

**House of Assembly Standing
Committee on Community
Development**

Inquiry into Palliative Care

TASMANIAN GOVERNMENT SUBMISSION



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INTRODUCTION

The Tasmanian Government welcomes the opportunity to make a submission to the *House of Assembly Standing Committee on Community Development (the Committee) Inquiry into Palliative Care (the Inquiry)*.

The Tasmanian Government notes the Inquiry's broad terms of reference to investigate the matter of care of palliative patients generally, as well as more specific matters. The first section of this submission provides an overview of palliative care in the Tasmanian health system context, including service delivery, policy setting and other matters considered relevant to the Committee's Inquiry, including the Tasmanian Law Reform Institute's Review of the *Tasmanian Guardianship and Administration Act 1995 (the GAA)*.

The second section of this submission provides information in response to the specific matters raised under the Inquiry's Terms of Reference, which includes:

- advance care directives;
- the administration of medical treatment to minors; and
- the administration of emergency medical treatment.


Defining palliative care

The World Health Organisation (WHO) defines palliative care as

...an approach that improves quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention of suffering by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual.¹

There are a number of different definitions of palliative care that are used in Australia and internationally. For example, 'hospice', 'end-of-life care' and 'specialist palliative care' are often used interchangeably with 'palliative care'. The DHHS approach to palliative care aligns with the WHO approach and acknowledges that palliative care is not simply about the terminal stage of life, and does not end when a person dies.

¹ World Health Organisation, Definition of Palliative Care, available at www.who.int



The WHO outlines the holistic, all-encompassing nature of palliative care services and notes that palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help the patient live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their bereavement; and
- uses a team approach to address the needs of the patient and their family²

² *Ibid.*



I. PALLIATIVE CARE IN TASMANIA

The Tasmanian Government's approach to palliative care service design and delivery, as led by the Department of Health and Human Services (DHHS) and the Tasmanian Health Service (THS), is family-centred and based on the WHO palliative care standards and definitions.

In Tasmania's health system, palliative care is considered an active and total approach to the care of a patient with a life-limiting illness. The provision of palliative care focuses on enhancing the patient's quality of life and supporting the family through preventing and relieving suffering by means of early identification, assessment, intervention and treatment of pain and other problems, the provision of psychosocial and spiritual care, and care through death and bereavement. Palliative care is provided not only to the patient but to their carer and family as needed. It is also appropriate in supporting carers and family members both prior to and following the patient's death.

I.1 POLICY

Palliative care policy development and service delivery in Tasmania has been informed by the *National Palliative Care Strategy 2010 – Supporting Australians to Live Well at the End of Life* (the National Strategy) and the Australian Government's investment in palliative care in Tasmania through the Better Access to Palliative Care (BAPC) program.

The focus in Tasmania is to deliver a person-centred approach to palliative care that recognises and involves community members in improving health and wellbeing outcomes, whilst prioritising the most vulnerable in the population. The approach is informed by the National Palliative Care Strategy, the Tasmanian Palliative Care Service Delivery Model, links to various other Australian Government palliative care initiatives, and to Primary Health Tasmania and the THS.

The National Palliative Care Strategy

The National Strategy was approved by health ministers in 2010 to encourage a consistent and coordinated approach to delivering palliative care across Australia. The Strategy represents the combined commitments of the Australian Government, state and territory governments, palliative care service providers and community-based organisations to improving palliative care in Australia.



The National Strategy guides the development and implementation of nationally consistent palliative care policies, strategies and services across Australia³.

The National Strategy has four goal areas for improving palliative care in Australia:

1. Awareness and Understanding

- To significantly improve the appreciation of dying and death as a normal part of the life continuum.
- To enhance community and professional awareness of the scope of, and benefits of timely and appropriate access to palliative care services.

2. Appropriateness and Effectiveness

- Appropriate and effective palliative care is available to all Australians based on need.

3. Leadership and Governance

- To support the collaborative, proactive, effective governance of national palliative care strategies, resources and approaches.

