(s)</p> <p>Health professional to support the Enduring Guardian</p>	<p>Content of discussion:</p> <ul style="list-style-type: none"> • Designation of Enduring Guardian and the degree of flexibility desired in decision-making by the Enduring Guardian and healthcare team.
	<p>Action items:</p> <ul style="list-style-type: none"> • Assist the patient to appoint an Enduring Guardian(s) using an EPG and include them in all ACP discussions. • Educate the patient and Enduring Guardian(s) on what to expect and establish agreed plans for managing future disease exacerbations. • Document wishes and treatment preferences and provide a written copy of discussion and decisions to the patient, Enduring Guardian(s) for their records & to share with other treating health professionals. • Consider separate discussions with the Enduring Guardian(s) to determine their understanding of the situation and their own needs and issues.
	<p>Communication examples:</p> <ul style="list-style-type: none"> • If you become too sick to tell me what you want, who would you like me to speak with? Have you talked to ___ about this? Would you like to have them included in this discussion?

ACP Process for the Health Professional	
<p>Aims: Patient to consider preparing an AHD and/or a common law directive</p> <p>If an AHD and/or common law directive exists the patient should consider reviewing and/or updating these documents</p>	<p>Content of discussion:</p> <ul style="list-style-type: none"> • Prognosis and likely disease course, symptoms and their management, risks and benefits of treatments and likely outcomes with and without treatment and offer palliative or hospice care as appropriate. • Potential outcome states from serious illness or traumatic accidents, such as PVS, coma, other serious neurological disabilities; general treatment preferences; and general treatment options, such as cardiopulmonary resuscitation (CPR), antibiotics, ventilation, and artificial nutrition/hydration. • Treatment goals. • Time-limited trials of aggressive treatment, with explicit timeframes (e.g., 72 hours), parameters of response to treatment, timing/criteria for re-evaluation, and directions about stopping treatment(s) if ineffective. • What is important to the patient in terms of quality of life. • Personal beliefs, preferences, religious or spiritual values (eg. Jehovah's Witness) and how these should guide end-of-life care.
	<p>Action items:</p> <ul style="list-style-type: none"> • Document wishes and treatment preferences. • Assist to develop an AHD for specific treatment preferences such as time-limited trials of aggressive treatment. • Provide a written copy of discussion and decisions to the patient for their records and share with other treating health professionals.
	<p>Communication examples:</p> <ul style="list-style-type: none"> • How do you feel things are going for you right now? • Have you thought about how you would like to be cared for if you become more unwell? • I think you'll recover well after this stroke. Doing the exercises given by the physiotherapist and the speech therapist will help. As we've talked about, the warfarin, the drug which thins your blood will make your chance of having another stroke less. But the chance is still there. Would you like to talk about planning what we should do if you have another stroke? • Do you have any questions or concerns about how we care for you if your health gets worse? • If you have another big stroke or your heart stops beating, we can treat it in many different ways. We can treat this in a full-on way like you might have seen on TV, using CPR (full resuscitation). But in your case with your condition, even if we did that we might not be able to get you back to where you are now. There's a chance that we might end up with you not being able to talk and look after yourself. How would you feel about that? What's important to you in terms of how we look after you?

	ACP Process for the Health Professional
	<ul style="list-style-type: none"> • Asking “What if...?” questions can help to identify the patient’s preferences. • If you were to die suddenly, what would be left undone?

ACP for the person with a life-threatening illness or who is imminently dying

The transition from curative to palliative treatment is one of the most difficult conversations for physicians and patients. Research has shown that terminally ill patients (those with a 1 year or less prognosis or for whom a ‘sudden’ death would not be a surprise to the clinician) often prefer that a surrogate decision-maker and/or their health care team make decisions for them in the context of their current situation rather than specify treatment preferences or follow previously documented preferences (this may require a patient to consider reviewing their AHD or common law directive if either exist). Indeed, it may be more important for the health professional to discern the individual’s preferences about how patient’s want their end-of-life decisions to be made (e.g., whether and in what way they are interested in micro-managing their own situation, the amount of leeway they want surrogate decision makers to have, and who they want involved in the decisions).

Extensive research over the past 20 years has consistently identified a set of common themes about what people and families want, need and expect at the end-of-life. These include:

- Adequate pain and symptom management and excellent comfort care
- Avoiding inappropriate prolongation of dying
- Retaining control over end-of-life decisions and clear patient-centered decision making
- Relieving burdens that their dying would impose on loved ones
- Strengthening relationships with loved ones
- Effective patient-physician communication and physician-family communication
- Being prepared for what to expect
- Achieving a sense of completion in life
- Being treated as a ‘whole person’
- Seamless continuity of care across health care settings and home
- Emotional, practical, and spiritual support
- Grief and bereavement support before and after the death.

In addition, there is general consensus among health professionals concerning what constitutes quality of care at the end of life: person and family centered decision-making; excellent symptom management and comfort care; spiritual and emotional support; and organisational support for health professionals.

