A paradigm shift in medical treatment decision making: ‘best interests’ to ‘preferences and values’

Nicolina Scarcella – *Coordinator of Advice and Education Services, OPA, Victoria*

Sonia Gardiner – *Senior Medical Treatment Decisions Officer, OPA, Victoria*

Office of the Public Advocate

Our presentation

- *Medical Treatment Planning and Decisions Act* 2016 introduced on 12 March 2018
- The paradigm shift
- A case study – Abby
- Reflections

The paradigm shift

Best interests

the object of the *Guardianship and Administration Act* 1986 s.4(2)(b): *that any decision is exercised or performed so that "the best interests of a person with a disability are promoted"*

Preferences and values

the principle of the *Medical Treatment Planning and Decisions Act* 2016 s.7(d) is that: *"a person's preferences, values…should direct decisions about the person's medical treatment"*

Medical treatment decision making

A case study to demonstrate medical treatment decision making ‘before and after’ 12 March 2018:

- ‘before’ - the Best Interests paradigm; and
- ‘after’ - the Preferences and Values paradigm

Case study – Abby

- 23 year old female
- ID diagnosis
- dental treatment under a general anaesthetic has been recommended
- GP recommends pap smear at the same time, without advising Abby
- assessed as lacking decision making capacity for these matters

Before - s.42K notice: Best Interests…..

Medical Practitioner's role and legal obligations

s.42K of the *Guardianship and Administration Act* 1986

(b) the practitioner believes that on reasonable grounds that the proposed treatment is in the best interests of the patient; and

(c) the practitioner, before carrying out the medical or dental treatment, gives notice to the Public Advocate

……..continued

OPA’s role and obligations

- to receive the notice
- to ensure compliance with legislation
- to advise MP whether notice has complied with legislation

Determining Ms W's Best Interests

- what are Abby's wishes in regard to the proposed treatment?
- what consequences are there for Abby if the treatment were not carried out?
- what are the nature and degree of any significant risks associated with the proposed treatment?
- what alternative treatment (if any) is available and why is that not considered to be appropriate?

After - s.63 request: Preferences and Values

I must make the medical treatment decision that I reasonably believe is the decision Abby would have made if she had decision making capacity. To do this I must first consider:

- Abby's expressed preferences; *then*
- her expressed values; *or*
- values inferred from her life; *then*
- effects, consequences and effectiveness of the medical treatment; *then*
- any alternative treatment: *then*
- whether refusing treatment would be more consistent with Abby's preferences and values

Establishing Ms W’s preferences and values

- received s.63 form from dentist and on behalf of GP
- spoke with dentist: multiple occasions
- met with Abby’s key carers
- met with Abby: multiple occasions
- spoke with GP: multiple occasions

The outcomes

s.42K notice:

- notice registered
- health practitioners to make a note in Ms W's medical records
- OPA advise legislative requirements met
- treatments proceeded without consent

s.63 request:

- decision made to consent to the dental treatment
- decision concerning the gynaecological treatment deferred

What to expect from the Preferences and Values paradigm

- more thorough
- patient visited/contacted
- other parties contacted
- primary consideration is to the patient, not the illness/treatment
- individualised outcomes
- a decision is made: consent or refuse

Some reflections

- respectful to how the patient has lived their life
- upholding human rights
- mixed feedback from health practitioners
- education challenges
- seeking a decision not merely consent