4. Capacity and Capability

- To build and enhance the capacity of all relevant sectors in health and human services to provide quality palliative care.

The National Strategy refocuses palliative care policy and practice away from an individualised and medicalised approach to death and dying to a health promoting and population based approach.

A population based approach to palliative care places the focus on building the capacity of individuals and communities to take greater control over their health and wellbeing.

³ Department of Health and Ageing, 2010, *Supporting Australians to Live Well at the End of Life: National Palliative Care Strategy 2010*, Australian Government, Canberra.



Better Access to Palliative Care

As part of the Tasmanian Health Assistance Package, the Australian Government funded the BAPC program to strengthen palliative care services in Tasmania. Its primary objective is to increase Tasmania's capacity to provide access to community based palliative care for people with life limiting illness, nearing the end of their life, while at a service level it aims to strengthen and enhance linkages between public and private providers and primary, secondary and tertiary providers. Enhancing the capacity of specialist palliative care teams is also a feature.

BAPC has provided funding to support the work of partner organisations in Tasmania including The District Nurses to establish the hospice@HOME service and to Palliative Care Tasmania (formerly the Tasmanian Association of Hospice and Palliative Care) to deliver a range of community development, education and professional development activities.

Together, significant progress has been made in the design and planning of new services, enhancement of existing services and the further development of the palliative care sector across Tasmania. Future policy work in Tasmania will aim to embed national standards and best practice approaches for palliative care, improve bereavement care and deliver specialist palliative care service models.


1.2 SYSTEM

Palliative care roles and responsibilities

Under Australia's federal system of government, palliative care service provision sits within the remit of states and territories. The Australian Government provides financial assistance to deliver these services and sets broad national policy directions.

Palliative care services are delivered in almost all health settings, including acute, primary, community, and aged care sectors. Palliative care is the responsibility of all health professionals but tends to be delivered by two distinct categories:

1. primary care providers; and
2. health professionals who specialise in palliative care.



Primary care providers may include medical, nursing or allied healthcare professionals. Specialist health professionals provide specialist palliative care services through a cohesive interdisciplinary network.⁴

A dedicated Specialist Palliative Care Service (SPCS) is delivered by the THS and provides a cohesive, interdisciplinary network of specialist palliative care providers. The SPCS consults across the various sectors of the healthcare system and takes on the entire healthcare provision role for complex palliative care patients.

While SPCS plays an integral role in treating patients, a large proportion of palliative care patients will not be referred to SPCS and are effectively managed by primary care providers. DHHS estimates that 30 per cent of all palliative care patients receive services through SPCS, with the remaining 70 per cent cared for by community nurses, general practice, and the non-government and community sectors.

The Tasmanian Government recognises the important role communities play in providing support for people at the end of their life, independent of formal health and community services. Communities can provide practical support and care for those who are dying, have experienced loss, or are bereaved. In this way social, psychological, spiritual and physical support – the key components of palliative and end of life care – are provided proactively, are more sustainable and there is less reliance on episodic direct service provision⁵. Palliative care in the community may include assistance from family and friends, volunteers, social workers and pastoral carers, community groups etc.


1.3 SERVICES

Appropriate, timely, and cost-effective palliative care services will become increasingly important into the future. According to the Australian Institute for Health and Welfare (AIHW), with the growth and ageing of Australia's population, and an increase of chronic and generally incurable illnesses, the types of patient groups requiring palliative care has widened.⁶

⁴ *Palliative Care Service Provision in Australia: A Planning Guide*, Palliative Care Australia 2003, available at <http://palliativecare.org.au/wp-content/uploads/2015/07/Palliative-Care-Service-Provision-in-Australia-a-planning-guide.pdf>

⁵ Kellehear, A, 1999, *Health Promoting Palliative Care*. Oxford University Press, Melbourne.

⁶ Australian Institute for Health and Welfare, Palliative Care, available at www.aihw.gov.au/palliative-care.