ACP Process for the Health Professional	
<p>Aims: Health professional to support the Enduring Guardian</p> <p>Revise or complete an AHD and/or common law directive</p>	<p>Content of discussion:</p> <ul style="list-style-type: none"> • Designation of Enduring Guardian and the degree of flexibility desired in decision-making by the Enduring Guardian and healthcare team. • Explicit discussion of the prognosis and the process of dying; the symptoms and their management; risks, benefits and likely outcomes of treatments/no treatment/withdrawal of treatments; benefits of palliative or hospice care. • The management of end-of-life symptoms. • What is important to the patient in terms of quality of life. • Personal beliefs, preferences, religious or spiritual values (e.g. Jehovah's Witness) and how these should guide end-of-life care. • Preferred place of death and any specific wishes or preferences for the end-of-life.
	<p>Action items:</p> <ul style="list-style-type: none"> • Include the patient and Enduring Guardian(s) in all healthcare discussions. • Document specific end-of-life treatment preferences (e.g. CPR, ventilation, artificial nutrition or hydration, antibiotics) and other wishes in the medical record. • Assist to develop an AHD for specific treatment preferences such as palliative care. • Establish agreed plans for managing disease exacerbations (e.g. re-hospitalisation, time-limited trials, palliative care, or to remain at home, etc.) and for terminal care including where patient wants to die (e.g. home or hospice). • Prepare the family and the setting for the death. • Provide caregivers and family with information, support and other psychosocial services both before and after the death.
	<p>Communication examples:</p> <ul style="list-style-type: none"> • How are things are going for you now? • Your breathing is a problem for you almost all of the time now, isn't it? Have you thought about how you would like to be cared for if it gets worse? • This is the fourth time we've given you radiotherapy for the cancer. How did you find the radiotherapy this time? It came back faster and the chances are it will come back again. Next time we will find it harder to treat as the cancer is more resistant. We need to think about whether you want to have radiotherapy next time. I know it knocks you about a lot and it takes you a while to recover. • We will do all we can to help you keep going as long as you can, but there's only so much we can do. What are your biggest worries for the future? What do you think will happen? What do you hope for? What don't you want to happen? What do you expect the end to be like? • If you were to die soon, what would be left undone?

ACP Process for the Health Professional	
	<ul style="list-style-type: none"> • You've told me before that you want us to focus on keeping you comfortable and pain-free. You said you didn't want to go to hospital even if you were to get more short of breath. Is that still the case? If that happens, and the usual medications don't work, we can use morphine to make you feel more comfortable. • We will be with you right to the end and will keep you comfortable. We'll make sure you are not in pain or short of breath. • What do we need to know to help your family? • Where would you like to be at the end of your life?

Healthcare systems issues: What works?

There are a number of factors associated with successful advance care planning programs. These include:

- A standardised, facilitated and multidisciplinary initiated discussion process to develop individualised plans
- Standardised documentation procedures and forms
- Proactive but appropriately staged timing of discussions and scheduled review of established plans
- Targeted discussions that are patient focused
- Systems and processes that ensure planning and documentation occurs, and
- Evaluation of the process/program for quality improvement .

Other factors that facilitate ACP are when health professionals lead discussions with the patient and the family about patient wishes, values and preferences. This should occur whenever the patient's condition changes. Thus provides opportunities for meaningful discussions concerning end-of-life planning and wishes for future treatment. These factors are more easily included in a comprehensive, system-wide, and standardised approach to ACP can be embedded 'in the woodwork' and as part of normal routine, such as in palliative care organisations or residential aged care facilities, where advance care planning is highly relevant to nearly all patients.

Treatment options

Aggressive treatment

Aggressive treatment includes medical and surgical life-sustaining measures which prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation.

Life-sustaining treatment

Life-sustaining treatment include medical, surgical or nursing procedure directed at supplanting or maintaining a vital bodily function that is temporarily or permanently incapable of independent operation. Life-sustaining treatments include

cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

Mechanical ventilation

Treatment in which a mechanical ventilator supports or replaces the function of the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease.

Time-limited trials

Time-limited trials of life-sustaining treatment for a mutually agreed upon and clinically relevant period of time, after which determination would be made to withdraw these interventions if the individual's condition did not improve.

Palliative care also called "comfort care," a comprehensive approach to treating serious illness that focusses on the physical, psychological, and spiritual needs of the patient . Its goal is to achieve the best quality of life available to the patient by relieving suffering, controlling pain and other symptoms, and enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values is an essential component.

Continuous review

Advance care planning should be revisited at least every two years or when there has been a significant change in the course of their illness to ensure that the person's wishes and preferences have not changed. If they have changed, these changes should be included in the patient's medical record and communicated to all other relevant health care professionals involved in the patient's care and to significant others identified by the patient. If an AHD had previously been created, it should be revoked, all copies destroyed and replaced by a new AHD.

