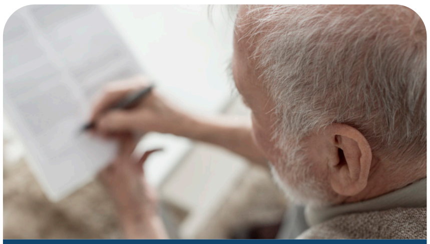
Knowing the law can support you to care for people at the end of life.

Knowing the law can help you to:

- Support decision-making by the people you care for, families and substitute decision-makers.
- Manage legal issues that arise in aged care with confidence.
- Deliver high-quality, optimal care for older people at the end of life.

End of Life Law Toolkit

Learn about end of life law in aged care in the ELDAC End of Life Law Toolkit, a free resource developed by health professionals and legal experts. The toolkit can support you to know the law across 9 areas:



Advance Care Directives

Capacity and Consent

Emergency Medical Treatment

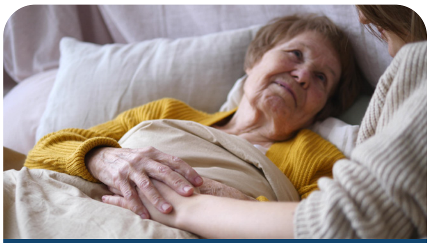
Futile or Non-Beneficial Treatment

Managing Disputes

Pain and Symptom Relief

Substitute Decision-Making

Voluntary Assisted Dying



Withholding and Withdrawing Treatment

The ELDAC End of Life Law Toolkit contains free printable fact sheets, case studies, and mythbusters. As the law is different in each State and Territory, the toolkit connects you to trustworthy information relevant to your place of work.

Find out more about the toolkit at **eldac.com.au**

ELDAC is funded by the Australian Government Department of Health and Aged Care

eldac.com.au

Overview: Capacity and Consent to Medical Treatment

A person may consent to or refuse medical treatment if they have decision-making capacity. Generally health professionals must obtain consent before medical treatment can be provided to an older person. This factsheet explains the law on decision-making capacity, and consent to medical treatment.

Clarifying the law

This factsheet explains:

- When consent to treatment is required, and when it will be valid
- When a person will have capacity to make decisions about medical treatment
- Whether a person with capacity can make a decision that others disagree with
- Whether a person's capacity can change over time

Consent to medical treatment when a person has capacity

A person with decision-making capacity has the right to decide what is or is not done to their bodies. This means they **can consent to medical treatment, or refuse it**.

The following section provides a brief overview of the law on consent to treatment. For detailed information access the End of Life Law Toolkit factsheet *Consent to medical treatment: A guide for aged care providers.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/Consent-to-medical-treatment_A-guide-for-aged-care-providers.pdf)

When is a person's consent to treatment required?

Valid consent should be obtained from a person with capacity **prior to examining them or providing medical treatment**.

A health professional who examines or treats a person without consent could be liable under civil or criminal law (for example, being charged with assault), or be subject to disciplinary action.

Consent is not required from a person when:

- **urgent medical treatment** is needed to save the person's life, prevent serious damage to health, or prevent significant pain and distress, and neither the person nor their substitute decision-maker can provide consent; or
- they have **impaired decision-making capacity** (discussed below). In this situation, consent can be provided in an Advance Care Directive or by a substitute decision-maker. This is discussed further in the End of Life Law Toolkit's *Advance Care Directives* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives) and *Substitute Decision-Making* factsheets. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making)

In Queensland, New South Wales, Victoria, Tasmania, and the Northern Territory, minor or routine treatment may be given without consent to a person without capacity in exceptional circumstances.

Learn more about minor or routine treatment in the End of Life Law Toolkit factsheet *Consent for minor or routine treatment in aged care.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/Consent-for-minor-or-routine-treatment-in-aged-care.pdf)

What is valid consent to treatment?

For consent to be valid:

- the person must have **capacity** to consent;
- the person must provide that consent **freely and voluntarily**. This means the decision is made without undue influence, coercion or manipulation; and
- the **consent must apply to the treatment to be given**.

Appropriate advice and decision-making support from the person's family and health professionals will not be undue influence so long as the person is still making the decision they want. However, a person changing their treatment decision when another person is present may alert a health professional to possible undue influence.

Are there formal requirements for consent?

Consent can be given verbally or be implied (for example, if a person offers their arm so that a nurse can take blood). Sometimes, (for example, before a major procedure), **it may be appropriate to obtain written consent**.

A health professional should also provide information about treatment risks and consequences, and any other information a person needs to provide consent. This is part of a health professional's duty of care to the person they care for, as well as good practice. Not doing this could result in civil liability for not warning about an adverse outcome.

Learn more about consent in the End of Life Law Toolkit factsheet *Consent to medical treatment: A guide for aged care providers.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/Consent-to-medical-treatment_A-guide-for-aged-care-providers.pdf)

Decision-making capacity

When does a person have capacity?

All adults are presumed to have capacity to consent to or refuse treatment, unless it can be shown that they do not.

A person will have capacity for a medical treatment decision if they can:

- **comprehend and retain the information** needed to make the decision, including the consequences of the decision; and
- **use and weigh that information** as part of their decision-making process.

Information about treatment can include the proposed treatment and alternatives, and the consequences and risks of different treatment options.

Guardianship and medical treatment legislation in each State and Territory sets out similar capacity tests, but some have additional requirements e.g. the person must also be able to communicate the decision in some way.

Learn about the requirements for a person to have decision-making capacity in your State or Territory at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/capacity#statetercap)

Supported decision-making

It may be possible in some situations for a person, such as an adult with cognitive impairment, to have capacity to make their own decisions with assistance and participate in decision-making. This is known as **supported decision-making**.

In Victoria, Queensland, the Australian Capital Territory, Tasmania, and the Northern Territory, a **person will have decision-making capacity for medical treatment decisions if they can make a decision with appropriate support**.

Support for decision-making can include a health professional adjusting their language to communicate about treatment in a way the person understands; using visual aids; or giving the person more time e.g. during a consultation to process and discuss the information with others.

Learn more about supported decision-making at *End of Life Law in Australia*:

- Victoria. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/victoria#supported)
- Queensland. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/queensland#qldsupported)
- Australian Capital Territory. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/australian-capital-territory#supported)
- Northern Territory. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/northern-territory#ntsupported)
- Tasmania. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/tasmania#tassupported)

Who decides whether or not someone can make their own decisions?

Generally **capacity is assessed by a person's doctor or a medical practitioner with expertise in capacity assessment** e.g. a psychologist, but in some cases, such as if there is doubt about a person's capacity, a court or tribunal might be asked to decide this.

What if a person makes a decision that others disagree with?

A person with capacity **can make a decision that others disagree with**, and that decision must be respected. A person does not lack capacity just because they make a decision someone disagrees with, or that a health professional considers is not in the person's interests.

For example, **a person with capacity can refuse life-sustaining medical treatment, even if it is recommended by a doctor.** Or, they can refuse to be transferred to hospital, even if a health professional or family member thinks they should go.

This is because capacity relates to the person's ***ability* to make a decision, not what decision they make**. However, an unwise or unusual decision may be a prompt for health professionals to check a person's capacity, for example, by referring the person to a medical practitioner with expertise in capacity assessment.

Learn about refusals of treatment in the End of Life Law Toolkit factsheet *Withholding and Withdrawing Life-Sustaining Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Withholding-and-Withdrawing-Life-Sustaining-Medical-Treatment) Refusal of hospital transfer is discussed in the *Urgent Medical Treatment* factsheet. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Urgent-Medical-Treatment)

Can a person have capacity for some decisions but not others?

Some medical treatment decisions are more complex than others. A **person may have capacity to make a simple decision about medical treatment but not a more complex one**.

For serious decisions, such as refusing medication which may be necessary to keep a person alive, the process of understanding, retaining and weighing the information (and risks involved) will be more complex than for more minor decisions, such as consenting to a blood test.

Can a person's capacity change over time?

A person's **capacity to make a decision can also change over time**. For example, a person in aged care may have *fluctuating capacity* because of delirium, some forms of dementia or mental illness.

Capacity will be judged at the time a treatment decision is required. A person may be able to make a decision at one time of day, but not at another time on the same day.

It is important to remember that a person does not lack capacity just because they have a medical condition, mental illness or intellectual disability. They can make their own treatment decisions so long as they meet the test for decision-making capacity.

> *'Capacity is decision specific so even if you have been diagnosed with dementia, you may still have capacity to make all or at least some of your own decisions, especially if you have been diagnosed with early dementia.*
>
> *Decision-making capacity may fluctuate over time and depend on the context such as the time of day, location, noise, stress or anxiety levels, medication, or infection'.*
>
> *Dementia and your legal rights*, Alzheimer's Australia, 2016

Key points to remember

1. A person with capacity must give valid consent before medical treatment can be lawfully provided to them. Treating without consent could lead to civil or criminal liability, except in some limited circumstances.
2. Consent to treatment is valid only when the person has capacity, gives consent freely and voluntarily, and the consent relates to the proposed treatment.
3. An adult is presumed to have capacity to consent to medical treatment, unless it can be proved that they do not.
4. A person will have capacity for a medical treatment decision if they are able to comprehend and retain the information needed to make the decision, and can use and weigh that information when deciding.
5. An adult with capacity can make decisions that others disagree with, including to refuse life-sustaining treatment, or not to be transferred to hospital.
6. A person's capacity should be assessed at the time a treatment decision is needed. A person may have capacity for some decisions but not others, and their capacity to make a decision can change over time.

Mythbusters: Capacity and Consent to Medical Treatment

Myth 1: An adult who makes an unusual decision about medical treatment (for example, refusing to go to hospital even though they are having a heart attack and know they might die) lacks decision-making capacity.

No. *An adult is presumed to have capacity to make decisions. An adult with capacity is legally entitled to make decisions that others disagree with. However, a decision that a health professional regards as an unwise or unusual decision may be a prompt for clinicians to check the person's capacity.*

Myth 2: A man with pneumonia and early-stage dementia refuses antibiotics and may die if he does not take them. He cannot decide to refuse this treatment because his dementia means he lacks capacity to consent.

No. *A diagnosis of dementia does not of itself mean that a person lacks capacity (although it may prompt an assessment of capacity). If the person has capacity despite their dementia, they are able to lawfully refuse life-sustaining treatment at that time (even if it will result in death).*

Myth 3: A person must prove that they have decision-making capacity, otherwise they cannot make medical treatment decisions.

No. *The law 'presumes' that a person has capacity unless there is reason to believe they do not. If a family member advises that an aged care resident does not have capacity, the residential aged care facility should take steps to be satisfied of this. This could be done, for example, through a capacity assessment conducted by a medical practitioner with expertise in assessing capacity.*

A person is able to make their own treatment decisions and provide valid consent so long as they meet the legal test for decision-making capacity in their State or Territory. Access the legal test for capacity in your State and Territory at ***End of Life Law in Australia.*** (https://end-of-life.qut.edu.au/capacity#statetercap)

Consent for minor or routine treatment in aged care

Obtaining consent for medical treatment is a fundamental requirement of the law and good clinical practice. However, sometimes treatment or health care that is minor or routine in nature - e.g. suturing a wound - may be able to be provided without consent.

This factsheet explores the law on consent for minor or routine treatment or health care.

Before you begin

The law on consent to medical treatment and decision-making capacity is explored in the End of Life Law Toolkit's factsheet *Overview: Capacity and Consent to Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview) It is suggested you read that factsheet as a starting point.

Consent to medical treatment or health care

Consent should be obtained *before* a person receives medical treatment or undergoes a medical examination e.g. a physical examination involving touching.

Not obtaining consent can result in a health professional being liable under civil or criminal law, or subject to disciplinary action.

A person with decision-making capacity can consent to their own medical treatment or health care. If they do not have capacity, consent can be given in an Advance Care Directive or by a substitute decision-maker.

The law on Advance Care Directives and substitute decision-making is discussed in the End of Life Law Toolkit's *Advance Care Directives* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives) and *Substitute Decision-Making* factsheets. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making)

There are limited situations where consent is not required. For example, treatment or health care that is urgently needed to save a person's life or prevent serious injury can be given if the person does not have capacity, does not have a valid Advance Care Directive, and it is not possible to obtain consent from their substitute decision-maker.

Learn more about the law on urgent treatment in the End of Life Law Toolkit's factsheet *Urgent Medical Treatment*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Urgent-Medical-Treatment/Factsheet)

Another situation where consent may not be required is where the treatment is 'minor' or 'routine'.

Minor or routine treatment and the rules on consent

Victoria, New South Wales, Queensland, and Tasmania

In **Victoria, New South Wales, Queensland, Tasmania, and the Northern Territory**, guardianship and medical treatment legislation allows medical treatment or health care that is minor or routine to be given without consent to a person without capacity **in some limited situations**.

The laws in **New South Wales, Queensland, and Tasmania**, also allow first aid, administration of non-prescription medication, and visual examinations to be given or undertaken without consent.

The table below provides *possible examples* of minor or routine treatment or health care relevant to aged care, and when consent is not required. Other types of treatment or health care not listed here may also be considered minor or routine.

Though the law does not require consent in these situations, it is still good clinical practice to obtain consent (and make a record of this) if possible before providing treatment.