AIHW analysis shows that demand for palliative care in Tasmania is greater and likely to increase more rapidly than in most other states and territories due to the highest overall incidence of cancer, the second highest rate of burden of disease as a result of chronic disease, and a rapidly ageing population.⁷

Service standards and frameworks

Palliative care services delivered by DHHS and the THS are informed and led by the National Safety and Quality Health Service Standards, which provide mandatory practice standards across all health services. The delivery of specialist palliative care services are guided by the Standards for Providing Quality Palliative Care for all Australians, developed by the Palliative Care Australia (the peak national body for palliative care).

In addition to these mandatory practice standards, the National Consensus Statement⁸: Essential Elements for Safe and High-Quality End-of-Life Care provides recommended practice guidance and promotes a philosophical vision for compassionate and appropriate end-of-life care.

Tasmania's Specialist Palliative Care Service

The SPCS helps relieve the physical symptoms of a person's illness, helps assist with other issues which may arise, and supports a patient's carers and family. Specialist palliative care teams deliver this service by:

- undertaking a comprehensive assessment;
- focusing on management of symptoms;
- advance care planning;
- addressing emotional, spiritual and cultural aspects;
- including a variety of health professionals in coordinated teams; and
- considering the patient's choice of setting of care where possible.

⁷ Australian Institute of Health and Welfare, 2013, *Palliative Care Services in Australia*, HWI 123, Canberra.

⁸ Australian Commission on Safety and Quality in Healthcare, *The National Consensus Statement*, available at <http://www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/implementing-r-and-r-systems/the-national-consensus-statement/>



Other palliative care services delivered across the system include:

- relief of pain and other symptoms;
- providing resources such as equipment needed to aid care at home;
- assistance for families to come together to talk about sensitive issues;
- links to other services such as home help and financial support;
- support for people to meet cultural obligations;
- support for emotional, social and spiritual concerns;
- counselling and grief support; and
- referrals to respite care services.


The SPCS takes referrals in a number of ways including from primary care providers (such as general practice), residential aged care facilities, family and self-referrals, medical specialists, community nursing and the acute sector.

Models of Palliative Care

Palliative care services are not restricted to within hospitals – service delivery spans the full breadth of the healthcare system, including the acute, primary, community and residential aged care sectors. For patients with a life limiting illness, much of the care usually occurs at home and is provided by a network of carers, family and health professionals.

Palliative care services are provided by a diverse workforce and can include:

- medical practitioners, including palliative care specialists across acute, inpatient and community palliative care;
- allied health staff including occupational therapists, physiotherapists, pharmacists, social workers, music therapists; and
- nursing staff, including community nursing.



Palliative care models differ across Australia. In Tasmania, palliative care services are provided by a network of primary and specialist providers, with the setting determined by patient choice and need. The relationship between primary and specialist services is mutually supportive.

The service delivery model in Tasmania recognises that patients with life-limiting illnesses require different levels of involvement of primary and specialist providers based on their needs and the primary provider's capability and capacity to meet those needs. There are four levels of involvement under the model (see below). Roles and responsibilities of providers vary across the levels to ensure patients' needs are appropriately met, and in the right clinical setting.

The Tasmanian palliative care model


Many patients receive palliative care in a primary care setting, without having any contact with the THS (level one). The model makes a clear distinction between consultation/liaison (level two); shared care (level three); and specialist palliative services provided directly by SPCS (level four). SPCS supports palliative care service provision across all four levels.

1.4 GUARDIANSHIP AND ADMINISTRATION ACT 1995

The GAA is a fundamental part of the legal framework in Tasmania for medical decisions made at the end of a person's life if the person has lost the capacity to make those decisions.

The GAA provides a statutory basis for consent to medical treatment for persons with a disability, who are incapable of giving consent to the carrying out of medical or dental treatment.

The Attorney General has requested the Tasmanian Law Reform Institute (the Institute) review the GAA and provide recommendations for improvements and updates. If the Institute accepts the request, the review would consider whether guardianship and administration law in Tasmania is responsive to the needs of persons in the community with impaired decision making capacities and advances, promotes and protects the rights of people with impaired decision making capacity.