Exercises

1. What are the potential advantages of advance care planning within an aged care facility?
2. What are the factors which are important to people and families in the care provided towards the end of life?

Advice and further assistance

The Department of Health (Office of the Chief Medical Officer)

PO Box 8172, Perth Business Centre, WA 6849

T: (08) 9222 2300

E: chiefmedicalofficer@health.wa.gov.au

W: www.health.wa.gov.au/advancehealthdirective

Appendix 1:

AHD Form

(visit www.health.wa.gov.au/advancehealthdirective)

Optional statement about legal or medical advice

Notes about statement:

- You are encouraged (but are not required) to seek legal or medical advice before making this advance health directive.¹
- If you wish to indicate that you have obtained legal or medical advice and wish to identify the person who gave you the advice, complete the relevant part of the statement.
- If you wish to indicate that you have obtained legal or medical advice but do not wish to identify the person who gave you the advice, cross out and initial the relevant part of the statement.
- If you do not wish to indicate whether or not you have obtained legal or medical advice, you may (but do not have to) cross out and initial the statement.
- If you do not wish to obtain legal or medical advice, you may (but do not have to) cross out and initial the statement.
- You do not have to say anything in this advance health directive about whether or not you have sought or obtained legal or medical advice. You can leave the statement blank and do not have to cross out or initial any part of it.

Before making this advance health directive, I obtained legal advice about making it.
I obtained that legal advice from _____
(Details of person who provided legal advice)

Before making this advance health directive, I obtained medical advice about making it.
I obtained that medical advice from _____
(Details of person who provided medical advice)

Optional statement about enduring power of guardianship

Notes about statement:

- If you wish to indicate that you have made an enduring power of guardianship, put a tick (✓) or cross (✗) in the box next to the statement.
- You do not have to say anything in this advance health directive about whether or not you have made an enduring power of guardianship. You can leave the box next to the statement blank.

I have made an enduring power of guardianship

¹ Guardianship and Administration Act 1990 s. 110(1)(g) and (2) and 110(2A).

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Advance Health Directive

Notes:

- To make an advance health directive, you must be 18 years of age or older and have full legal capacity.¹
- A person who makes an advance health directive is called "the maker".

This advance health directive is made under the *Guardianship and Administration Act 1990* Part 5B on the _____ day of _____ 20____

by _____
(maker's full name)

of _____
(maker's residential address)

born on _____
(maker's date of birth)

This advance health directive contains treatment decisions in respect of my future treatment.
A treatment decision in this advance health directive operates in respect of the treatment to which it applies at any time I am unable to make reasonable judgments in respect of that treatment.

Notes about treatment decisions:

- Treatment is any medical, surgical or dental treatment or other health care (including palliative care and life sustaining measures such as assisted ventilation and cardiopulmonary resuscitation).²
- A treatment decision is a decision to consent or refuse consent to the commencement or continuation of any treatment.³
- A treatment decision operates only in the circumstances that you specify.⁴
- Treatment to which you consent in this advance health directive can be provided to you.
- Treatment to which you refuse consent in this advance health directive cannot be provided to you.
- Your enduring guardian or guardian or another person cannot consent or refuse consent on your behalf to any treatment to which this advance health directive applies.⁵

¹ Guardianship and Administration Act 1990 s. 110P
² Guardianship and Administration Act 1990 s. 2(1) definition of "the continuing measure", "palliative care" and "treatment"
³ Guardianship and Administration Act 1990 s. 2(1) definition of "treatment decision"
⁴ Guardianship and Administration Act 1990 s. 110S(2)
⁵ Guardianship and Administration Act 1990 s. 110ZJ

Appendix 2:

Six Step Capacity Assessment tool

The Six Step Capacity Assessment tool developed by the Geriatric Research Group at McMaster University and published in 1999. This tool provides a framework for all capacity assessments. The assessment provides a determination of capacity at a single point in time, regardless of what the domain in question is.

Step 1 – Establish the Trigger

A valid trigger is necessary to initiate a capacity assessment. Triggers are events, circumstances or behaviours that put a person or others at risk.

Step 2 – Assent

The person needs to be engaged in the assessment process and agree to participate. If the person refuses then the assessment cannot take place.

Step 3 – Information gathering

The assessor needs relevant information about the person and the circumstances of the situation before the assessment can proceed. This may mean speaking to family members and carers.

Step 4 – Education

The subject of the assessment needs to be told what they will be tested on. If capacity to give informed consent is being tested, then the person needs to be given a list of all the treatment options available for their condition.

Step 5 – Assessment

The assessor asks open ended questions about the context of the situation, knowledge of the facts, about the choices the person has and the consequences of those choices. More specific questions may be needed if the person does not freely volunteer information. The assessor then is able to make a judgment as to whether the person has capacity using decisional aids.

Step 6 – Action

The result of the assessment leads to action on the part of the assessor and treating team. An incapable person will be unable to give informed consent, sign an AHD or EPG etc, depending on the domain being tested.

