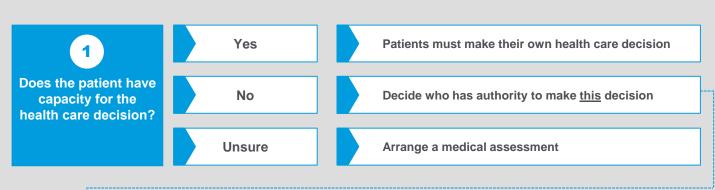


Flowchart for Health Care Decision Making in Adults Without Capacity

An Advance Care Planning Resource for Health Care Professionals



Consider:

Capacity may fluctuate and require more than one assessment over a treatment period. It may also vary depending on the type and gravity of the decision being made. An adult with impaired capacity has a right to adequate and appropriate support for decision making. There may be different decision makers depending on the health care in issue. For further information consult the Queensland Capacity Assessment Guidelines 2020.*

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Who will make the health care decision?

The patient

if

an **Advance Health Directive** is in place.

An AHD is lawfully binding as though the individual had capacity and was currently in a position to consent to or refuse. Refer to sections 4 and 5. Restrictions apply for decisions to withdraw or withhold health treatment

Substitute decision maker



- 1. there is a Guardian appointed by the Tribunal; or
- 2. an **Enduring Power of Attorney** authorised to make all health care decisions except **special health matters**; or
- 3. a Statutory Health Attorney in the following order:
 - a. A spouse if the relationship is close and continuing;
 - b. A person who has care (not a paid carer);c. a close friend or relation (not a paid carer);
 - c. a close friend or relation (not a paid care
 - d. the public guardian

Note

An Acute Resuscitation Plan (which acts as a medical order by a doctor) or a Statement of Choices (which can record a patient's values and preferences) are not legally binding and do not substitute for a lawful consent.

These documents may be used as **guidance** for medical practitioners and legally recognised substitute decision makers (section 4 below).

Disagreements between statutory heath attorneys can be referred to the Public Guardian.



Can the medical practitioner act without consent of a patient or a substitute decision maker?

Yes, if the treatment is minor

Yes, if the treatment is urgent

nd if there are no known objections by the patier

The documented wishes of the patient are clear, unambiguous and valid.



And it is **not reasonably practicable** to find a substitute decision maker **and**:

- a. it is necessary to promote the patient's health and wellbeing; and
- b. the treatment is **minor** or **uncontroversial**

Examples include external physical examinations, diagnostic tests, analgesia, minor wounds or treating infection (including intravenous).



And the proposed treatment is required to prevent **imminent** risk of life or health **or** significant pain or distress

Examples include **life sustaining** and **prolonging** measures: CPR, ventilation, nutrition, hydration, antibiotics – but **not** blood transfusions, organ donation. Refer to **section 5** for decisions about not treating or withdrawing treatment.

Note:

A decision to withhold or withdraw life sustaining measures (except nutrition and hydration) can only be made and acted upon immediately in an acute emergency if there are no known objections and only if the provision of life sustaining or life prolonging measures would be inconsistent with good medical practice (being recognised clinical and ethical standards of the medical profession). Objections can be written, oral, or ascertained by conduct.

Further information:

There are **limits** to the obligation to comply with a patient's wish for certain treatment, such as:

- unlawful requests
- treatment that would be futile in accordance with good medical

Ideally, the AHD will be in the **format** provided by the Queensland Department of Justice and Attorney General but not necessarily. Seek legal advice if an AHD is in a different format.

Validity of an AHD or EPOA may be questioned if there is any cause for concern about the document/s such as:

- if circumstances have changed to the extent that the directions are inappropriate
- if it was made at a time the adult did not have capacity
- if not signed and witnessed or fails to include medical officer certification (where required)
- if there is inconsistent wording or actions by the adult
- if there is evidence of a changed

mind.
Legal advice should be sought if there are any questions about the validity or compliance of an AHD or EPOA provided, including if produced interstate, so that any regulation requirements can be checked.

Voluntary Assisted Dying (VAD)

Access to VAD will become lawful on 1 January 2023. If a patient makes a request for VAD, the request and assessment process in this Act must be followed. The patient must be assessed under this Act as eligible, including having decision-making capacity for VAD. This document does not apply to VAD.



When should the documented wishes of the patient be followed?

Binding



An AHD is **lawfully binding** as though the individual had capacity and was currently in a position to consent to or refuse (noting restrictions in section 5 below).

A substitute decision maker or medical practitioner who acts contrary to the patient's direction relating to a refusal of treatment – for example no CPR – could be liable for civil or criminal action.

Not binding



An Acute Resuscitation Plan or a Statement of Choices (or other values based type document) is good evidence of a patient's wishes and may be used as a guide by legally recognised substitute decision maker/s and medical staff when making decisions about the provision of, or the withholding or withdrawal of, health care. Consent by a substitute decision maker about the health matter is still required.



Does the decision involve withholding or withdrawing a life-sustaining measure?

Yes

The decision can be made if a medical practitioner believes that treatment is inconsistent with good medical practice. Consent is still needed.

This applies even if there is an AHD that directs the withholding or withdrawal of the treatment and **only if** the patient has no reasonable prospect of regaining capacity and one of the following:

- a. an incurable condition or terminal illness, where in the opinion of two doctors, death is expected within 12 months; or
- severe and irreversible brain damage causing a persistent vegetative state or permanent unconsciousness; or
- c. no reasonable prospect of living without life sustaining measures.

Decisions about life-sustaining measures must be based on standards of good medical practice and the patient's best interests, even if there is an AHD.

*Queensland Capacity Assessment Guidelines 2020: https://www.publications.qld.gov.au/dataset/capacity-assessment-guidelines