The Institute has also been asked to consider provisions in relation to consenting to medical and dental treatment and how to address long term or indefinite medical treatment in institutional and non-institutional settings.



2. ADVANCE CARE DIRECTIVES

Advance care planning

Advance care planning is a process that provides a person with an opportunity to plan and record their values, goals and preferred health and medical care in case they become ill or injured and unable to express these wishes. Advance care planning involves the patient, the patient's family, and health care professionals.

Advance care planning usually includes assessment of, and discussion about, a person's understanding of their medical condition and prognosis, values, preferences and personal and family resources. Advance care planning is particularly important because the patient may later lose the capacity to participate in discussions when difficult decisions need to be made as the end of their life nears.

Advance care planning supports the individual in communicating their wishes and desired direction about their end of life.⁹


A person must have legal capacity in order to make decisions or directions in relation to their future health care. This includes advance care planning decisions, appointing an enduring guardian and Advance Care Directives (ACDs).

Enduring Guardianship

Tasmania has a statutory process for appointing an 'enduring guardian'. Subject to the conditions of appointment, an enduring guardian will generally have the powers of a full guardian as set out in section 25 of the GAA if the appointer subsequently becomes unable by reason of disability to make reasonable judgements in respect of matters relating to his or her personal circumstances, including health care (Part V of the GAA).

The appointment of an enduring guardian may be done by any person who wishes to have certainty about who will make personal decisions on their behalf if they lose capacity and, in particular, any person who wishes to give specific instructions in the instrument of appointment.

⁹ Department of Health and Ageing, 2010, *Supporting Australians to Live Well at the End of Life: National Palliative Care Strategy 2010*, Australian Government, Canberra.



Under Tasmanian law, a formal enduring guardianship form must be completed and registered with the Guardianship and Administration Board in accordance with Part 5 of the GAA.

Section 32(6) of the GAA provides that “the powers conferred by an instrument appointing an enduring guardian are, unless the Board otherwise directs, to be exercised in accordance with any lawful directions specified in the instrument.” The instrument of appointment of an enduring guardian may therefore include particular directions on specific matters relating to end of life care (so that the instrument of appointment may fall within the general definition of an ACD (see below).

Section 35 of GAA provides that “an enduring guardian may apply for advice or direction by the Board on any matter relating to the scope of his or her appointment as such or the exercise of any power by the guardian under the instrument of appointment.”

Advance care directives

An ACD may be understood as a statement, written or otherwise recorded by a person in anticipation of the person being in a state of incapacity, which is intended to have effect if the person actually becomes incapacitated¹⁰. While this definition may apply to an instrument appointing an enduring guardian (see above) the phrase is not restricted to such documents.

ACDs provide a way to formalise a person’s treatment wishes and consent and refusal of possible future treatments. It may arise from a conversation between a patient, their family and health care providers or be independently drafted by the patient. It may even take the form of an oral statement to witnesses. An ACD is appropriate for anyone, at any life stage and in respect of any health care situation, including those who:

- have chronic or life-limiting health conditions;
- are entering residential care facilities;
- believe their family may have different views, beliefs or value-system, or where there is no family to consult; or

¹⁰ McIlwraith, J and Madden, B, *Health Care and The Law* (Fifth Edition), 2010 Thomson Reuters (Professional) Australia Limited, pages 134 – 135.

- have a condition that may lead to a loss of capacity to make decisions.

Every competent adult has the right to agree to or refuse medical treatment, and an ACD is a way of conveying the person's consent to particular future treatments and refusal of others at a time when the individual has the capacity to consent.

There is no statutory framework for ACDs in Tasmania. However, existing case law from overseas jurisdictions suggests that an ACD will be effective, so long as:

- The patient was competent at the time the directive was made;
- The patient intended and anticipated their decision to apply to the situation that ultimately arose, and is clear and unequivocal;
- No undue influence was exerted on the patient in making the directive¹¹; and
- The person's circumstances have not changed so that the person would no longer have intended it to apply e.g. where, at the time a person made an ACD she or he was a Jehovah's Witness and refused blood transfusions but the person has now renounced that faith.