If a person without capacity refuses consent or objects in some other way (e.g. physically or verbally) to minor or routine treatment, consent will be required from a substitute decision-maker. This area of law is complex and legal advice should be sought.

Table: Minor or routine treatment laws: Victoria, New South Wales, Queensland, and Tasmania

State	Types of treatment and terminology	Rule	Explanations and possible examples of minor or routine treatment or health care relevant to aged care	Useful resources
Victoria	**Routine treatment**	May be given without consent to a person without capacity if an Advance Care Directive or a medical treatment decision-maker cannot be located. If treatment or health care is routine, health professionals must record their decision in the person's clinical records.	• Standard antibiotics • Suturing or dressing a wound • Needles – subcutaneous/intramuscular/intravenous (cannula) • Personal care, such as hygiene care • Insulin • Ventolin • Analgesic – paracetamol, aspirin • Rehabilitative exercises, including physiotherapy, occupational therapy and speech pathology • Visual examination • Physical examination (touching) • Teeth cleaning and imaging • Standard x-rays, ultrasounds and respiratory function tests **Important note** If the treatment may cause the person a significant degree of bodily intrusion, or significant risk, side effects, or distress it is *significant treatment requiring consent.*	The *Significant treatment clinical guidelines for Medical Treatment Planning and Decisions Act 2016* (https://www.health.vic.gov.au/publications/significant-treatment-clinical-guidelines-for-the-medical-treatment-planning-and) can help health professionals decide if medical treatment for a person without capacity is routine treatment.

State	Types of treatment and terminology	Rule	Explanations and possible examples of minor or routine treatment or health care relevant to aged care	Useful resources
Queensland	**Minor or uncontroversial health care**	May be given without consent to a person without capacity if it is: • necessary and of the type that will best promote the person's health and wellbeing, • the person does not object (including in an Advance Health Directive), and • the health practitioner is not aware of any previous decisions or disputes about the treatment. It must be noted in the person's clinical records that these requirements have been met.	Has to be 'minor and uncontroversial'. Examples: • Providing an antibiotic that has been acquired by prescription • Giving a tetanus or hepatitis injection • Taking blood pressure • Giving asthma medication • A flu vaccination • Giving eye drops • Checking teeth	The *Queensland Office of the Public Guardian.* (https://www.publicguardian.qld.gov.au/health-decisions/making-health-care-decisions-for-others) has information about minor and uncontroversial health care.
	Visual examinations, first aid, non-prescription medication	No consent required for a person without capacity.	• Non-intrusive examinations (for diagnostic purposes) e.g. a visual examination of the mouth, throat, nasal cavity, eyes or ears • First aid • Administration of *non-prescription* medication within recommended dosages, normally self-administered (e.g. paracetamol)	

State	Types of treatment and terminology	Rule	Explanations and possible examples of minor or routine treatment or health care relevant to aged care	Useful resources
New South Wales	**Minor treatment**	Can be given without consent to a person without capacity if: • there is no person responsible or they cannot, will not or are unable to consent, • the treatment is necessary and of the type to promote the person's health and wellbeing, and • the person does not object (and has not previously objected) to the treatment. It must be certified in the person's clinical records that the treatment was necessary and to promote the person's health and wellbeing, and that the person does not object to the treatment.	Minor treatment is anything that is *not major or special treatment*. It is treatment that does *not* involve, e.g.: • Drugs of addiction • General anaesthetic or sedation (except to manage broken or dislocated limbs or for a diagnostic endoscopy) • 'restricted substance' (except for specified therapeutic purposes) • Substantial risk of: - death - brain damage - paralysis - permanent loss of function of any organ or limb - permanent and disfiguring scarring - extreme pain or distress to the person - removal of a substantial number of teeth.	NCAT Guardianship Division factsheets: • ***Consent to medical or dental treatment.*** **(https://ncat.nsw.gov.au/documents/factsheets/gd_factsheet_consent_to_medical_or_dental_treatment.pdf)** • *Person responsible* (see pg. 2). **(https://ncat.nsw.gov.au/documents/factsheets/gd_factsheet_person_responsible.pdf)**
	Visual examinations, first aid, non-prescription medication	No consent required for a person without capacity.	• Non-intrusive examinations (for diagnostic purposes) e.g. a visual examination of the mouth, throat, nasal cavity, eyes or ears • First aid • Administration of *non-prescription* medication within recommended dosages, which is normally self-administered (e.g. paracetamol).	

State	Types of treatment and terminology	Rule	Explanations and possible examples of minor or routine treatment or health care relevant to aged care	Useful resources
Tasmania	**Medical or dental treatment without consent**	May be given without consent to a person without capacity if: • there is no person responsible, • the treatment is necessary and will promote the person's health and wellbeing, and • the person does not object to having the treatment. It must be certified in the person's clinical records that: • the treatment was necessary and to promote the person's health and wellbeing, and • reasonable inquiries have been made to find out if the person has an Advance Care Directive and steps taken to locate it.	Any treatment *not* involving: • drugs of addiction (except for cancer or palliative care for the terminally ill) • a restricted substance to control the person's conduct (i.e. chemical restraint) • removal of a substantial number of teeth • substantial risk of: - death - brain damage - paralysis - permanent loss of function of any organ or limb - permanent and disfiguring scarring - extreme pain or distress to the person.	TASCAT factsheets: • *Consent to Medical or Dental treatment.* (https://www.tascat.tas.gov.au/guardianship/publications_/factsheets) • *Consent to Medical treatment by a Person Responsible.* (https://www.tascat.tas.gov.au/guardianship/publications_/factsheets)
	Visual examinations, first aid, non-prescription medication	No consent required for a person without capacity.	• Non-intrusive examinations (for diagnostic purposes) e.g. a visual examination of the mouth, throat, nasal cavity, eyes or ears • First aid • Administration of *non-prescription* medication within recommended dosages, which is normally self-administered (e.g. paracetamol).	

State	Types of treatment and terminology	Rule	Explanations and possible examples of minor or routine treatment or health care relevant to aged care	Useful resources
Northern Territory	**Routine Treatment**	Consent to routine health care is not required where the person with impaired capacity: - is consulted about the health care to be given, and gives implied consent, and - does not object to the carrying out of the health care.	Routine treatment is any treatment that is not significant treatment. Examples are provided on pages 5 - 10 of the Northern Territory Public Guardian and Trustee's ***Routine health care guideline***. (https://pgt.nt.gov.au/sites/default/files/pgt_-_routine_health_care_guideline.pdf) Significant treatment is medical treatment that is: - objected to by the adult - consists of an ongoing course of treatment - causes a significant degree of intrusion into the body of the adult - creates a significant risk of harm to the adult - causes significant side effects to the adult - causes significant pain or distress to the adult. ***Important note*** In deciding if treatment is routine, how the treatment impacts the person must be taken into account e.g. if the treatment may cause the person significant distress it is ***significant treatment requiring consent***.	The Northern Territory Public Guardian and Trustee, ***Routine health care guideline***. (https://pgt.nt.gov.au/sites/default/files/pgt_-_routine_health_care_guideline.pdf) can help health professionals decide if medical treatment for a person without capacity is routine treatment.

Western Australia, South Australia, and the Australian Capital Territory

In **Western Australia, South Australia, and the Australian Capital Territory**, consent is required from the person (or, if they do not have capacity, their substitute decision-maker) for all types of treatment or health care, even if it is minor or routine in nature.

However, if the treatment is needed urgently e.g. in an emergency, it can be given without consent if the person does not have capacity and it is not possible to obtain consent from their substitute decision-maker.

Practice tip

If you are uncertain about whether consent to treatment is required, discuss this with your facility manager. The Office of the Public Advocate or Public Guardian in your State or Territory may also be able to provide information. If you are a GP, you can seek advice from your medical insurer or medical defence organisation.

This case study provides an example of how the laws on consent for minor or routine treatment or health care apply in aged care.

Consent for examining and treating Myra

Myra has advanced dementia and resides in a residential aged care facility (RACF). A month ago she was assessed by a geriatrician as not having capacity for medical treatment decision-making. Her cognition has deteriorated since that time, and her capacity remains impaired.

Anna, a care worker, discovers Myra has a wound on her arm that looks red, swollen, and infected. Arrangements are made for Myra's GP, Chris, to visit. Chris prescribes standard oral antibiotics for Myra and asks Rahul, an enrolled nurse, to clean and dress the wound.

Whether consent must be sought to examine Myra, administer oral antibiotics, and clean and dress her wound depends on the State or Territory Myra resides in.

1. Consent for GP's medical examination

In **Queensland, New South Wales, Tasmania, and the Northern Territory**, consent for Chris to visually examine Myra is not required.

In **Victoria**, consent must be sought from Myra's medical treatment decision-maker. If the medical treatment decision-maker cannot be located, then the examination can proceed without consent.

In **Western Australia**, **South Australia**, **and the Australian Capital Territory**, consent from Myra's substitute decision-maker is required.

2. Administering oral antibiotics

In **Queensland and the Northern Territory**, the antibiotics can be administered to Myra without consent, providing she does not object. In the Northern Territory, Myra must also be consulted and give implied consent.

In **New South Wales and Tasmania**, Myra's substitute decision-maker (e.g. a person responsible) must be contacted for consent. If there is no person responsible, or (in New South Wales) a person responsible cannot, will not or is unable to consent, the antibiotics can be administered without consent, so long as Myra does not object.

In **Victoria**, consent must be sought from Myra's medical treatment decision-maker. If the medical treatment decision-maker cannot be located, then the antibiotics can be given without consent.

In **Western Australia**, **South Australia, and the Australian Capital Territory**, consent must be obtained from Myra's substitute decision-maker.

3. Cleaning and dressing the wound

In **all States and Territories**, the answer to whether consent is needed for Rahul to clean and dress Myra's wound is the same as for number 2 above (consent for administering oral antibiotics).

Key points to remember

1. In most situations consent must be obtained before medical treatment or health care can be lawfully provided to a person. Treating without consent could lead to civil or criminal liability, except in some limited circumstances.
2. Some States have legislation about consent to minor or routine treatment or health care. These laws enable minor or routine treatment or health care to be given without consent to a person who does not have decision-making capacity in limited situations.

For more information about the law on consent to medical treatment visit:

- **ELDAC End of Life Law Toolkit** factsheets:
    - *Consent to medical treatment: A guide for aged care providers.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/Consent-to-medical-treatment_A-guide-for-aged-care-providers.pdf)
    - *Overview: Capacity and Consent to Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview)
- **End of Life Law in Australia** (for State and Territory laws about consent). (https://end-of-life.qut.edu.au/capacity#statetercap)
- **End of Life Law for Clinicians online Module 2: Capacity and consent to medical treatment.** (https://ellc.edu.au)

Consent to medical treatment: A guide for aged care providers

Obtaining consent to medical treatment is fundamental to good clinical practice in aged and palliative care. It is also a key requirement under the Australian Aged Care Quality Standards.

For a medical examination or treatment to be lawful, consent must be given by the appropriate person, validly obtained, and provided at the right time.

This factsheet explains:

- **Who can provide consent**
- **When consent is required**
- **How consent can be obtained.**

It is designed for aged care providers including residential aged care facilities and home care services.

Important information

As a starting point, please read the End of Life Law Toolkit's factsheet *Overview: Capacity and Consent to Medical Treatment* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview) to understand the basic legal principles on consent to medical treatment and decision-making capacity.

Each State and Territory has guardianship and medical treatment legislation that outlines the requirements for consent. Learn more about consent in your State and Territory at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/capacity#statetercap)

Different laws apply to consent for restrictive practices and are not discussed in this factsheet.

Who can provide consent?

Who can provide consent to medical treatment or a medical examination depends on whether the person has decision-making capacity.

A person with decision-making capacity can consent to their own medical treatment or refuse it. A person will have capacity if they can:

- **comprehend and retain the information needed to make the decision, and**
- **use and weigh that information when deciding**.

If a **person does not have decision-making capacity**, consent can be provided by either:

- the person, in their Advance Care Directive,
- the person's substitute decision-maker,
- in some States and Territories, the Public Advocate or Public Guardian (as a last resort), or
- by a Court or Tribunal.

Consent given in an Advance Care Directive will not apply unless the person no longer has capacity. The consent must also relate to the specific medical circumstances that have arisen.

Example

Stan, an aged care resident, does not have capacity. He has an Advance Care Directive refusing consent to cardiopulmonary resuscitation (CPR), but not other treatments. If Stan requires a blood transfusion for anaemia, his Advance Care Directive will not apply (i.e. it cannot be used to consent to or refuse the transfusion) because it is a different treatment situation to CPR. Consent for the blood transfusion would need to be given by Stan's substitute decision-maker.

A **person's substitute decision-maker (e.g. an appointed guardian, family member) cannot consent to treatment while the person still has decision-making capacity**. They cannot override a decision made by a person with capacity, even if they do not agree with the decision.

Health professionals working in aged care and residential aged care facilities cannot consent to medical treatment for a person they care for. However, in South Australia, an adult who oversees the person's ongoing day-to-day supervision, care and wellbeing may provide consent in rare circumstances.

Learn more about decision-making capacity, Advance Care Directives, and substitute decision-making in the following **End of Life Law Toolkit factsheets**:

- *Overview: Capacity and Consent to Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview)
- *Advance Care Directives.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives/Factsheet)
- *Substitute Decision-Making.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making/Factsheet)

Which treatment and clinical situations require consent?