Appendix 3:

Frequently Asked Questions - Advanced Health Directives

What is an Advance Health Directive?

An Advance Health Directive (“AHD”) is a document that sets out a person’s decisions with respect to their future treatment. These treatment decisions may be to either consent or to refuse consent to specified treatment.

Treatment is any medical, surgical and dental treatment and other health care.

An AHD is made at a time that the person has full legal capacity, and only comes into effect when the person is unable to make reasonable judgements about the treatment decision at the time that the treatment decision is required.

A person will have full legal capacity if they are capable of understanding the nature and effect of their AHD. A person may lack full legal capacity if their decision making is impaired, for example, by reason of illness, disease or injury, or the effects of medication, drugs or alcohol.

How is an Advance Health Directive different from a “Living Will”?

Under the common (or judge made) law, it is possible to make a “living will”. This is a general term for a written statement made in advance regarding the person’s wishes with respect to future treatment.

An AHD is a specific type of “living will” which is recognised by legislation. The Act enshrines the enforceability of the AHD, subject to certain safeguards, and provides protections for health professionals who take treatment actions in good faith.

Despite the introduction of the legislation, it is still possible for people to make a “living will” and for this to be valid under the common law.

If you have doubts about the validity of a “living will”, or the person has made both a “living will” and an AHD and they are inconsistent with each other, it is recommended that you obtain legal advice.

How is an Advance Health Directive different from an Enduring Power of Guardianship?

An AHD allows adults with full legal capacity to make their own decisions about their future treatment.

An Enduring Power of Guardianship (“EPG”) allows adults with full legal capacity to appoint another person, the Enduring Guardian, to make a range of personal, lifestyle and treatment decisions, on their behalf.

An AHD takes precedence over an EPG. That is, the Enduring Guardian, if one has been appointed, cannot override treatment decisions in an AHD.

Who can make an Advance Health Directive?

Any person who has reached the age of 18 years and who has full legal capacity may make an AHD.

What does an Advance Health Directive look like?

It is possible that people may adapt the form so that it may look slightly different in presentation from the form prescribed in the legislation. This does not affect the validity of the AHD as long as it is “substantially in the form” prescribed by the legislation.

What if a person asks me to assess their capacity to make an Advance Health Directive?

A person may only make an AHD if they have full legal capacity. Where there is doubt as to the persons’ capacity to make the AHD, it is recommended that they obtain an assessment by a medical practitioner.

You should ensure that you make comprehensive notes of any formal assessment of legal capacity you conduct. In the event of any later uncertainty or conflict, you may be required to provide evidence to the State Administrative Tribunal.

What if a person asks me to help them make an Advance Health Directive?

Health professionals have a key role to play in providing information and advice to persons wishing to make an AHD.

If a person asks you for advice, relevant issues for consideration may include:

- Are they at least 18 years of age?
- Do they have full legal capacity?
- A person will have full legal capacity if they are capable of understanding the nature and effect of the AHD.
- Do they have a known medical condition, and are they making the AHD in anticipation of the progression of that condition?

Where a person has a known medical condition, you may be able to assist their decision making process by explaining the likely progression of the condition, and the types of medical interventions that are commonly involved in the treatment and management of the condition.

The person will then be in a position to make an informed decision as to which treatments they would or would not like to consent to in their AHD.

- If they do not have a known medical condition, are they making the AHD in anticipation of advancing age?

Where a person does not have a known medical condition but due to advancing age, would not like extraordinary measures to be taken in the event of subsequent illness, injury or disease, you can assist them to identify the common types of life sustaining measures that are available to health professionals.

The person will then be in a position to make an informed decision as to whether they would or would not like to consent to those life sustaining measures.

- Does the person have an objection to receiving a particular type of treatment? For example, a person may object to receiving blood and blood products on religious grounds.

In these cases, you may be able to assist the person to more accurately identify and describe the type of treatment that they wish to refuse.

- Has the person considered whether to discuss their treatment decisions with their family and other key people in their life?

There are limited circumstances in which a treatment decision contained in an AHD may be held by the State Administrative Tribunal to be invalid. These may be issues that you wish to explore with the person seeking your assistance with the making of the AHD.

In the event of any later uncertainty or conflict, it is possible that you may be required to provide evidence to the State Administrative Tribunal about the content of your discussions with the person and your opinions based on those discussions.

What about organ and tissue donation?

Although it is not possible for decisions about organ and tissue donation to be recorded in an AHD, this may be a good opportunity to raise the issue and refer the person to a Medicare Australia Office or its website at www.medicareaustralia.gov.au for information regarding the Australian Organ Donation Register.

What if a person asks me to witness an Advance Health Directive?

The AHD must be signed in the presence of two witnesses. Both witnesses must be 18 years of age, and one must also be a person who is authorised to witness statutory declarations.