The THS has developed a standard form titled *Advance Care Directive for Care at the End of Life (Tasmania)* to encourage consistency and accuracy when recording an individual's ACD. The THS has also implemented a statewide Advance Care Directive Protocol to guide the use of advance care directives. The purpose of the Protocol is to ensure that patients who are unlikely to benefit from medical treatment aimed at cure receive care appropriate to their condition, and are not subjected to burdensome or futile treatments (particularly cardiopulmonary resuscitation and Medical Emergency Team (MET) calls, especially where this is contrary to their wishes). These documents are maintained by the THS and reviewed against a set schedule to maintain safety, quality and accuracy.

Currently, ACDs tend to be more predominant within the acute care setting. There are opportunities for broader uptake in primary care settings, including within disability services and aged and community care sectors.

¹¹ Ibid, page 135.



The National Framework for Advance Care Directives

The *National Framework for Advance Care Directives* (the Framework) produced by the Australian Health Ministers' Advisory Council in 2011 recognises the potential improvements ACDs may make to care and decision-making during times of incapacity, especially towards the end of life. The purpose of the Framework is to provide guidance on policy and best practice in relation to advance care directives.¹²

The Framework provides context for ACDs and informs the THS approach to advance care planning. The Framework also includes a *Code for Ethical Practice for Advance Care Directives* (Code for Ethical Practice) to guide practice where ACDs are applied in health, institutional and aged care settings.

Medical Goals of Care

The Medical Goals of Care (MGOC) concept provides for decisions regarding whether or not to administer medical treatment aimed at cure, remission or restoration of a patient's condition.¹³ It recognises that there are limits to the capacity of modern medical treatment and that these limits need to be defined and communicated with clarity and compassion when the need arises.


MGOC encompass a dying person's wishes and preferences for care, and the outcome of medical decisions based on the treating doctor's assessment of the realities of the person's medical condition. A best practice approach to determining MGOC ensures that medical decision making and planning is informed by conversations that are ongoing between a doctor and their patient as part of the advance care planning process.¹⁴

DHHS has initiated its own MGOC program that supports advance care planning. To improve the standard of clinical decision making and documentation a MGOC Plan has been developed for use in Tasmanian hospitals and community settings. The purpose of the MGOC Plan is to clearly communicate the priorities of care in the case of a life-limiting illness where decisions about limitations of medical care are appropriate and necessary.

¹² Australian Government Department of Health, available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/acp>

¹³ Thomas. RL, Zubair. M Y, Hayes. B, Ashby. MA, 2014, 'Goals of care: a clinical framework for limitation of medical treatment'; MJA 201;(8):20 October 2014.

¹⁴ AMA Position Statement, 2014, *Position statement on end of life care and advance care planning*, Australian Medical Association, Barton, ACT, Australia.



All patients who are admitted to public hospitals, and all patients in community settings for whom limitations of treatment apply, should have a MGOC Plan. A post-implementation review of the MGOC Plan has indicated it also helps to identify those patients who wish to decline treatments based on their beliefs, for example blood product treatments.



3. ADMINISTRATION OF MEDICAL TREATMENT TO MINORS

Provision of care and care planning

Palliative Care Australia, the national peak body for palliative care, describes palliative care for children as:

...“enabl[ing] the child or adolescent to live in an environment where curative treatment can be part of their life, but not their entire focus. It aims to provide the best quality of life through a holistic approach which supports the physical, emotional, social and spiritual aspects of the child and their family. The goal is to add life to the child’s years, not simply years to the child’s life.”¹⁵

Palliative care is predominantly provided to older Tasmanians, reflecting Tasmania’s ageing population and higher incidence of chronic illness and disease. Within this context, overall demand for paediatric palliative care in Tasmania is low. The administration of medical treatment to a child is covered under common law and the GAA. For children with mental illness, the *Mental Health Act 2013* applies.