When consent is required

Consent is required **before a person receives medical treatment or undergoes a medical examination**. Some examples of situations where consent must be obtained are when the person requires:

- physical examination (e.g. involving touching) or a visual examination that is intrusive (e.g. of the breasts, genitals)
- medical investigation (e.g. medical testing, screening, scans)
- a surgical operation or other invasive treatment
- general anaesthetic
- a medical procedure
- medication or another intervention
- a blood transfusion or administration of blood products.

Consent is also required to transfer a person to hospital.

A health professional who acts without first obtaining consent could be liable under civil or criminal law, or subject to disciplinary action.

Consent is valid only when:

- the **person has capacity**,
- consent is **given freely and voluntarily**, and
- the consent **relates to the proposed treatment or procedure**.

When consent is not required

When a person does not have capacity, **there are some limited situations where consent to medical treatment is not required**. These situations are discussed below.

Urgent (emergency) treatment

Treatment and/or hospital transfer needed urgently to save a person's life, or prevent serious injury can be provided without consent to a person who does not have capacity, so long as there is no:

- Advance Care Directive refusing the treatment/transfer, or
- substitute decision-maker to provide or refuse consent at that time. However, it is good clinical practice to obtain a substitute decision-maker's consent if possible and time permits.

Sometimes in an emergency a person may still have capacity. In this case, the person's consent is required before treatment can be provided.

Example

Maria has advanced pancreatic cancer. One day Maria advises care staff at the residential aged care facility (RACF) she resides in that she has bad chest pain.

Paramedics are called to examine Maria. They suspect she is at risk of cardiac arrest and advise her that they want to transfer her to hospital for treatment. Maria says that she does not want treatment or to be transferred, and that she wishes to stay where she is.

The paramedics are confident Maria has decision-making capacity. They proceed according to the law by complying with Maria's refusal of treatment and not transferring her to hospital. With Maria's consent, appropriate pain and symptom relief is provided to her at the RACF.

Minor or routine treatment

In **Victoria, New South Wales, Queensland, Tasmania, and the Northern Territory**, medical treatment or health care that is minor or routine can be given without consent to a person without capacity in some limited situations. Examples of treatment that may be minor or routine include suturing or dressing a wound or providing Ventolin.

In **New South Wales, Queensland, and Tasmania**, first aid, administration of non-prescription medication, and visual examinations e.g. of the mouth, throat, nasal cavity, eyes, or ears can be given or undertaken without consent.

In **Western Australia, South Australia, and the Australian Capital Territory**, consent is required from the person (or, if they lack capacity, their substitute decision-maker) for all types of treatment or health care, even if it is minor or routine in nature.

Learn more about minor or routine treatment or health care in the ELDAC End of Life Law Toolkit factsheet *Consent for minor or routine treatment in aged care*. (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/Consent-for-minor-or-routine-treatment-in-aged-care.pdf)

Withholding or withdrawing futile or non-beneficial treatment

Generally, a health professional **does not need to obtain consent from a person or their substitute decision-maker to withhold or withdraw futile or non-beneficial treatment**.

In **Queensland**, however, where a person does not have capacity, consent from a substitute decision-maker is required. This issue is complex. Visit *End of Life Law in Australia* (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/queensland#QLDfutile) for further information.

Though consent is generally not required in this situation, it is **good clinical practice for health professionals to engage in shared decision-making with the person or their substitute decision-maker about treatment considered to be futile or non-beneficial**.

Example

Hugo has dementia, coronary heart disease, and hypertension. One afternoon a care worker discovers Hugo in his room, unconscious. Hugo is transferred to hospital where he is diagnosed as having had a cardiac arrest with several minutes of cerebral hypoxia. He remains comatose and is placed on artificial ventilation in the Intensive Care Unit.

Due to the extent of his brain damage and pre-existing chronic conditions, the treating team believe Hugo is unlikely to significantly improve or be able to survive without artificial ventilation.

They explain to Hugo's family that continuing to provide ventilation would be invasive, of little benefit in improving his condition, and may cause him pain and suffering. They discuss withdrawing ventilation and providing comfort care. The family agrees.

Palliative care

In Victoria and the Northern Territory, consent is not needed for a health practitioner to administer palliative care to a person without capacity. This is the case even if a person's medical treatment decision-maker refuses palliative care for the person. The health professional must however take into account any values or preferences expressed by the person (e.g. a refusal of palliative care in the person's Advance Care Directive) and consult with the person's decision-maker.

In **other States and Territories the normal rules for consent to treatment - as set out above – apply to palliative care**.

At what point in time should consent be obtained?

Where consent to medical treatment or examination is required, **consent should be sought immediately before any treatment is provided**. Seeking consent at the time treatment is needed allows (1, 2):

- Health professionals and the person or their substitute decision-maker to **discuss the reasons for the treatment, treatment options and alternatives, and the risks, benefits, and burdens** of the treatment. Health professionals have a duty to warn the person or their substitute decision-maker of any risks of the treatment prior to obtaining consent.
- The person or their substitute decision-maker to **ask questions, seek further information if they wish, and communicate their decision** to the health professional.
- Health professionals to **determine whether the person has decision-making capacity** to consent to the treatment, or whether a substitute decision-maker must decide. **A person's capacity can only be determined at the time a decision is required**. This is particularly important where a person in aged care has fluctuating capacity due, for example, to dementia or cognitive impairment. In these situations, **the person can still provide consent if they have capacity at the time the decision about medical treatment or examination is required**. Capacity must be determined each time a decision is required.
- The person or their substitute decision-maker to **refuse treatment**.

How can consent be given?

Consent can be given verbally, in writing, or implied (e.g. where a person offers their arm so a nurse can take blood). Written consent should be obtained for significant treatment e.g. surgical procedures, general anaesthesia, other invasive procedures, or where there are risks to the person e.g. chemotherapy, blood transfusions.

Health department consent policies may provide guidance on processes for obtaining consent in your State or Territory.

A person with capacity may want to decide about treatment independently, or may choose to involve their family, substitute decision-maker, or support network or community in decision-making.

A person e.g. someone with cognitive impairment can be supported to provide consent using supported decision-making approaches.

Example

Richard is in the early stages of dementia and has type 2 diabetes. He resides at home where he is visited several times a week by his home care nurse for medication management. His understanding is always better in the mornings, especially if his daughter is visiting and can help explain information to him.

Richard has been experiencing abdominal pain and passing blood. The home care nurse arranges an early morning GP appointment for Richard and, with Richard's agreement, suggests to Richard's daughter that she might want to accompany him.

At the appointment the GP advises Richard needs a colonoscopy. Richard's daughter helps Richard to understand the information provided by the GP about the colonoscopy by explaining in simple language what it involves, so that Richard can decide whether to have the procedure.

Learn more about supported decision-making at *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/treatment-decisions/adults#supporteddecisionmaking)

Can consent be given in advance?

Consent should be obtained from a person with capacity immediately prior to examining them or providing medical treatment. Forms or documents signed by a resident or their family giving a 'blanket' consent to treatment or administration of medication indefinitely are unlikely to be lawful.

A person cannot provide a blanket consent for medical treatment or for unknown situations. This practice is also contrary to the Aged Care Quality Standards. It is best practice for health professionals to seek consent to treatment each time a resident requires medical examination, medical treatment (including minor or routine treatment), or hospital transfer i.e. at the time it is required.

However, a person with capacity can consent to future treatment using an Advance Care Directive, which will operate once they lose decision-making capacity. A person may also make an Advance Care Plan in which they express their treatment values or preferences.

Learn more about Advance Care Directives and Advance Care Plans in the **End of Life Law Toolkit factsheet** ***Advance Care Directives.*** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives/Factsheet)

How long is consent valid?

Consent is valid until:

- **it is withdrawn by the person or their substitute decision-maker**, or
- **the person's circumstances change**. For example, their condition may deteriorate or improve, or their treatment goals or regime may change e.g. they decide to cease curative treatment and commence palliative care.

Consent can be withdrawn by the person or their substitute decision-maker at any time.

Practice tips: Obtaining consent in aged care

Aged care providers can effectively manage consent by:

- **Developing clear policies, procedures, and processes** to support obtaining and recording of consent. All staff and visiting health professionals should be provided with education and training on these.
- Ensure staff and visiting health professionals:
  - **Always obtain consent from the person (or if they cannot consent, their substitute decision-maker) immediately prior to providing any treatment or health care** (unless one of the exceptions discussed in this factsheet applies).
  - **Contemporaneously document consent discussions** and include written consent forms (where appropriate) in the person's records.
- **Clearly documenting in all residents' or home care recipients' records**:

- whether or not the person has decision-making capacity, of if their capacity fluctuates
- whether the person has an Advance Care Directive or Advance Care Plan
- any treatment they have objected to or refused
- details of the person's substitute decision-maker/s.

Key points to remember

1. Consent must be obtained immediately before medical treatment or health care is provided to a person. Treating without consent could lead to civil or criminal liability, except in some limited circumstances.
2. A person with decision-making capacity can consent to their own treatment and health care. If the person does not have capacity, consent must still be sought from a person's substitute decision-maker.
3. There are limited situations where consent for treatment is not required e.g. urgent treatment, where treatment is minor or routine, or to withhold or withdraw futile or non-beneficial treatment (except in Queensland where the person does not have capacity).
4. Consent can be given orally or be written or implied. Consent must be sought at the time treatment is required, so cannot be provided in advance through 'blanket' consent forms or documents.
5. All aged care providers should develop policies, procedures, and processes to effectively manage obtaining consent.

For more information about consent visit:

- **Aged Care Quality and Safety Commission:**
  - *Consent for medication in aged care.* (https://www.agedcarequality.gov.au/sites/default/files/media/consent-for-medication-in-aged-care-fact-sheet_0.pdf)
  - *Frequently asked questions about consent.* (https://www.agedcarequality.gov.au/sites/default/files/media/frequently-asked-questions-about-consent_0.pdf)
- **Other consent factsheets:**
  - Australian Commission on Safety and Quality in Health Care, Factsheet for clinicians: *Informed consent in health care*. (https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf)
  - Avant, *Consent essentials factsheet*. (https://www.avant.org.au/Resources/Public/consent-essentials/)
- **State and Territory consent policies and guidelines:**
  - Australian Capital Territory: *Canberra Hospital and Health Services Policy Consent and Treatment*. (https://www.canberrahealthservices.act.gov.au/before,-during-and-after-your-care/staying-at-the-adolescent-mental-health-unit/during-your-stay/participating-in-your-care/consent)
  - New South Wales: *Consent to medical or dental treatment factsheet and person responsible*. (https://www.ncat.nsw.gov.au/ncat/publications-and-resources/fact-sheets/guardianship-division-fact-sheets.html#Consent4)

- New South Wales: *Consent to Medical and Healthcare Treatment Manual – Policy and procedure manuals*. (https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx)
- Northern Territory: *Determining decision making capacity for a health care decision guideline.* (https://pgt.nt.gov.au/sites/default/files/pgt_-_determining_decision_making_capacity_for_a_health_care_decision_guideline.pdf)
- Queensland: *Queensland Capacity Assessment Guidelines.* (https://www.publications.qld.gov.au/dataset/capacity-assessment-guidelines/resource/23e5bde1-40d7-4115-a15d-c15165422020)
- Queensland: *Queensland Clinical Excellence Division Guide to Informed Decision-Making in Health Care*. (https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf)
- South Australia: *SA Health Policy Guideline: Consent to Medical Treatment and Health Care*. (https://www.sahealth.sa.gov.au/wps/wcm/connect/f0ee918046d8588f8b8ffb22d29d99f6/Guideline_Consent+to+Medical+Treatment+and+Health+Care_June2015.pdf?MOD=AJPERES)
- Tasmania: *TASCAT Guardianship Stream Consent to Medical or Dental Treatment Factsheet.* (https://www.tascat.tas.gov.au/__data/assets/pdf_file/0006/684123/4.-Consent-to-Medical-or-Dental-Treatment.pdf)
- Western Australia: *WA Health Consent to Treatment Policy 2016*. (https://www.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Consent-to-Treatment-Policy/Consent-to-Treatment-Policy.pdf)

ELDAC
End of Life Directions for Aged Care

Capacity and Consent to Medical Treatment

Case Study

Nina's story

Nina has Chronic Kidney Disease (CKD) secondary to Type 2 Diabetes Mellitus. Despite her recent diagnosis of dementia, Nina is still cognitively stable and is able to live independently while receiving regular visits from Susan, a home care nurse, and increased support from her daughter Alison. Nina does not have an Advance Care Directive.

Susan has cared for Nina for a long time and as a result, she is familiar with her typically friendly disposition. On one visit however, Nina becomes agitated when Susan attempts to complete Nina's routine blood sugar level test. Susan reviews Nina's webster pack, and observes that Nina's medications have not been taken for the last 24 hours. When she encourages Nina to take them, Nina appears confused and refuses to take the medications, claiming 'you are trying to kill me'. She tries to stand up but becomes unsteady, and says she feels dizzy. Nina's behaviour is unusual as in Susan's experience Nina is usually cooperative, cognitively alert and orientated.

Susan shares her concerns about Nina with Alison, who has arrived to visit Nina. Alison agrees that Nina's behaviour is out of character and decides to take Nina to see her GP. When reviewing Nina's recent blood test results, the GP realises that Nina's renal function is impaired, and her haemoglobin is 70. He is aware Nina has suffered anaemia several times in recent years. In light of this, her CKD and current symptoms, the GP advises that he wants to admit Nina to hospital for a blood transfusion and further investigation.