In the health context, the following categories of people are authorised to witness statutory declarations:

- Chemists
- Chiropractors
- Dentists
- Doctors
- Nurses,
- Optometrists,
- Physiotherapists

- Podiatrists
- Psychologists
- Public servants

Although the role of the witness is to merely observe the execution of the AHD, you should not act as a witness if you have concerns as to whether the person has full legal capacity.

What if a person asks me to hold a copy of their Advance Health Directive on their medical record?

People will be encouraged to provide copies of their AHD to all treating health professionals, including any hospitals or health services that they regularly attend or are likely to attend in the future.

If an AHD is provided to you, you should ensure that it is placed in a prominent position on the medical record and that it comes to the attention of all treating health professionals. Although each health service should consider how best this can be achieved, as a minimum an entry in the Integrated Progress Notes should be made to record the receipt of the AHD.

Do I need to follow the treatment decisions contained in an Advance Health Directive?

Except in the very limited circumstances outlined below, you must comply with the treatment decisions contained in an AHD.

Treatment not clinically indicated

A treatment decision contained in an AHD cannot compel you to provide treatment that is not otherwise clinically indicated.

Urgent treatment in cases of attempted suicide

You may provide urgent treatment to a person despite a treatment decision contained in an AHD if:

- The person needs urgent treatment;
- The person is unable to make reasonable judgments in respect of the treatment; and
- You reasonably suspect that the person has attempted to commit suicide and they need the treatment as a consequence.

Urgent treatment is treatment that is urgently required to save the person's life, prevent serious damage to the person's health, or to prevent the person from suffering or continuing to suffer significant pain or distress.

Invalid treatment decision

For information as to when a treatment decision is invalid see the following FAQ.

Inoperative Advance Health Directive

For information as to when an AHD will be inoperative see the following FAQ.

When will a treatment decision contained in an Advance Health Directive be invalid?

A treatment decision contained in an AHD will be invalid (void) if:

- It is not made voluntarily.

For example, if the person was pressured by another person to make the treatment decision, and they felt that they had no choice but to do so.

- It is made as a result of inducement.

For example, if the person was told that they or another person close to them would receive some financial benefit if they agreed to make the treatment decision, and they made the treatment decision for this reason.

- It is made as a result of coercion.

For example, if the person was told that their family would only continue to care for them if they agreed to make a treatment decision, and they made the treatment decision for this reason.

At the time that the person made it, they did not understand the treatment decision.

For example, if the person made a treatment decision which provided consent to receive a particular type of treatment, and they did not know what this treatment was, what it involved or what the risks of the treatment were.

- At the time that the person made it, they did not understand the consequences of making the treatment decision.

For example, if the person did not understand that the treatment that was refused was necessary to save their life.

When will a treatment decision contained in an Advance Health Directive be inoperative?

A treatment decision contained in an AHD will be inoperative (of no effect) if:

- Circumstances relevant to the treatment decision have changed since the person made the treatment decision.
- The person could not have reasonably anticipated those changes at the time that they made the treatment decision.
- A reasonable person with knowledge of the change of circumstances would now change their mind about the treatment decision.

An example might be where a person made a treatment decision in anticipation of the progression of a terminal illness, and a new treatment or cure became available since the time that the treatment decision was made.

Factors that should be considered in making this assessment include:

- The age of the person at the time they made the AHD.

- The current age of the person.
- Whether the person reviewed the AHD at any stage.
- The nature of the condition for which the person needs treatment, the nature of the treatment and the consequences of providing and not providing the treatment.

How does an Advance Health Directive apply in the mental health context?

An adult who has full legal capacity may make an AHD with respect to any aspect of their treatment, including psychiatric treatment.

As a general rule, the treatment decisions contained in the AHD will govern the treatment that may be provided to the person in the same manner as in any other health context.

The exception to this general rule is where the person is an involuntary patient within the meaning of the *Mental Health Act 1996*. In circumstances where the *Mental Health Act 1996* permits psychiatric treatment to be provided without consent, treatment decisions contained in an AHD do not apply. In this context, consent for treatment continues to be governed by the provisions of the *Mental Health Act 1996* (although it may be appropriate for you to consider the content of the AHD and the extent to which the views and wishes of the person may be incorporated into the treatment plan).

What protections are there for health professionals?

The Act contains protections which recognise that health professionals do the best they can in the circumstances to properly ascertain the patient's treatment decisions.

The Act protects health professionals who take treatment actions (including commencing, continuing or not commencing or discontinuing treatment) where the decision by the health professional was made in good faith.

This protects a health professional in circumstances where it is subsequently determined as a result of further information not available to the health professional at the time that some other course of action was more appropriate.

Frequently Asked Questions - Enduring Power of Guardianship (EPG)

What is an Enduring Power of Guardianship?

An Enduring Power of Guardianship ("EPG") is a document in which a person appoints another person (called the Enduring Guardian) to make a range of personal, lifestyle and treatment decisions on their behalf.

An EPG is made at a time that the person has full legal capacity, and only comes into effect when the person is unable to make reasonable judgments about a personal, lifestyle and treatment matter about which a decision is required.