When it is provided, paediatric palliative care planning will occur with a child’s family. Medical and nursing staff will meet with the family and child to discuss care planning, MGOC, symptom management and a plan for where care is best provided (home/hospital).


There is a close relationship with the paediatrics unit and treating paediatricians (and often oncologists) and paediatric palliative care specialists in Melbourne may be consulted. Children who will be cared for at home will be referred to community palliative care and community nursing, supported by a paediatric outreach service.


Preferences for care

The Northern Hospice Feasibility Study¹⁶ identified the following needs and considerations of children in providing paediatric palliative care:

¹⁵ Palliative Care Australia and the Australian New Zealand Paediatric Palliative Care Reference Group 2015, *Paediatric Palliative Care Position Statement*, available at www.palliativecare.org.au/policy

¹⁶ Department of Health and Human Services Tasmania, *Northern Hospice Feasibility Study Final Report*, 2016.

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- Families and care providers can be reluctant to move a child receiving palliative care from a familiar environment. For this reason, many families requiring access to paediatric palliative care have a preference for the child to remain in the family home or on the ward where they have received treatment. The familiarity of the environment and staff in these locations provides a sense of comfort for both the child receiving care and their family.
 - Due to the age of paediatric patients, the make-up of the family group is often quite different to adults receiving palliative care. Family networks for a child are likely to involve multiple generations of the family, potentially including:
 - parents;
 - young siblings/cousins;
 - grandparents; and
 - aunts and uncles.
 - The presences of multiple generations within the family group can result in a very large care network, with different needs to adults. When providing paediatric palliative care, the specific requirements of each generational group need to be considered, and appropriate support provided. In particular, care and support for siblings was identified as being very important when they are also of a young age.
 - It is important to ensure that the physical care environment is suitable to the needs of the paediatric patient and their large carer group. Inpatient rooms may need to be established in a manner which ensures that they are appropriate for, and can accommodate, multiple generations. Specific considerations include:
 - Ensuring that the room is not overly clinical and can be decorated in a way which is appealing to a child (for example, use of child friendly colours, images and bedding.
 - Ensuring that play equipment is available for use by younger siblings of the patient. This may be within the room, or in a nearby family area.
 - Allowing additional space to accommodate numerous family members at any given time.

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- Establishing facilities so that parents can stay with the child while they are receiving care. This may be supporting overnight accommodation in the child's room, or in a family room adjacent to the child.

Minors and consent to medical treatment

The administration of medical treatment to minors is informed by the DHHS Clinical Consent Policy, which sets out the legislative requirements and guiding principles for healthcare interventions for a child. The THS has developed a statewide *Consent for Procedure or Treatment Protocol* to enact the Clinical Consent Policy.


Patient consent is required before treatment may be started or stopped. The Clinical Consent Policy states that in all decisions concerning children or young people their best interests shall be the primary consideration. The family of a child or young person should be heard and involved in their care and treatment, unless it is contrary to his or her best interests for this to occur.

The ability of a parent to consent diminishes as a young person's or child's capacity for decision making increases. The capacity to consent depends on the young person's or child's maturity and the ability to understand and appreciate the proposed healthcare and is dependent on the type of healthcare in question.

Both the Supreme Court and the Family Court have jurisdiction to decide cases relating to medical treatment for children at the end of life. Cases arise in the rare situation where the medical professionals and parents have differing points of view on what is in the best interests of a child. Most cases are heard by the Supreme Court, which has power to make decisions for children as part of its '*parens patriae*' (protective) jurisdiction. However, the Supreme Court exercises its powers cautiously, and only in cases where the court's intervention is needed - see *Re Heather* [2003] NSWSC 532.

Consent to medical treatment for persons with a disability

Part 6 of the GAA provides a statutory basis for the provision of medical and dental treatment to persons with a disability who are incapable of giving consent to the carrying out of medical or dental treatment. Section 36(2) of the GAA provides that "a person is incapable of giving consent to the carrying out of medical or dental treatment if the person is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the treatment".