Points for reflection

1. What factors must be satisfied for Nina to have capacity to make medical treatment decisions and to provide valid consent?
2. If you were the GP in this scenario, how would you determine if Nina has capacity?
3. In this case, do you think Nina has capacity to consent to a blood transfusion? Why or why not?
4. Does Nina's dementia mean that she will always lack capacity for treatment decisions?

1. What factors must be satisfied for Nina to have capacity to make medical treatment decisions and to provide valid consent?

Nina will have capacity to consent to or refuse medical treatment if she can comprehend and retain the information required to make the decision, including the consequences of that decision. Nina must then be able to use and weigh that information to make a decision.

To provide valid consent, Nina must:

- have decision-making capacity,
- give consent freely and voluntarily without undue pressure or influence, and
- consent specifically to the treatment that will be given – in this case, a blood transfusion.

The GP should inform Nina about treatment risks and other information relevant to making the decision.

2. If you were the GP in this scenario, how would you determine if Nina has capacity?

The GP should explore whether Nina has capacity to consent by asking questions to determine whether she understands that she is anaemic; that she requires a blood transfusion to treat this; and the associated risks of consenting to or refusing the blood transfusion.

If the GP is not certain that Nina has capacity, he should refer Nina for a formal capacity assessment by a medical practitioner with expertise in this.

Learn more about the legal requirements for capacity and consent in the **End of Life Law Toolkit's *Capacity and Consent to Medical Treatment*** resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment)

3. In this case, do you think Nina has capacity to consent to a blood transfusion? Why or why not?

It is unlikely that Nina has capacity to consent to the blood transfusion due to her current cognitive state. Her confused behaviour (e.g. claiming that Susan is trying to kill her) indicates that she does not currently have insight into her condition, and that she is unable to make informed decisions about her treatment at this time. If Nina does not have capacity, as she does not have an Advance Care Directive consent will be required from Nina's legally recognised substitute decision-maker.

Learn more about substitute decision-makers in the **End of Life Law Toolkit's *Substitute Decision-Making*** resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making)

4. Does Nina's dementia mean that she will always lack capacity for treatment decisions?

No. Nina's capacity to consent to treatment must be determined on a case by case basis, at the time treatment is proposed. She will not lack capacity simply because she has dementia. In fact, it is likely in this case that Nina's capacity fluctuates depending on the current state of her health and cognitive condition. Generally her baseline cognition is alert and orientated, and she is usually willing to take her medication. If Nina was not unwell, she may in fact have capacity to make all, or at least some, medical treatment decisions. If there is doubt, a formal capacity assessment should be sought.

Learn more about capacity and consent to treatment in your **State or Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/capacity#statetercap)

Final legal observations

After asking Nina questions about her condition and discussing her symptoms and treatment options, the GP concludes that Nina does not understand her condition or the information about the proposed blood transfusion (including its risks), and that she does not have capacity to provide consent.

As Nina does not have an Advance Care Directive, a substitute decision-maker will be required to consent to a blood transfusion being provided. Alison could be Nina's substitute decision-maker, but this will depend on the law of the State or Territory, and where Alison sits in the order of decision-makers.

Advance Care Directives

An Advance Care Directive can be a useful tool for people to communicate instructions about future health care decisions. This factsheet explains the key legal principles for Advance Care Directives.

Clarifying the law

This factsheet explains:

- What an Advance Care Directive is, and how it can be used
- When a person can make an Advance Care Directive
- What types of Advance Care Directives there are
- When an Advance Care Directive must be followed

About Advance Care Directives

An Advance Care Directive (Directive) is a legal document that a person with decision-making capacity makes about future health care decisions. It can be used to:

1. **Make specific decisions about future treatment.** This can include consenting in advance to treatment but more commonly involves refusing treatment, even if that might result in death.
2. **Express preferences about medical treatment and care** (for example, goals of care, or wanting to die at home rather than in hospital) **and personal values** (spiritual, religious or cultural beliefs relevant to the person's care).
3. In most States and Territories, **appoint a substitute decision-maker** to make future health care decisions if the person loses capacity.

Learn more about substitute decision-making in the End of Life Law Toolkit factsheet *Substitute Decision-Making*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making/Factsheet)

Making an Advance Care Directive

An Advance Care Directive will be valid if it was made by the person **voluntarily** (i.e. nobody has pressured the person to make the decision), when the person had capacity. The definition of **capacity** differs between Australian States and Territories. Learn when a person will have capacity in your State or Territory at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/capacity)

A person who has lost capacity cannot make a Directive. In that case, generally a substitute decision-maker e.g. a family member or friend must be called upon to make a decision. Learn more in the End of Life Law Toolkit factsheet *Substitute Decision-Making*. (https://www.eldac.com.au/tabid/4963/Default.aspx)

Advance care planning

Advance care planning should be part of routine practice for health professionals providing aged care.

For practical tips on how to undertake advance care planning with a person you care for visit *Advance Care Planning Australia* (https://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-areas/advance-care-planning-and-aged-care) and explore the *Advance Care Planning in Aged Care Implementation Guide*. (https://www.advancecareplanning.org.au/__data/assets/pdf_file/0031/179293/advance-care-planning-in-aged-care-implementation-guide.pdf)

You can also use *How to do advance care planning: A quick guide for health professionals*. (https://end-of-life.qut.edu.au/__data/assets/pdf_file/0015/1320531/How-to-do-Advance-Care-Planning-2024.pdf)

Types of Advance Care Directives

Australia has two types of Advance Care Directives:

- **Common Law Advance Care Directives** which are recognised by the common law (decisions made by judges in the courts) and generally must be followed. These types of Directives exist in **all States and Territories except Queensland**.
- **Statutory Advance Care Directives** which are governed by State and Territory legislation. These types of Directives exist in **all States and Territories except New South Wales.**

Mental health legislation in Victoria and the Australian Capital Territory also allows people with mental health conditions to make specific types of Directives about their treatment preferences. Mental health Advance Care Directives are generally not about end of life decision-making so are not discussed further here.

The law on Advance Care Directives differs across Australia. Learn more about the law in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/advance-care-directives/state-and-territory-laws)

How are Advance Care Directives made?

Common Law Advance Care Directives

A **Common Law Advance Care Directive does not have to be in a particular form – it can be verbal or in writing**. There are no other formal requirements, except that it be made voluntarily, by a person with capacity. Witnesses are not required.

Examples of a Common Law Advance Care Directive include:

- A written document which refuses some type of treatment.
- A card in a person's wallet which refuses treatment (such as a blood transfusion or resuscitation).
- A verbal direction refusing specific treatment that is given to a health professional or personal care worker when the person has capacity.

There is no requirement for the person to first receive information about the treatment they want to refuse or request.

Statutory Advance Care Directives

Most Statutory Advance Care Directives must be:

- **made in writing**. Most legislation about Directives has an 'approved form' which can or must be used. In the Australian Capital Territory and Tasmania, a Statutory Advance Care Directive can also be made orally or in another way,
- **signed by the person making the Directive** (who must have capacity and make the Directive voluntarily), and
- **witnessed**. In some places it must also be witnessed by a health professional.

In some States and Territories, the person must also receive information or medical advice about the treatment they want to refuse or request.

Can a Statutory Advance Care Directive made in one Australian State or Territory apply in another?

Some States and Territories recognise valid Statutory Advance Care Directives that were made interstate (provided certain requirements are met), while others do not.

Even if not formally recognised by another State or Territories' legislation, a Directive could still be a valid Common Law Advance Care Directive which will apply across Australia, except in Queensland where these Directives are not legally binding.

If a person's Directive is not recognised by another State or Territory, it still provides guidance to health professionals and substitute decision-makers about the person's values, beliefs and treatment preferences.

Learn more about recognition of interstate Advance Care Directives in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/advance-care-directives/state-and-territory-laws)

When must an Advance Care Directive be followed?

When Advance Care Directives apply

A Directive will generally apply **only when the person loses capacity** to make the treatment decision. This might occur when the person is unconscious, or has severe cognitive impairment e.g. because of advanced dementia. The Directive must also apply to the health care situation that has arisen.

In the **Australian Capital Territory**, a statutory Health Direction will apply both when the person has capacity or lacks capacity.

Following an Advance Care Directive

Generally, **a valid Directive must be followed** by a health professional, even if it refuses life-sustaining treatment which will result in a person's death. If they do not, a health professional could be liable under the criminal or civil law.

Usually **a person's family or substitute decision-maker cannot disregard specific treatment decisions made by a person in a valid Directive**.

There are some **limited circumstances** in which a Directive does not have to be followed. Examples are:

- a Directive is too uncertain to guide decision-making,
- circumstances have changed so much since the person made the Directive that it should not be followed, or
- the person has requested futile or non-beneficial treatment.

The law on this differs across Australia.

Learn more about the law on following Common Law Advance Care Directives (https://end-of-life.qut.edu.au/advance-care-directives/common-law-advance-care-directives) and Statutory Advance Care Directives (https://end-of-life.qut.edu.au/advance-care-directives/state-and-territory-laws) in your **State or Territory** at ***End of Life Law in Australia***.

Learn more about futile or non-beneficial treatment in the **End of Life Law Toolkit's *Futile or Non-Beneficial Treatment* resources.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Futile-or-Non-Beneficial-Treatment/Factsheet)

Practical tips: Advance Care Planning in aged care

It is important to remember that:

- Making an Advance Care Directive is voluntary – a person may choose not to make a Directive, and cannot be required by an aged care provider to do so.
- Only the person can make a Directive. The person's family or substitute decision-maker cannot make a Directive for the person.
- Advance care planning discussions should occur early e.g. when a resident enters aged care. These discussions can also be undertaken by staff with residents (and if the person consents, their family) at any time.
- It is good practice after a person experiences deterioration e.g. is hospitalised and returns to a facility, or experiences a significant change to their health, to revisit advance care planning discussions and/or review existing documents.

For more practical tips and information visit:

- *Advance Care Planning Australia* (https://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-areas/advance-care-planning-and-aged-care)
- End of Life Law Toolkit *Advance Care Directives* resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives/Resources)

Key points to remember

1. An Advance Care Directive records a person's decisions, values and preferences about health care and medical treatment now in case they do not have decision-making capacity in the future.
2. It can request or refuse health care, including life-sustaining treatment. In some parts of Australia it can be used to appoint a substitute decision-maker.
3. Advance Care Directives are recognised throughout Australia by the common law (except in Queensland) and by legislation in all States and Territories (except New South Wales). The law is different in each jurisdiction.
4. An Advance Care Directive must be made voluntarily, when the person has capacity. It cannot be made by a person's family or substitute decision-maker.
5. For an Advance Care Directive to apply, the person must not have capacity, and it must relate to the health care situation that has arisen. A Statutory Advance Care Directive must also meet formal requirements of legislation.
6. A health professional generally must follow a valid Advance Care Directive. If they do not, they might be criminally or civilly liable. There are limited situations where a Directive does not need to be followed.

Mythbusters: Advance Care Directives

Myth 1: A person must have an Advance Care Directive

No. *Making an Advance Care Directive is every person's choice, and that choice should be respected. Directives are a useful advance care planning tool, but there may be legitimate reasons why a person chooses not to have a Directive.*

Myth 2: Advance Care Directives are just recommendations to inform clinical decision-making

No. *Advance Care Directives can be legally binding documents that health professionals are obliged to follow. For example, the law will generally require a health professional to follow a refusal of treatment in a Directive where:*

- *the Directive is legally valid (made voluntarily, when the person had capacity, and meets any formal requirements required by State and Territory legislation), and*
- *it applies to the health care situation that has arisen.*

There are situations where Advance Care Directives do not have to be followed and this varies by State and Territory. Visit State and Territory Advance Care Directives *at* ***End of Life Law in Australia*** *for more information.* (https://end-of-life.qut.edu.au/advance-care-directives/state-and-territory-laws)

Myth 3: A person can't use their Advance Care Directive to refuse treatment needed to keep them alive (life-sustaining treatment)

No. *A person can refuse life-sustaining treatment in their Advance Care Directive, even if not having that treatment will result in death.*

Myth 4: A health professional must always give a person the treatment they request in their Advance Care Directive

No. *The law generally does not require a health professional to provide treatment they believe is non-beneficial, futile, or not in the person's best interests. Where a person's Advance Care Directive requests such treatment, a health professional does not breach the law, or other professional obligations, by not giving that treatment. The position in Queensland is different where the person does not have capacity, and treatment is futile or non-beneficial.*

Learn more in the End of Life Law Toolkit factsheet ***Futile or Non-Beneficial Treatment***. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Futile-or-Non-Beneficial-Treatment/Factsheet)

ELDAC
End of Life Directions for Aged Care

Advance Care Directive

Case Study

Alistair's story

Alistair has Coronary Heart Disease (CHD) and Parkinson's disease. After experiencing a Cerebral Vascular Accident last year, Alistair's cognition and functional ability has significantly deteriorated. Upon routine review, Alistair's GP Elizabeth believes his Parkinson's disease is entering its later stages.