A person will have full legal capacity if they are capable of understanding the nature and effect of their EPG. A person may lack full legal capacity if their decision making is impaired, for example, by reason of illness, disease or injury, or the effects of medication, drugs or alcohol.

Unless there are limitations contained in the EPG form, an Enduring Guardian has the same authority as a Guardian appointed by the State Administrative Tribunal.

This *includes* the authority to decide:

- where the person lives and with whom;
- with whom the person is to associate;
- which support services the person should have access to;
- whether the person should work, and if so, any matters related to that work; and
- what education and training the person is to receive.

Importantly, an Enduring Guardian also has the authority to make treatment decisions on behalf of the person. These treatment decisions may be to either consent or to refuse to consent to specified treatment. Treatment is any medical, surgical or dental treatment or other health care.

A decision made by an Enduring Guardian has the same effect as if it had been made by the person.

An Enduring Guardian must act according to his or her opinion as to the best interests of the person, and in a manner consistent with any specific directions imposed by the person on the EPG form.

It is possible for a person to appoint more than one Enduring Guardian. This includes by appointing two or more persons to act together as Joint Enduring Guardians, or by appointing a Substitute Enduring Guardian.

How is an Enduring Guardian different from a Guardian?

There are two key differences between an Enduring Guardian and a Guardian.

Firstly, an Enduring Guardian is appointed by the person themselves, whereas a Guardian is appointed on their behalf by the State Administrative Tribunal.

Secondly, an Enduring Guardian can only be appointed by the person while they retain full legal capacity. In contrast, a Guardian can only be appointed by the State Administrative Tribunal if the person is incapable of looking after their own health and safety; is unable to make reasonable judgments about matters relating to his or her person; or if the person is in need of oversight, care or control in the interests of his or her own health and safety or for the protection of others.

How is an Enduring Power of Guardianship different from an Enduring Power of Attorney?

An Enduring Power of Attorney is a document in which a person appoints another person (called the Enduring Attorney) to make financial and property decisions on their behalf.

An Enduring Attorney does not have authority to make personal, lifestyle or treatment decisions merely because they have been appointed as an Enduring Attorney. It is however possible that the same person may also be appointed to act as an Enduring Guardian, or be a person responsible who can make treatment decisions under the Treatment Hierarchy.

How is an Enduring Power of Guardianship different from an Advance Health Directive?

An EPG allows adults with full legal capacity to appoint another person, the Enduring Guardian, to make a range of personal, lifestyle and treatment decisions, on their behalf.

An Advance Health Directive (“AHD”) allows adults with full legal capacity to make their own decisions about their future treatment.

An AHD takes precedence over an EPG. That is, the Enduring Guardian, if one has been appointed, cannot override treatment decisions in an AHD.

Who can make an Enduring Power of Guardianship?

Any person who has reached the age of 18 years and who has full legal capacity may make an EPG.

What does an Enduring Power of Guardianship look like?

A copy of the EPG form as produced by the Office of the Public Advocate is available from the Office of the Public Advocate website www.publicadvocate.wa.gov.au and the State Law Publisher Website: www.slp.wa.gov.au .

It is possible that people may adapt the form so that it may look slightly different in presentation from the form prescribed in the legislation. This does not affect the validity of the EPG as long as it is “substantially in the form” prescribed by the legislation.

What if a person asks me to assess their capacity to make an Enduring Power of Guardianship?

A person can only make an EPG if they have full legal capacity. Where there is doubt as to the persons’ capacity to make the EPG, it is recommended that they obtain an assessment by a medical practitioner.

You should ensure that you make comprehensive notes of any formal assessments of legal capacity you conduct. In the event of any later uncertainty or conflict, you may be required to provide evidence to the State Administrative Tribunal.

What if a person asks me to witness an Enduring Power of Guardianship?

The EPG must be signed in the presence of two witnesses. Both witnesses must be 18 years of age, and one must also be a person who is authorised to witness statutory declarations.

In the health context, the following categories of people are authorised to witness statutory declarations:

- Chemists,
- Chiropractors
- Dentists
- Doctors
- Nurses
- Optometrists
- Physiotherapists
- Podiatrists
- Psychologists
- Public servants

Although the role of the witness is to merely observe the execution of the EPG, you should not act as a witness if you have concerns as to whether the person has full legal capacity.

What if a person asks me to hold a copy of their Enduring Power of Guardianship on their medical record?

People will be encouraged to provide copies of their EPG to all treating health professionals, including any hospitals or health services that they regularly attend or are likely to attend in the future.

If an EPG is provided to you, you should ensure that it is placed in a prominent position on the medical record and that it comes to the attention of all treating health professionals. Although each health service should consider how best this can be achieved, as a minimum an entry in the Integrated Progress Notes should be made to record the receipt of the EPG.

Do I need to seek out and comply with treatment decisions made by an Enduring Guardian?