The Part uses broad and simple language and is applicable across a broad range of situations. Part 6 provides that consent to the carrying out of medical or dental treatment on a person to whom the Part applies may be given by the Board or, if the medical treatment or dental treatment is not special treatment, by the person responsible for that person. A guardian of such a person may also consent to the carrying out of or continuing of special treatment if the Board has previously consented to the treatment and authorised the guardian to give consent to the continuation of the treatment or to further treatment of a similar nature. “Person responsible” has the meaning provided in section 4 - note that for a minor the person responsible is the parent.



4. THE ADMINISTRATION OF EMERGENCY MEDICAL TREATMENT

There are common medical emergencies in palliative care and these can be anticipated and planned for, and occasionally prevented. These can include:

- haemorrhage;
- airway obstruction or severe shortness of breath;
- pain crisis or other unrelieved symptoms; and


Discussions on what to expect occurs between clinicians, patients and their family/carers and treatment decisions can be planned for and documented in an ACD. As part of the planning process, consideration will be given to:

- what type of emergency might occur;
- whether or not it is reversible;
- the stage of underlying illness and the patient's energy levels as active treatment may not maintain or improve quality of life;
- a patient's comfort, because treatment may cause unnecessary discomfort or distress; and
- a patient's or carer's wishes, and wider support available to them.

The SPCS has developed *Care Management Guidelines for Emergencies in Palliative Care* which addresses the common emergencies and provides guidance on appropriate levels of care (in the absence of an existing ACD or other advance care plan).

Section 40 of the GAA sets out when emergency treatment may be given to a person with disability. The section reflects the common law immunity for medical practitioners (or dentists) for the provision of treatment in life-saving and emergency situations.

For people with a mental illness, the circumstances in which a person may be taken to lack decision making capacity and given psychiatric treatment in urgent circumstances are regulated by the *Mental Health Act 2013 (Tas)*.



An adult who is conscious and who appears to be competent may refuse emergency treatment. An adult may also refuse treatment in advance, and an advance refusal of treatment via an ACD will be valid provided the person was competent at the time the treatment was refused, and the refusal covers the circumstances that have later arisen. Where the person's competence or the validity or extent of the person's prior refusal is in doubt then the person's consent may generally be presumed and treatment that is necessary to preserve the person's life and health given on this basis.

Advance care planning and emergency patient transport


Tasmania's emergency patient transport services are provided by Ambulance Tasmania (AT). Taking into account advance care planning decisions, within the context of emergency services provided by AT, is more complex than within other settings. This reflects the primary role of an ambulance crew to provide for the swift transfer of patients to an emergency department.

AT provides treatment to patients in line with its *Clinical Practice Guidelines for Paramedics* (Clinical Guidelines) which includes information on palliative care and the use of ACDs. Any care that extends beyond the Clinical Guidelines requires treating paramedics to consult with an on-call Clinical Consultant.

Tasmanian ambulance crews may withhold resuscitation efforts in the following circumstances:

- For an adult (18 years or older) – where a clear and relevant ACD has been completed for a current condition which most likely caused the cardiac arrest.
- For a child (less than 18 years) – where an order, that has been issued by a Court exercising *parens patriae* jurisdiction, is provided to the attending ambulance crew indicating that a cardiopulmonary resuscitation is not to be commenced.
- Where a clear and relevant ACD is available for the patient. If an ACD is known to exist for a patient, this will be taken into account in their treatment. If there is an ACD, but is not to hand, then emergency treatment should be given until such time as the person's wishes can be ascertained.

An ACD may be sighted by the attending ambulance crew or they may accept in good faith the advice of those present at the scene. If there is any doubt about the application of an ACD the default position of resuscitation is adopted. Ambulance crews must



clearly record full details of the information given to them and the basis for their decision regarding resuscitation. This is particularly important in circumstances where a copy of an ACD or other order has not been sighted.