Until now Alistair and his wife Mary have lived independently while receiving occasional help from their daughter, Helen. Due to worsening arthritis, Mary can no longer care for him, and they reluctantly decide that Alistair should to move into Hilltop Grove, a residential aged care home.

By the time Alistair transitions to Hilltop Grove his Parkinson's disease has deteriorated significantly and he no longer has capacity to make medical treatment decisions. Mary provides the Nurse Manager with Alistair's Advance Care Directive. It was made when Alistair had capacity, and refuses life-sustaining treatment, as well as antibiotics.

Two months later, Alistair contracts severe Community Acquired Pneumonia and Elizabeth attends Hilltop Grove to review his condition. She observes that his vital signs are unstable and that he is deteriorating due to the severity of the infection. Hilltop Grove's Manager contacts Mary and Helen to advise them of Alistair's condition.

Elizabeth reviews Alistair's Advance Care Directive and, in accordance with his refusal of life-sustaining treatment, does not call an ambulance or administer antibiotics. She instructs the Hilltop Grove nursing staff to focus Alistair's care on ensuring his comfort, and charts medications to adequately manage his symptoms.

Helen arrives at Hilltop Grove alone as Mary is unwell. She becomes distressed when she speaks to a nurse attending to Alistair and learns that no treatment other than medication for pain and symptom relief has been provided. She is unaware of Alistair's Directive and believes that Elizabeth should be providing medical interventions to save his life.

Points for reflection

1. Was Elizabeth's decision not to provide antibiotics lawful?
2. Are there any circumstances in which Elizabeth would be justified in not following Alistair's Advance Care Directive?
3. If you were Elizabeth, how would you approach your discussion with Helen about Alistair's care? Is there anything Elizabeth could have done differently?

1. Was Elizabeth's decision not to provide antibiotics lawful?

Generally, a valid Advance Care Directive must be followed by a health professional, even if it refuses life-sustaining treatment that is needed for the person to live.

In States and Territories which have **Statutory Advance Care Directives** governed by legislation **(all jurisdictions except New South Wales)**, Alistair's Advance Care Directive will be valid if it is:

- **in writing** (usually using an approved form outlined in State and Territory legislation). In the Australian Capital Territory and Tasmania, it can also be made verbally or in another way,
- **signed by Alistair** (who must have made the Directive voluntarily when he had decision-making capacity),
- **witnessed**, and
- **applicable to the medical situation**.

The Directive must also comply with any other legislative requirements e.g. receiving information or medical advice before completing it.

In States and Territories which have **common law Advance Care Directives (all States and Territories except Queensland)**, Alistair's Directive will be valid, regardless of whether it is verbal or in writing, so long as it was **made voluntarily, when Alistair had capacity**.

In **Queensland**, an Advance Health Directive which refuses life-sustaining treatment will only apply if certain conditions are met.

Learn more about Queensland's law on Advance Health Directives at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/advance-directives/state-and-territory-laws/queensland#547671)

Here, there is no reason to suggest that Alistair's Directive is not valid. It applies to Alistair's medical situation as it refuses life-sustaining treatment and antibiotics. Elizabeth acted lawfully by following Alistair's Directive and treatment refusal. If Elizabeth had provided Alistair antibiotics, she may be liable under criminal or civil law for committing an assault.

2. Are there any circumstances in which Elizabeth would be justified in not following Alistair's Advance Care Directive?

There are **limited circumstances where an Advance Care Directive does not need to be followed**. These differ in each State and Territory. Some common examples are:

- Where a Directive is too uncertain or ambiguous to guide medical decision-making.
- Where the person's circumstances have changed to such an extent since the Directive was made that it should not be followed.
- Where a Directive requests treatment that the health professional believes is non-beneficial, futile or not in the person's best interests.

In **Queensland**, a health professional does not have to follow a direction in an Advance Health Directive that is uncertain or inconsistent with good medical practice.

As none of these circumstances exist in Alistair's situation, there is no reason why Elizabeth should not follow Alistair's Advance Care Directive.

The law on following Advance Care Directives varies across Australia. Learn about the law in each **State and Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/advance-directives/state-and-territory-laws)

3. If you were Elizabeth, how would you approach your discussion with Helen about Alistair's care? Is there anything Elizabeth could have done differently?

Elizabeth should communicate openly with Helen about Alistair's Advance Care Directive and treatment preferences. This could involve discussing:

- The purpose of an Advance Care Directive e.g. to record a person's decisions, preferences or values around their medical treatment and care where they lack decision-making capacity, and that it enables Alistair's treatment choices to be respected.
- That a person can refuse life-sustaining treatment in their Advance Care Directive even if following that request will result in their death.
- That a Directive is a legally binding document that health professionals are obliged to follow.

It would also be helpful for Elizabeth to listen to Helen's concerns and answer any questions about Alistair's condition and future management.

Better practice in this scenario may have been for Elizabeth or her colleagues to have met with Helen immediately on her arrival to discuss Alistair's prognosis and the implications of his Advance Care Directive. This approach may have enabled early, proactive management of the situation and reduced Helen's distress.

For further tips on managing end of life conversations with the people you care for and/or their families, refer to the:

- End of Life Law Toolkit's *Managing Disputes about Medical Treatment Decision-Making* resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Managing-Disputes-about-Medical-Treatment-Decision-Making)
- *End of Life Essentials education modules.* (https://www.endoflifeessentials.com.au/Education-Modules)

Final legal observations

Alistair had a valid Advance Care Directive that was made voluntarily when he had the capacity to do so. It refused life-sustaining treatment and antibiotics, and was relevant to the medical situation. Elizabeth therefore acted lawfully in following the Directive and complying with Alistair's refusal of treatment.

Substitute Decision-Making

As a person ages, they may lose their ability to make decisions about health care or medical treatment. When this happens, these decisions will need to be made by someone else. That person is commonly referred to as a substitute decision-maker. This factsheet explains the law on substitute decision-making.

Clarifying the law

This factsheet explains:

- The role of a substitute decision-maker
- How a substitute decision-maker is appointed
- Who can be a substitute decision-maker
- What decisions a substitute decision-maker can make
- How substitute decision-makers make decisions
- When a substitute decision-maker's decision must be followed

What is the role of a substitute decision-maker?

A **substitute decision-maker is a person who makes a health care or medical treatment decision for a person who has lost decision-making capacity.**

The substitute decision-maker 'stands in the shoes' of the person to make the decision. Generally **the substitute decision-maker's decision has the same legal effect as if the person had capacity and had made the decision themselves.**

A substitute decision-maker will not need to make the decision if the person without capacity has a valid Advance Care Directive.

Supported decision-making

Supported decision-making is a process that involves providing support so that a person, such as an adult with a cognitive impairment, can make their own decisions with assistance and participate in decision-making.

Examples of support include:

- Providing information to the person in a way they can understand e.g. by adjusting language or using visual aids or technology, so that they can participate in decision-making.
- Giving the person more time to process and discuss the information with others.
- Helping a person in the decision-making process e.g. by talking through options with them.
- Communicating decisions made by the person to health professionals.

Victoria, Queensland, the Australian Capital Territory, Tasmania, and the Northern Territory have laws on supported decision-making. In these jurisdictions, a person will have decision-making capacity for medical treatment if it is possible for them to make a decision with appropriate support. If the person cannot make their own decision with support, then substitute decision-making can occur.

Learn more about supported decision-making at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults#guardianshiplaw)

Who will be the substitute decision-maker?

A person with capacity can plan for a later time when they may lose capacity by **appointing someone to be their substitute decision-maker.** An Advance Care Directive can be used to appoint a substitute decision-maker in most States and Territories.

Learn which document is used to appoint a substitute decision-maker in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

If a person has not appointed someone to make decisions for them, then the **laws in all States and Territories set out who will be the substitute decision-maker**. This person is usually someone who has a close and continuing relationship with the person, such as a spouse or other family member. A person who is listed in records as the 'next of kin' will not necessarily be the substitute decision-maker.

Where there is more than one potential decision-maker, the law sets out an order to determine who will be recognised as the substitute decision-maker.

If the person does not have someone close to them who can make health care or medical treatment decisions, **a public official e.g. the Public Guardian or Public Advocate may be able to make the decision** on their behalf. Sometimes, a tribunal will appoint a guardian to make the health decision.

Who may be a substitute decision-maker and the terminology given to them differs throughout Australia. Learn who may be a substitute decision-maker in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

Avant Mutual also has factsheets on substitute decision-makers in each **State and Territory**. (https://www.avant.org.au/Resources/Public/Substitute-decision-makers/)

What decisions can a substitute decision-maker make?

A substitute decision-maker **can make most health care or medical treatment decisions for a person who has lost capacity**. These decisions can include whether life-sustaining treatment should be provided or withdrawn.

Whether or not a substitute decision-maker has power to make a health decision will depend on the law of the State or Territory.

Learn more about substitute decision-makers' powers in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

What should a substitute decision-maker consider when making a decision?

The laws in each State and Territory set out principles to guide substitute decision-makers. These differ between States and Territories, but generally **a substitute decision-maker needs to consider the following principles when making a decision** about health care or medical treatment:

- what decision the person would have made, based on the person's views, wishes and conduct when they had capacity; and
- the person's interests and wellbeing (sometimes referred to as the person's 'best interests') after considering such things as potential risks, burdens and benefits of treatment.

Most States' and Territories' legislation prioritises a person's wishes over other principles.

Learn more about substitute decision-makers' powers and considerations for decision making in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

Shared decision-making can achieve consensus between individuals, families and health professionals about treatment and goals of care, and prevent conflict about withholding or withdrawing treatment.

This process involves, '*discussion and collaboration between an older person and their health care provider. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person'*.

Where the person does not have capacity, these discussions should occur with the person's family or substitute decision-maker.

Learn more at the ***Australian Commission on Safety and Quality in Health Care***. (https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making)

Should a substitute decision-maker's decision be followed?

Generally, **a substitute decision-maker's decision should be followed**, even if the decision is to refuse life-sustaining treatment which could result in the person's death.

A health professional may be liable under criminal or civil law or subject to disciplinary action if they provide treatment that has been refused by a substitute decision-maker.

The situation is more complex if the substitute decision-maker is requesting treatment that a health professional considers to be futile or not in the person's best interests. This is discussed further in the **End of Life Law Toolkit factsheet *Futile or Non-Beneficial Treatment***. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Futile-or-Non-Beneficial-Treatment/Factsheet)

Learn more about following a substitute decision-maker's decision in your **State or Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

Key points to remember

1. A substitute decision-maker can make a health care or medical treatment decision for a person who does not have capacity, and does not have a valid Advance Care Directive.
2. If a person has not appointed a substitute decision-maker, a tribunal can appoint a decision-maker for them. But often, the substitute decision-maker will be a spouse or other family member with a close relationship to the person. If there is no one who can act in this role, the Public Advocate or Public Guardian may be able to make the decision.
3. The law in all States and Territories sets out who will be the substitute decision-maker in a particular situation. The legislation and terminology for a substitute decision-maker is different in each jurisdiction.
4. Substitute decision-makers can make most decisions about health care or medical treatment, even decisions to refuse treatment at the end of life. However, the law on substitute decision-makers' powers differs between States and Territories.
5. When making decisions, generally substitute decision-makers must think about what decision the person would have made and what would be in the person's best interests.
6. Generally a decision made by a substitute decision-maker about health care or medical treatment must be followed by a health professional.

7. Supported decision-making involves supporting an older person with cognitive impairment to make their own decisions with assistance and to participate in decision-making. In some States and Territories attempts must be made to support a person to make their own decisions before substitute decision-making can occur.

Mythbusters: Substitute Decision-Making

Myth 1: If a person doesn't have decision-making capacity, decisions about health care or medical treatment should be made by his or her 'next of kin'.

No. *'Next of kin' is an informal term commonly used to refer to a person's immediate or close family members. The term is not recognised in the laws about decision-making for health care or medical treatment.*

The person who will make a health care or medical treatment decision for a person without decision-making capacity is known as the person's 'substitute decision-maker'. Who will be the substitute decision-maker for the person will depend on the legislation in your State or Territory.

Myth 2: A resident I care for doesn't have capacity and has several close family members who visit regularly. I can ask any of them to make a treatment decision for the resident if a decision is needed while they are visiting.

No. *The guardianship and medical treatment legislation in each State and Territory sets out an 'order of priority' of people who can be a person's substitute decision-maker. The first person in that order who is willing, available and able to make the decision is the substitute decision-maker.*

ELDAC
End of Life Directions for Aged Care

Substitute Decision-Making

Case Study

Vivian's story

Vivian is an 80-year-old resident of the Sapphire Peaks Residential Aged Care home. She is generally well. While boarding the shuttle bus to do her weekly shopping, Vivian missed her footing and fell backwards, hitting her head on the pavement. She rapidly became unresponsive and was rushed to the closest Emergency Department.

Vivian is unconscious and does not have capacity to make decisions about medical treatment. The medical team discuss Vivian's treatment options with her children Amy (aged 47) and James (aged 45), their father Ed (Vivian's ex-husband who she hasn't seen since they divorced 15 years ago, and who is visiting with Amy from interstate), and Vivian's sister Rachel, who has a close relationship with Vivian. Amy and James are also close to their mother and visit her often.

The neurosurgical specialist team advise that due to her severe head injury, Vivian requires urgent surgery to relieve intercranial pressure caused by the bleeding around her brain. The surgery is needed for Vivian to survive, but it is an invasive procedure, and given her age and the extent of the trauma there is a risk that she may not survive the anaesthesia or operation.