Except in the very limited circumstances outlined below, if a person is unable to make a treatment decision, and they have not previously made an AHD, you must attempt to obtain treatment decisions from the Enduring Guardian.

Treatment not clinically indicated

- An Enduring Guardian cannot compel you to provide treatment that is not otherwise clinically indicated.

Urgent treatment in cases of attempted suicide

You may provide urgent treatment to a person despite a treatment decision made by an Enduring Guardian if:

- the person needs urgent treatment;
- the person is unable to make reasonable judgments in respect of the treatment; and
- you reasonably suspect that the patient has attempted to commit suicide and they need the treatment as a consequence.

Urgent treatment is treatment that is urgently required to save the person's life, prevent serious damage to the person's health, or to prevent the person from suffering or continuing to suffer significant pain or distress.

How does an Enduring Power of Guardianship apply in the mental health context?

Unless there are limitations contained in the EPG form, an Enduring Guardian may make treatment decisions regarding any aspect of treatment, including psychiatric treatment.

As a general rule, the treatment decisions made by an Enduring Guardian will govern the treatment that may be provided to the person in the same manner as in any other health context.

The exception to this general rule is where the person is an involuntary patient within the meaning of the *Mental Health Act 1996*. In circumstances where the *Mental Health Act 1996* permits psychiatric treatment to be provided without consent, treatment decisions of an Enduring Guardian are of no effect. In this context, consent for psychiatric treatment continues to be governed by the provisions of the *Mental Health Act 1996* (although it may be appropriate for you to consider the extent to which the views of the Enduring Guardian may be incorporated into the treatment plan).

What protections are there for health professionals?

The Act contains protections which recognise that health professionals do the best they can in the circumstances to properly ascertain the patient's treatment decisions.

The Act protects health professionals who take treatment actions (including commencing, continuing or not commencing or discontinuing treatment) where the decision by the health professional was made in good faith.

This protects a health professional in circumstances where it is subsequently determined as a result of further information not available to the health professional at the time, that some other course of action was more appropriate.

Frequently Asked Questions - State Administrative Tribunal (SAT)

What is the State Administrative Tribunal?

The State Administrative Tribunal was established in 2005 and is an independent body responsible for making decisions about a range of administrative, commercial and personal matters.

The jurisdiction of the State Administrative Tribunal includes matters arising under the *Guardianship and Administration Act 1990*, including all issues to do with AHDs, EPGs, and Guardianship.

The State Administrative Tribunal is comprised of a Supreme Court judge, who acts as the President of the Tribunal, two District Court judges who act as Deputy Presidents, and a number of members with relevant expertise and experience.

What is the role of the State Administrative Tribunal in relation to Advance Health Directives?

In relation to AHDs, the State Administrative Tribunal may:

- declare that an AHD is valid or invalid;
- declare that a treatment decision in an AHD is valid or invalid;
- declare that the maker of an AHD is unable to make reasonable judgments in respect of the treatment to which a treatment decision in an AHD applies;
- give direction as to the giving of effect to a treatment decision in an AHD;
- give direction as to the construction of the terms of an AHD;
- declare that a treatment decision in an AHD has been revoked;
- recognise an instrument created in another jurisdiction as being an AHD; and
- declare that a person is unable to make reasonable judgments in respect of proposed treatment and determine who can make the treatment decision on behalf of the person.

What is the role of the State Administrative Tribunal in relation to Enduring Powers of Guardianship?

In relation to EPGs, the State Administrative Tribunal may:

- declare that an EPG is valid or invalid;
- declare that the person who made the EPG is unable to make reasonable judgments in respect of matters relating to his or her person;
- give direction as to the exercise of an EPG;
- give direction as to the construction of the terms of an EPG;
- revoke an EPG;
- revoke the appointment of one or some of the persons who are joint Enduring Guardians under an EPG;
- revoke or vary any of the terms of an EPG;
- recognise an instrument created in another jurisdiction as being an EPG;
- declare that a person is unable to make reasonable judgments in respect of proposed treatment and determine who can make the treatment decision on behalf of the person.

Who can make an application to the State Administrative Tribunal?

Any person who, in the opinion of the State Administrative Tribunal, has a proper interest in the matter may apply for a decision. The person, their Enduring Guardian or Guardian will generally have a proper interest in making an application to the State Administrative Tribunal. Depending on the particular circumstances, the person's family and treating health professionals may also have a proper interest in making an application to the State Administrative Tribunal.

How can I contact the State Administrative Tribunal?

Further information in relation to the State Administrative Tribunal, including information on how to make an application, is available on the State Administrative Tribunal website at www.sat.justice.wa.gov.au/.

Alternatively, the State Administrative Tribunal can be contacted by telephone on 1300 306 017 or 9219 3111.

If possible, public health professionals should seek legal advice from Legal & Legislative Services at the Department of Health prior to making any application to the State Administrative Tribunal with respect to an AHD or EPG. You can request legal advice from Legal & Legislative Services by completing the form found at: <http://intranet.health.wa.gov.au/LLSD/home/> . Health professionals employed by a teaching hospital may contact the State Solicitor's Office.