Vivian does not have an Advance Care Directive, or a guardian or attorney, so a substitute decision-maker's consent is needed to proceed with the surgery. Amy recalls a recent conversation with her mother, following a friend's death, where she told Amy that she would not want to have any major operations or medical treatment at this stage of her life, and would not want to be kept alive if she were dying. Ed remembers Vivian having similar conversations with him when they were married. Amy and James want to respect their mother's wishes and although devastated, they decide not to consent to the operation. Rachel is horrified and cannot bear the thought of Vivian dying if there is a chance she might survive. She begs Amy and James to reconsider.

Points for reflection

1. Who is Vivian's legally recognised substitute decision-maker?
2. What happens if there is a disagreement among Vivian's family members about her treatment?
3. Can Vivian's substitute decision-maker/s refuse consent to the operation?
4. What factors should Vivian's substitute decision-maker/s consider when making the decision?
5. Does the clinical team have to follow the decision?

1. Who is Vivian's legally recognised substitute decision-maker?

As Vivian does not have an Advance Care Directive, or appointed guardian or attorney, the laws in all States and Territories set out a hierarchy of 'default' substitute decision-makers (known as a person responsible, Statutory Health Attorney, medical treatment decision-maker, health care decision maker, or health attorney, depending on the State or Territory). The appropriate decision-maker is usually someone who has a close and continuing relationship with the person e.g. the person's spouse or another family member.

As Vivian is divorced from Ed and they do not have a close and continuing relationship, he is no longer her spouse and cannot be her decision-maker. Applying the law in each State and Territory, Vivian's decision-makers are as follows:

- In **Queensland, South Australia, Tasmania, the Australian Capital Territory and New South Wales**, Vivian's relatives who have a close and continuing relationship with her can make the decision. Therefore, **Amy, James and Rachel** can be her decision-makers.
- In the **Australian Capital Territory**, the health professional may ask the decision-maker they believe is best able to represent the person's views to give consent.

Learn more about the law in the **Australian Capital Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/australian-capital-territory)

- In **Victoria**, Vivian's adult children who have a close and continuing relationship with her (Amy and James) are higher on the list of decision-makers than an adult sibling (Rachel). Where there are two or more adult children, the eldest can make the decision, in this case, **Amy**.
- In **Western Australia**, Vivian's nearest relative who maintains a close relationship with her is her decision-maker. In the order of priority among relatives, a person's children (Amy and James) are higher in the list than a sibling (Rachel). Therefore, **Amy and James** can be Vivian's decision-makers.
- In the **Northern Territory**, Amy and James are higher in the hierarchy of decision-makers than Rachel. They are therefore Vivian's decision-makers.

2. What happens if there is a disagreement among Vivian's family members about her treatment?

When disputes arise, it is rare for the guardianship and other legal systems to become involved, and for cases to be decided by courts or tribunals. Most conflicts are managed within the treating hospital or health service using internal dispute resolution policies or procedures. These seek to facilitate open communication and achieve consensus among decision-makers through processes such as clinical reviews, obtaining an independent second medical opinion, family or case conferences, and mediation. Legal advice may also be sought from the health service's legal team.

In some States and Territories, guardianship and medical treatment legislation sets out how disagreements can be resolved. This may involve referring the disagreement for dispute resolution (e.g. through the Public Advocate or Public Guardian in some jurisdictions), and, as a last resort, applying to tribunals or courts to make the decision.

This area of law is different in each **State and Territory**. Learn more at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

In this case, Rachel disagrees with Amy and James and wants Vivian to have the surgery. In practice the hospital would most likely hold a family meeting to attempt to reach consensus among them.

Learn more about how to manage medical treatment decision-making disputes in the **End of Life Law Toolkit's *Managing Disputes about Medical Treatment Decision-Making* resources**. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Managing-Disputes-about-Medical-Treatment-Decision-Making)

3. Can Vivian's substitute decision-maker/s refuse consent to the operation?

A substitute decision-maker can make most medical treatment decisions for a person who no longer has capacity, including decisions about whether life-sustaining treatment should be provided, withheld or withdrawn.

In all **States and Territories**, Vivian's decision-maker/s can refuse consent to the operation.

This area of law can be complex, especially in relation to stopping life-sustaining treatment once it has started.

Learn more about decisions that a substitute decision-maker can make in your **State or Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

4. What factors should Vivian's substitute decision-maker/s consider when making the decision?

When making the treatment decision, Vivian's substitute decision-maker/s should consider:

- what decision Vivian would have made if she had capacity; and
- whether treatment would be in Vivian's interests, after considering the potential risks, burdens and benefits of the treatment.

The laws in each State and Territory also set out principles to guide substitute decision-makers e.g. decision-making principles, health care principles. The principles in most jurisdictions require substitute decision-makers to consider the person's:

- views, preferences and wishes (if known);
- interests and welfare; and
- treatment options, risks and alternatives.

Here, Vivian's decision-maker/s should consider Vivian's previous statements about her treatment preferences e.g. that she does not want any major operations or medical treatment, and does not want to be kept alive if she is dying. The risks of the surgery (e.g. death); other available treatment options (here, there are none); the benefits of future treatment (she may survive) and the burdens (including what her prognosis would be if she does survive); and other decision-making principles should also be considered.

Learn more about making substitute decisions in your **State or Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

5. Does the clinical team have to follow the decision?

Generally a substitute decision-maker's decision should be followed, even if refusing treatment will result in a person's death. If the clinical team undertakes the surgery without first obtaining consent from a substitute decision-maker, they could be liable under criminal or civil law or be subject to disciplinary action.

If a clinical team is concerned about the decision a substitute decision-maker makes (e.g. they believe it is not in the person's best interests), they may seek advice from the hospital or health service's legal team, or a medical defence insurer. In some State and Territories, the Public Guardian or Public Advocate's office may be able to provide information or assistance.

Final legal observations

Vivian's legally recognised substitute decision-makers (which vary depending on which State or Territory Vivian is in) must decide whether or not to consent to the operation. In doing so they must take into consideration the factors discussed in reflection point 4. If there is disagreement among Vivian's decision-maker/s, a meeting could be held between the family and clinical team to reach consensus. In this scenario the clinical team should follow the substitute decision-maker's/s' decision about Vivian's treatment, unless they have concerns about the decision, in which case legal advice should be sought.

Withholding and Withdrawing Life-Sustaining Medical Treatment

Decisions to withhold or withdraw life-sustaining medical treatment are common in end of life and palliative care. Sometimes they are made by the person themselves (if they have decision-making capacity), and sometimes they are made on behalf of the person (if they no longer have decision-making capacity). This factsheet explains the law on withholding and withdrawing on life-sustaining treatment.

Clarifying the law

This factsheet explains:

- What is life-sustaining treatment
- When a decision to withhold or withdraw life-sustaining treatment can be made
- Who can make the decision
- When the decision must be followed

What is life-sustaining treatment?

'Life-sustaining treatment' is treatment that is needed to prolong a person's life. Examples include cardiopulmonary resuscitation, artificial hydration and nutrition, artificial ventilation, and in some circumstances, antibiotics and blood transfusions.

When is it lawful to withhold or withdraw treatment?

A decision to withhold or withdraw treatment is a common feature of medical practice when a person is approaching the end of life. The law that governs this practice differs depending on whether the person has capacity to make treatment decisions.

Where the person has capacity

A person with capacity may refuse any medical treatment, even if it is needed to keep the person alive. **It is lawful for a health professional to withhold or withdraw treatment from a person with capacity who has refused that treatment**. In fact, a health professional who provides treatment contrary to a refusal will have committed an assault on the person.

Where the person does not have capacity

When a person does not have decision-making capacity, a decision to withhold or withdraw life-sustaining treatment can still be lawful in some cases. These include:

1. When the person has a valid **Advance Care Directive which refuses that treatment**.
2. A **decision made by the person's substitute decision-maker** to withhold or withdraw treatment. The law on this is not the same throughout Australia. It is important to **consult the guardianship and medical treatment legislation in your State and Territory** (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws) to determine when a substitute decision-maker can make this kind of decision.
3. **When providing the treatment would not be in the person's best interests**. This is sometimes referred to as treatment that is futile or non-beneficial.

   An example of this kind of treatment may be the artificial nutrition or hydration of a person in the final stages of dementia who can no longer swallow.

Learn more about the law on withholding and withdrawing treatment in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

Decision-making about life-sustaining treatment is discussed further in the End of Life Law Toolkit's *Advance Care Directives* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives/Factsheet) and *Substitute Decision-Making* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making/Factsheet) factsheets.

Shared decision-making can achieve consensus between individuals, families and health professionals about treatment and goals of care, and prevent conflict about withholding or withdrawing treatment.

This process involves '*discussion and collaboration between an older person and their health care provider. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person*'.

Where the person does not have capacity, these discussions should occur with the person's family or substitute decision-maker.

Learn more at the *Australian Commission on Quality and Safety in Health Care*. (https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making)

Does a decision to withhold or withdraw treatment have to be followed?

Generally a **health professional must follow a decision to withhold or withdraw treatment** made:

- by a **person who has capacity**,
- **in a valid Advance Care Directive** (made when the person had capacity), or
- by a **person's substitute decision-maker**.

If they do not, a health professional could be liable under the criminal or civil law, and subject to disciplinary sanction.

However, generally a **health professional does not have to provide treatment that they consider is of no benefit, not in the person's best interests, or futile**, even when it is demanded by a person or their substitute decision-maker.

The law is different in Queensland when the person does not have capacity and their substitute decision-maker is wanting treatment.

Learn more about the law in Queensland at *End of Life Law in Australia* (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/queensland), or in the End of Life Law Toolkit factsheet *Futile or Non-Beneficial Treatment*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Futile-or-Non-Beneficial-Treatment/Factsheet).

Disputes about withholding or withdrawing treatment

Sometimes disputes arise between the person, health professionals, families and substitute decision-makers about whether treatment should be withheld or withdrawn.

In these situations early, proactive communication can prevent conflict from escalating. It is rare for the legal system to become involved, and most conflict can be managed within the aged care setting.

Learn how to resolve disputes in this kind of situation in the End of Life Law Toolkit's factsheet *Managing Disputes about Medical Treatment Decision-Making*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Managing-Disputes-about-Medical-Treatment-Decision-Making)

Key points to remember

1. Decisions about withholding or withdrawing life-sustaining treatment are common when caring for people who are approaching the end of life.
2. A person who has decision-making capacity can lawfully refuse treatment, even if it is needed to keep them alive. Such a refusal should be followed. The same is generally the case if the person refuses treatment in an Advance Care Directive they made when they had capacity.
3. If the person does not have capacity, their substitute decision-maker can, in some cases, decide to withhold or withdraw life-sustaining treatment. The law on this depends on the guardianship and medical treatment legislation in each State and Territory.
4. A health professional may be liable under the criminal or civil law if they do not comply with a request to withhold or withdraw life-sustaining treatment.
5. A health professional generally has no duty to provide futile or non-beneficial treatment, even if it is demanded by a person, their family or substitute decision-maker.

Mythbusters: Withholding and Withdrawing Life-Sustaining Treatment

Myth 1: A person or their substitute decision-maker cannot refuse treatment needed to keep the person alive

No. *The law allows all adults with capacity to decide what is, or is not done to their bodies. They can consent to or refuse medical treatment. Therefore, a person can refuse medical treatment even if that treatment is needed to keep them alive.*

Myth 2: A health professional who withholds or withdraws life-sustaining treatment performs voluntary assisted dying

No. *A health professional does not perform voluntary assisted dying (VAD) by withholding or withdrawing treatment.*

Withholding and withdrawing life-sustaining treatment is part of mainstream medical practice. It involves stopping (or not providing) treatment in situations where there is no legal requirement to do this e.g. because the person or their substitute decision-maker has refused treatment, or because treatment would be of no benefit to the person. It will be lawful so long as any necessary consents are obtained.

VAD is different in law and practice to withholding and withdrawing life-sustaining treatment. VAD occurs only when a person makes a clear request for VAD and is found to be eligible by an authorised medical practitioner. It involves the administration of a substance (either by the person themselves or by a health practitioner) which ends the life of the person.

In all States, a person can only be eligible for VAD if they:

- *have a terminal illness, disease or medical condition,*
- *are expected to die within six months, or 12 months if they are in Queensland or have a neurodegenerative condition; and*
- *meet all other eligibility criteria.*

VAD is lawful only if it occurs in accordance with each States' VAD laws. Currently VAD is not lawful in the Northern Territory or the Australian Capital Territory (though VAD laws have been passed in the ACT and will commence on 3 November 2025).

Learn more in the End of Life Law Toolkit factsheet *Overview of Voluntary Assisted Dying*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)

ELDAC
End of Life Directions for Aged Care

Withholding and Withdrawing Life-Sustaining Medical Treatment

Case Study

Renata's story

Renata is a resident at the Calypso Aged Care Home. Two years ago, she was diagnosed with advanced bowel cancer and received three intensive cycles of chemotherapy treatment after undergoing a bowel resection to create a permanent colostomy. Renata was aware that her cancer was incurable but with the help of her husband, she remained well and enjoyed a reasonable quality of life.

At the end of last year Renata's husband passed away suddenly. Following his death she became socially isolated and found it increasingly difficult to care for herself. With her children's support she moved into Calypso.

Not long after settling into Calypso, Renata began experiencing right-sided chest and upper abdominal pain. Following further investigations, Renata's oncologist, Rajesh, advises that the cancer has metastasised to her right lung, liver, and bones. He advises Renata to consider palliative chemotherapy as it may manage her disease symptoms and possibly prolong her life. Renata's son, Alejandro, is at the consultation and tells Rajesh he wants his mother 'to do everything possible and keep fighting'. Renata reluctantly agrees to schedule chemotherapy for later that week.

After the appointment, Renata returns to Calypso and reflects on her diagnosis. She is fatigued, and feels that her strength is deteriorating due to her age and conditions. She previously experienced severe side effects from chemotherapy and understands the palliative treatment will only temporarily extend her life but not cure her condition.

Later that week, Alejandro takes Renata to her appointment where she advises Rajesh that after much careful thought she does not want chemotherapy, and would prefer to focus on spending the time she has left with her family. Alejandro becomes distressed and demands that Rajesh 'make my mother have the chemo!'.

Points for reflection

1. Is it lawful for Renata to refuse chemotherapy, even if she may die sooner without that treatment?
2. Does Rajesh have to follow Renata's decision?
3. Can Alejandro demand that Renata have the treatment?
4. What if Renata did not have capacity to decide about chemotherapy?

1. Is it lawful for Renata to refuse chemotherapy, even if she may die sooner without that treatment?

The law presumes that all adults have capacity to consent to or refuse treatment, unless it is shown otherwise.

A person with decision-making capacity may refuse medical treatment, even if it is needed to keep them alive. This is because **capacity relates to a person's ability to make a decision, not what decision they make**. However, unwise or unusual decisions may be a prompt to check a person's capacity.

Renata will have capacity if she:

- is able to comprehend and retain the information needed to make the decision, including the consequences of the decision; and
- can use and weigh that information when deciding.

If Renata has capacity, provided her consent has been given freely and voluntarily (and relates to the proposed treatment) she can lawfully refuse the chemotherapy.

Renata appears to understand the proposed treatment, and the consequences of having or refusing the chemotherapy (she knows that if she does not have it the cancer will spread and cause death). She has considered the information provided by Rajesh and has weighed it.

For example, she has considered that the chemotherapy may prolong her life, but also its other implications including the potential for side effects and diminished quality of life. She has used and balanced that information against the consequences of refusing treatment, as part of her decision-making process.

Learn how to determine if a person has capacity to consent to medical treatment in the **End of Life Law Toolkit's *Capacity and Consent to Medical Treatment* resources.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment)

2. Does Rajesh have to follow Renata's decision?

A health professional must follow a decision to withhold or withdraw treatment made by a person who has capacity. In fact, a health professional who provides treatment contrary to a refusal will have committed an assault on the person, and may be subject to civil, criminal or disciplinary action. Therefore, if Renata has capacity Rajesh should accept her decision not to have chemotherapy.

3. Can Alejandro demand that Renata have the treatment?

No. If Renata has capacity, her decision to refuse treatment must be followed, even if Alejandro or others disagree with her decision.

4. What if Renata did not have capacity to decide about chemotherapy?

Where a person does not have capacity, a decision to withhold or withdraw life-sustaining can still be made:

- in a valid Advance Care Directive (made when the person had capacity); or
- by a person's substitute decision-maker, provided they have the power to do this under the law of their State or Territory.

Learn more about substitute decision-makers' powers in your **State or Territory** at ***End of Life Law in Australia.*** (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

When deciding to withhold or withdraw life-sustaining treatment from a person without capacity, a substitute decision-maker needs to consider the principles for decision-making set out in State or Territory laws. These differ between States and Territories but generally require the decision-maker to consider:

- what decision the person would have made, based on the person's views, wishes and conduct when they had capacity; and
- the person's interests and wellbeing (sometimes referred to as the person's 'best interests') after considering such things as potential risks, burdens and benefits of treatment.

Renata does not have an Advance Care Directive refusing treatment, so if she did not have capacity her substitute decision-maker would need to consider whether or not to consent to the chemotherapy. If Alejandro is her lawfully recognised substitute decision-maker, he would need to consider Renata's values and preferences, and apply the decision-making principles in Renata's State or Territory, in order to reach a decision.

Learn about:

- how decision-makers make decisions in your **State or Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)
- substitute decision-making in the **End of Life Law Toolkit's *Substitute Decision-Making resources***. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Substitute-Decision-Making).

Final legal observations

After further discussion, Rajesh considers that Renata understands the proposed treatment, and the consequences of having or refusing the treatment (e.g. that she will die). He believes she has considered the information provided and weighed it to arrive at her decision e.g. she has considered that the chemotherapy may prevent the cancer, but may also cause side effects; that it may prolong her life only temporarily; and that her preference is to spend time with her family. The law recognises Renata's choice not to have chemotherapy, which Rajesh must respect.

Legal Protection for Administering Pain and Symptom Relief

Providing medication for pain and symptom relief is important to ease suffering and improve the quality of life of a person with a life-limiting illness. However, uncertainty can arise for those giving pain relief medication about whether it is lawful, particularly when a person is close to death. This factsheet explains how the law can protect health professionals who provide appropriate pain and symptom relief.

Clarifying the law

This factsheet explains:

- Why providing appropriate pain and symptom relief is lawful
- What legal protection is available if a person dies after receiving pain and symptom relief medication
- That giving appropriate pain and symptom relief is not voluntary assisted dying
- That pain and symptom relief can be given where a person refuses food and water

About medication for pain and symptom management

Providing medication for pain and symptom management (e.g. morphine, fentanyl, hydromorphone, midazolam and haloperidol) is a key part of good palliative care for a person with a life-limiting illness. It may be given in hospital, in residential aged care or at home.

There are varying clinical views about whether or not some medication used in providing palliative care may hasten death. However, the law recognises that **medication used for pain and symptom relief is lawful in Australia** if the intention of the person giving the medication is to relieve the person's pain and symptoms and not to cause their death.

Legal protection when a person dies

In some cases it is possible for medication to have the 'double effect' of relieving pain and symptoms as well as hastening a person's death.

In those situations the **doctrine of double effect** ('double effect') can provide legal protection to the person who prescribed or administered the medication so they are not legally liable for the death.

What is double effect?

Double effect recognises that **giving medication to relieve a person's pain and symptoms is lawful so long as the health professional's intention is to relieve the person's pain and not hasten death.**

The medication **should be given in accordance with good medical practice** e.g. it should be appropriately titrated, and health professionals should apply reasonable care and skill to ensure that the right medication and dose is given.

Double effect is part of Australian law.
In **Queensland, Western Australia, South Australia** and the **Australian Capital Territory** there is also legislation which recognises double effect.

Learn more about the law in your **State or Territory** at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/palliative-care)

Where will double effect apply?

Double effect can apply when the person's death occurs in a hospital, residential aged care facility or other health service. It can also apply when the person dies at home.

Who is protected?

The person giving the pain or symptom relief does not need to be a doctor for double effect to apply. Other health professionals and care givers, including **nurses, aged care workers, paid or unpaid carers, or family members** may also be protected by double effect so long as there **is medical authorisation or supervision of the medication plan** by a doctor or nurse practitioner, and death was not intended. It is also good practice (and a requirement of the law in South Australia) for **consent to be sought from the person or, if they cannot consent, their substitute decision-maker**, before providing the medication.

Does the person need to be close to death?

Double effect is likely to apply only when the person is near death. In **South Australia**, the legal protection will apply only if the person is in the terminal phase of a terminal illness.

Appropriate pain and symptom relief is not voluntary assisted dying

A common misconception about medication for pain and symptom management is that it is the same as voluntary assisted dying if it causes the person's death e.g. *'If I give my patient medication for pain relief and she dies I will have assisted her to die'.* Sometimes these concerns have resulted in people not getting enough pain and symptom relief, which can cause suffering and distress for the person as well as their family.

Appropriate medication which is intended to relieve pain and symptoms is not voluntary assisted dying. The law views this as appropriate palliative care and, if the medication also has the effect of hastening the person's death, protects those providing the medication through double effect.

Learn more in the End of Life Law Toolkit's factsheet *Overview of Voluntary Assisted Dying*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)

Pain relief for a person who refuses food and water

Sometimes, a person who is close to death may refuse food and water. This is legal if the person has capacity to make this decision. **Everyone has the legal right to refuse food and water**, even if this results in their death.

When a **person decides to stop eating and drinking, medication can be given** to reduce any pain or symptoms they experience from this.

Learn more about capacity and refusal of treatment in the End of Life Law Toolkit factsheets *Overview: Capacity and Consent to Medical Treatment* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment/Overview) and *Withholding and Withdrawing Life-Sustaining Medical Treatment*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Withholding-and-Withdrawing-Life-Sustaining-Medical-Treatment/Factsheet)

Key points to remember

1. Giving appropriate medication for pain and symptom relief is lawful in Australia.
2. The doctrine of double effect provides legal protection to health professionals and others if a person dies after receiving medication for pain and symptom management. It applies if the person who prescribed or administered the medication intended to relieve pain and symptoms, not hasten death.
3. Double effect will only apply if the medication is administered by a doctor, or by someone else (for example, a nurse, carer, or family member) under a doctor or nurse practitioner's authorisation or supervision; and the person was already close to death.
4. Medication given with the intention of relieving pain and symptoms is not voluntary assisted dying.
5. A person with decision-making capacity has the right to refuse food and drink, even if it results in death. Medication to relieve the person's pain and symptoms can be given in these situations.

If you have concerns about providing medication for pain and symptom management, ask questions!

Support is available.

- If you work in aged care, discuss your concerns with your manager or Director of Nursing.
- If you are a GP, you can seek advice from your medical insurer.

People from diverse social and cultural backgrounds may communicate pain in different ways (including non-verbally). People may also have different views about pain management and using medication such as opioids. It is important to properly inform the person you care for about pain management options and make sure they understand the options.

Learn more about delivering palliative care to:

- Aboriginal and Torres Strait Islander people from the *Gwandalan e-Learning Modules* (https://gwandalanpalliativecare.com.au/elearning-modules/) and the Indigenous Program of Experience in the Palliative Approach. (https://pepaeducation.com/wp-content/uploads/2020/12/PEPA_CulturalConsiderationsFlipbook_Web.pdf).
- People from culturally and linguistically diverse backgrounds in *PCC4U's Topic 4: Culture-centred care of people with life-limiting illnesses*. (http://www.pcc4u.org/learning-modules/focus-topics/topic-4-culture-centred-care/)

Mythbusters: Legal Protection for Administering Pain and Symptom Relief

Myth 1: A health professional performs voluntary assisted dying if they provide pain relief medication that hastens a person's death

No. *Giving medication for pain and symptom management in accordance with good medical practice is legal so long as the health professional's intention is to reduce or relieve a person's pain and symptoms, and not to hasten death. This is the case even if the health professional knows death may be hastened by providing the medication. Health professionals are legally protected by the doctrine of double effect.*

Myth 2: A health professional or other person assists dying by allowing someone to refuse food or drink

No. *If a person has capacity to refuse food or drink, then respecting their refusal and not force-feeding the person is not assisting them to die.*

Myth 3: The doctrine of double effect will only protect a doctor

No. *In most Australian States and Territories a doctor, nurse, carer or family member can give medication and be legally protected by the doctrine of double effect. Generally however, the medication must be ordered or supervised by a doctor or nurse practitioner.*

The law in South Australia is slightly different. The medication must be given by the practitioner responsible for the person's treatment, or a person supervised by that practitioner, such as a nurse or carer.

ELDAC
End of Life Directions for Aged Care

Legal Protection for Administering Pain and Symptom Relief

Case Study

Peter's story

Peter is a resident of the Summer Gardens Residential Aged Care Facility. He has end stage Non-Small Cell Lung cancer. The cancer has metastasised to Peter's liver and bones, as well as his chest and spine, causing pain, discomfort and shortness of breath. Peter has been receiving therapeutic oxygen via nasal prongs for the last 6 months as his respiratory function has progressively deteriorated. Though he is still alert and can swallow, Peter has lost his appetite and has recently asked the staff to stop bringing him meals.

On Friday Peter's GP, Hannah, completes her routine visit to the facility. On review, she notes that Peter appears distressed. He complains of unbearable back pain and increased difficulty breathing despite receiving oxygen. Hannah believes the current background dosage of morphine Peter is receiving is no longer effective so she increases this dose on Peter's medication chart. She also requests that the nursing staff administer subcutaneous morphine and/or midazolam prn to control Peter's pain and reduce his shortness of breath, prescribing them on his medication chart with a dosage frequency of hourly.

Hannah contacts Peter's son Jeffrey to inform him that Peter's condition is deteriorating and that she believes Peter's life expectancy is short, likely days. She explains that she has instructed the staff to provide comfort care to manage Peter's symptoms and ensure he is comfortable at the end of his life.

Early on Saturday morning, Tilda, a Registered Nurse, is on duty. When Tilda visits Peter she notes that he is coughing, moaning and struggling to breathe. He tells Tilda 'I'm in agony', describing excruciating back and chest pain despite having a dose of morphine an hour ago. Following a review of Hannah's instructions in Peter's medication chart, Tilda administers a prn dose of subcutaneous morphine.