Appendix 4:

Answers to the Exercises

Section B: Advance Health Directives

1. Health professionals must follow the treatment decisions contained within a valid and operative AHD. In this circumstance the patient has given a specific treatment decision which meets the current circumstances so the health professionals should follow this.

The amendments to the *Criminal Code* provide exemption from criminal responsibility for the administration in good faith of reasonable medical treatment (including palliative care) even when death ensues. Legislative protection from criminal responsibility have now been extended to the withdrawal and withholding of medical treatment where the non-provision or cessation of that treatment is done in good faith and is reasonable to all the circumstances of the case, even where death ensues.

2. It is important to listen and respond to the daughter's concerns. But medical practitioners should explain to the daughter that they are legally bound to the instructions in a valid and operative AHD. If conflict remains health professionals may consider referring the issue to the State Administrative Tribunal
3. AHD's are of no effect following death and therefore wishes regarding organ donation should not be included on an AHD, Martin must separately contact his local Medicare office and express his desire for organ donation.
4. You should advise Diane of the new legislative changes in Western Australia allowing her to make an AHD in which she can state her treatment preferences in relation to being kept artificially alive. Also informing her that the AHD is legally binding and will ensure that her preferred treatment decisions be followed if she is unable to communicate her wishes at any time. Diane should also be counselled on treatment options, and encouraged to express her preferences to her family and medical specialists.

Section C: Enduring Powers of Guardianship

4. An EPG should be considered when people are planning their future health care and lifestyle decision-making. Any person who is at least 18 years with full legal capacity can make an EPG, and may be interested in doing so. It is particularly

recommended for people who have been diagnosed with a chronic life-limiting illness, where it is possible the person will lose decision-making capacity in the future.

Making an EPG will enables people to identify the person they would like to make decisions on their behalf, and for them to make their wishes about future personal, lifestyle and treatment decision-making known to this person.

2. Where the Enduring Guardian is no longer able or is unwilling to act on the person's behalf the Enduring Guardian may renounce the authority given to him or her under the EPG. The Public Advocate recommends that the Enduring Guardian advise the person in writing and return any copies of the EPG. If the person no longer has full legal capacity, the Enduring Guardian cannot renounce the power but must apply to the State Administrative Tribunal for an order revoking the EPG.
3. In these circumstances it may be appropriate to seek an order from SAT as to whether the Enduring Guardian should continue in the role. SAT can revoke an Enduring Power of Guardianship if a person is guilty of neglect or misconduct which renders the person unfit to continue as Enduring Guardian or appears to be incapable of carrying out their duties.
4. If there is concern about the legal capacity of the person when they made the EPG an application should be made to the SAT for determination of this issue. If there is any evidence about the legal capacity of the person at the time the EPG was made this should be included in the application to assist SAT making a decision.

Section D: Consent to Treatment

1. The Acts Amendment does not change this situation. An AHD cannot be used for the purpose of demanding or authorising unlawful medical interventions such as euthanasia. If a person requests euthanasia or physician-assisted suicide the health professional should discuss the basis for the request as it maybe associated with conditions such as a depressive or other mental disorder, dementia, reduced decision-making capacity, and/or poorly controlled clinical symptoms such as pain.

While medical practitioners have an ethical obligation to preserve life, when death is inevitable and treatment does not offer reasonable benefit or imposes an unacceptable burden on the person, death should occur with dignity and comfort. This may include not initiating or continuing life-prolonging measures and providing treatment intended to relieve symptoms which may have a secondary consequence of hastening death.

2. Health professionals have their own cultural and religious views and practices regarding end of life care and are under no obligation to participate in treatment to which they hold a conscientious objection. In such circumstances, the health professional should discuss why they are unwilling to participate in treatment with the person and the healthcare team and remove him/herself from that aspect of care and consider referral to another health care practitioner if appropriate.

Section E: Advance Health Care Planning

1. By facilitating discussions between patients, families and carers; advance care planning has the potential to empower patients by providing information and the opportunity to address concerns regarding future care. Furthermore, the process provides clarification to staff and families regarding the wishes of the patient over interventions and level of care desired in the event of any deterioration.

In Victoria, where similar legislation exists, a study in nursing homes (by Sylvester et al. (Respecting Patient Choices Program, Melbourne, 2006) showed that of 1100 nursing home residents, more than half completed an advance care plan (ACP), and of these residents 85 percent received end of life care in their nursing home. Of those without an ACP, 67 percent died in hospital while being cared for by staff who did not know the patient.

2. Issues that are consistently identified as important to patients at the end of life include cognitive function, independence, and dying with dignity.

It is also known that the quality of interactions between a patient and family and their carers has tremendous impact at this point. In this context, advance care planning has significant potential to address a patient's (and family's) physical, emotional and social needs.

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