An hour later, Tilda checks on Peter. While Peter is more settled than before, he is still moaning and struggling to breathe. Jeffrey, who is visiting Peter, asks Tilda 'Is there anything you can give him? I just want him to be comfortable'. Tilda assesses Peter and in accordance with Peter's medication chart she decides to administer a further dose of prn subcutaneous morphine with a dose of midazolam, to control his pain and breathlessness as optimally as possible. A short time later, Tilda checks on Peter. Although he is now unconscious his breathing has settled and he appears comfortable.

When Tilda returns from her afternoon tea break, a colleague informs her that Peter has just died peacefully. Tilda is worried that the prn medications might have caused his death and fears that she could be held responsible.

Points for reflection

1. Was Tilda's provision of pain and symptom relief to Peter lawful?
2. Has Tilda assisted Peter to die?
3. Before his death, Peter asked the staff not to bring him meals. Was it lawful for him to do so?

1. Was Tilda's provision of pain and symptom relief to Peter lawful?

Providing medication for pain and symptom relief as part of palliative care is important to ease suffering and improve the quality of life of a person with a life-limiting illness.

Sometimes providing medication may have the 'double effect' of relieving pain and symptoms as well as hastening a person's death. Where this occurs, the doctrine of double effect ('double effect') may apply and protect the person providing the medication from legal liability. Double effect recognises that **giving medication is lawful so long as the intention of the person giving it (e.g. the doctor or nurse) is to relieve the person's pain and symptoms and not to cause death**.

Double effect is part of Australian law. Queensland, South Australia, Western Australia and the Australian Capital Territory also have legislation that recognises double effect.

Double effect is likely to apply only when the person's death is imminent. In South Australia, double effect will apply only where the person is in the terminal phase of a terminal illness.

Double effect can protect doctors, as well other health professionals and care givers including nurses, paid or unpaid carers, or family members, so long as the medication and/or medication plan is authorised or supervised by a doctor or nurse practitioner caring for the person, and the person's death was not intended.

In this case, Peter's death was imminent, and the focus of care was to keep Peter comfortable at the end of his life. Providing the medication was necessary to manage and relieve the symptoms Peter was experiencing. Tilda acted in accordance with Peter's medication chart in which Hannah authorised prn morphine and/or midazolam. Her intention in providing the medication was to relieve Peter's pain and symptoms. Tilda therefore acted lawfully, and is protected by double effect.

Find out more about the law on palliative medication at *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/pain-relief)

2. Has Tilda assisted Peter to die?

No. A common misconception about pain and symptom relief is that it is the same as voluntary assisted dying if it causes the person's death. **Giving medication with the intention of relieving pain and symptoms is not voluntary assisted dying**. Providing such care is lawful, so long as the health professional's intention is to relieve a person's pain and symptoms, and not to hasten death. The medication that Tilda administered to Peter was provided to control and relieve his pain and shortness of breath, and provide comfort. The law views this as appropriate palliative care, not assisting dying.

3. Before his death, Peter asked the staff not to bring him meals. Was it lawful for him to do so?

A person who is close to death will often lose their appetite, and may refuse food and water. If the person has decision-making capacity, it is lawful for them to make this decision. **Everyone has the right to refuse food and water even if this accelerates their death**. If the person experiences any pain or symptoms as a result of stopping eating and drinking, it is also lawful to provide medication to manage those symptoms.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit's *Legal Protection for Administering Pain and Symptom Relief*** factsheet. **(https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief/Factsheet)**

Final legal observations

Tilda did not intend for Peter's death to be hastened; rather she gave the prn medication to relieve his pain and breathlessness and provide comfort in accordance with Hannah's instructions. The law would recognise this as appropriate palliative care. Tilda would be protected by the doctrine of double effect in this case.

Futile or Non-Beneficial Treatment

When medical treatment is considered to be futile, of no benefit or not in a person's best interests, a decision may be made to withhold or withdraw it. However, an older person, their family and/or health professionals may disagree about when treatment is futile or non-beneficial. This can make these decisions complex. This factsheet explains the law on futile or non-beneficial treatment.

Clarifying the law

This factsheet explains:

- What futile or non-beneficial treatment is
- Who decides if treatment is futile or non-beneficial, and how
- When a decision to withhold or withdraw futile or non-beneficial treatment can be made
- Health professionals' legal obligations regarding futile non-beneficial treatment

What is futile or non-beneficial treatment?

Futile or non-beneficial treatment is not defined in law, and there is disagreement about what it means. It is often used to describe treatment which:

- **is of no benefit,**
- **cannot achieve its purpose, or**
- **is not in the person's best interests.**

Examples of futile or non-beneficial treatment

There are different types of futile or non-beneficial treatment. One is **physiological futility, where treatment will not provide any physiological benefit to the person**. An example is where an aged care resident close to death is receiving palliative care, and is so medically compromised that cardiopulmonary resuscitation will not work if that person suffers a cardiac arrest.

More common is where **treatment might possibly work but doctors believe that in the person's case it is not worth providing**. For example, treating the person would be burdensome with a low prospect of success, or bring only limited improvement in the person's quality of life.

Who decides if treatment is futile or non-beneficial, and how do they decide?

A decision that treatment is futile or non-beneficial is generally made by the person's treating doctor or clinical team. However, these decisions are increasingly made through effective communication and shared decision-making between health professionals, the person, and families/substitute decision-makers (when the person does not have capacity). Involving individuals and families/substitute decision-makers in decisions about futile or non-beneficial treatment helps to:

- find out a person's values, preferences and goals of treatment, or the substitute decision-maker's understanding of these,
- communicate the risks, benefits and burdens of continuing or commencing treatment,
- explain why the health professional/s believe treatment is futile or non-beneficial, and
- come to a shared view about the options.

If there is a dispute, **the Supreme Court or a State or Territory tribunal may be asked to decide if treatment is futile or non-beneficial.** However, the courts have usually agreed with medical assessments about futility.

When will treatment be futile or non-beneficial?

There is no easy answer to this question, and **no set rules to decide if life-sustaining treatment is futile or non-beneficial**. Instead, it is generally decided on a case-by-case basis. Factors that are usually considered include:

- the person's treatment goals, and the likelihood they will be achieved by providing treatment,
- risks, burdens, and benefits of further treatment,
- treatment alternatives, and
- the person's prognosis and quality of life.

When the courts have been asked to decide whether or not treatment should be provided they have **decided based on the person's best interests, taking into account similar factors to those above**. The courts have also stated that the interests of others (including health organisations or systems) and resources are not relevant.

Is it lawful to withhold or withdraw futile or non-beneficial treatment?

It is **lawful for a health professional to withhold or withdraw treatment that is futile or non-beneficial**.

A health professional **does not need to obtain consent** from a person or their substitute decision-maker to withhold or withdraw futile or non-beneficial treatment. In **Queensland**, however, where a person does not have capacity, consent from a substitute decision-maker is required to withhold or withdraw life-sustaining treatment. This is the case even if the treatment is futile or non-beneficial. This issue is complex, and health professionals may wish to refer to *End of Life Law in Australia* for further information. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/queensland#QLDfutile)

Practice tip

Though consent is generally not required, it is good practice for health professionals to engage in shared decision-making with the person or their family/substitute decision-maker about treatment considered to be futile or non-beneficial.

Where treatment may be futile or non-beneficial, State and Territory guardianship and medical treatment laws about withholding and withdrawing treatment can also apply.

Learn more in the End of Life Law Toolkit factsheet *Withholding and Withdrawing Life-Sustaining Medical Treatment*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Withholding-and-Withdrawing-Life-Sustaining-Medical-Treatment)

Does a health professional have to provide futile or non-beneficial treatment?

Health professionals generally have **no legal obligation to provide treatment** that is **not in the person's best interests**, or would be **inconsistent with good medical practice**.

Therefore, a person and/or their substitute decision-maker **cannot require or demand that a health professional give futile or non-beneficial treatment**. An Advance Care Directive also cannot direct that futile or non-beneficial treatment be given.

Disputes about futile or non-beneficial treatment

Different views about when treatment is futile or non-beneficial can sometimes lead to disputes. For example, an older person's clinical team may consider providing or continuing life-sustaining treatment to be futile or non-beneficial, but the person or their family disagree and insist that treatment be provided.

In most situations, early, proactive communication can help avoid or resolve conflict.

Learn how to manage disputes in this kind of situation in the **End of Life Law Toolkit factsheet** ***Managing Disputes about Medical Treatment Decision-Making***. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Managing-Disputes-about-Medical-Treatment-Decision-Making)

Key points to remember

1. Futile or non-beneficial treatment is not defined in law, but is often used to describe treatment which is of no benefit, cannot achieve its purpose, or is not in the person's best interests.
2. Health professionals generally decide whether particular treatment for a person is futile or non-beneficial. When courts or tribunals are asked to review these matters, they have nearly always agreed with medical assessments of futility. However, it is good practice for health professionals to make shared decisions with the person or their family/substitute decision-maker about futile or non-beneficial treatment.
3. There are no universally accepted rules for deciding if treatment is futile or non-beneficial but a range of factors relating to the person, their treatment and condition, treatment risks, burdens and benefits, and quality of life will be considered.
4. When hearing a dispute about whether treatment should be provided, courts will decide this on the basis of the person's best interests. Treatment that is futile or non-beneficial will not be in the person's best interests.
5. It is generally lawful to withhold or withdraw treatment that is futile or non-beneficial.
6. A health professional has no duty to provide futile or non-beneficial treatment, nor to obtain consent to withhold or withdraw it. However, the law in Queensland is different. There, if the person does not have decision-making capacity, a substitute decision-maker's consent is required to withhold or withdraw futile or non-beneficial treatment.

Mythbusters: Futile or Non-Beneficial Treatment

Myth 1: A health professional must provide life-sustaining treatment to a person if the person's family insists that treatment be provided

No. *A health professional generally has no legal obligation to provide treatment they consider to be futile, non-beneficial or not in a person's best interests, even if family members or substitute decision-makers insist that the treatment be provided.*

It is always good practice to try to reach a shared decision with the person or their substitute decision-maker about withdrawing or withholding futile or non-beneficial treatment.

Myth 2: Courts will not support a health professional who does not want to provide futile or non-beneficial treatment

Courts and tribunals have generally supported medical opinion about futility when asked to decide if treatment is futile or non-beneficial. This is especially so when the person's health professionals have consulted other health professionals, acted in accordance with guidelines, and engaged in discussions with individuals and their families.

However, courts have not always agreed with medical opinion, and there have been legal cases where the court has overruled clinical decisions to withdraw life-sustaining treatment considered to be futile.

Myth 3: A health professional or residential aged care facility does not have to provide vaccinations (for example, influenza vaccinations) to residents of these facilities because that would be futile or non-beneficial treatment

No. *Whether or not treatment is futile or non-beneficial can be decided only on a case-by-case basis. This is because it depends on an individual person's needs and whether they would benefit from the treatment (including an assessment of the treatment's benefits and risks). Because of this, it is not possible to make global assessments about futile or non-beneficial treatment for people living in residential aged care facilities.*

ELDAC
End of Life Directions for Aged Care

Futile or Non-Beneficial Treatment

Case Study

Victor's story

Victor has hypertension, Type 2 Diabetes Mellitus and Coronary heart disease. He lives alone. Due to a recent fall he mobilises using a walking stick. Since his fall he has required assistance with some activities of daily living (showering, housework, meal preparation and shopping), and medication management. To assist his rehabilitation he receives a weekly visit from a Home Care provider team, and is transported once a week to appointments with a physiotherapist. He has capacity to make decisions about his healthcare, and does not have an Advance Care Directive.

One afternoon Victor experiences chest pain and presses the personal emergency alarm he wears around his neck. His son Patrick is alerted and rushes to Victor's house where he discovers Victor on the floor, unconscious.

Victor is transferred by ambulance to hospital where he is diagnosed as having suffered a cardiac arrest, with several minutes of cerebral hypoxia. He remains comatose, and is placed on artificial ventilation in the Intensive Care Unit. Within a few days his condition stabilises, but due to the extent of Victor's brain damage and his pre-existing chronic conditions, his specialists consider it is unlikely he will significantly improve, or be able to survive without artificial ventilation.

Hugh, an intensive care consultant, and Emma, Victor's critical care nurse, meet with Patrick, and Patrick's wife Claudia, to discuss Victor's prognosis. Hugh explains that the clinical team's unanimous opinion is that continuing to provide ventilation would not be in Victor's best interests as it would be invasive, of little benefit in improving his condition, and may cause him pain and suffering. Patrick asks whether the doctors can continue Victor's life support for a few more days to allow more time for him to show improvement. Hugh clarifies that in the unlikely event Victor did show improvement it would only be minimal, and that even if he could breathe independently he would most likely be immobile, with significant cognitive impairment and care needs. Hugh and Emma discuss with Victor's family withdrawing ventilation and providing comfort care to Victor.

Points for reflection

1. Is it lawful for the clinical team to withdraw Victor's ventilation?
2. If Patrick disagreed with the clinical team's decision and insisted that Victor continue to be ventilated, does that request have to be followed?

1. Is it lawful for the clinical team to withdraw Victor's ventilation?

Health professionals generally have **no obligation to provide treatment that would not be in the person's best interests, or is inconsistent with good medical practice**. This type of treatment is known as **futile or non-beneficial treatment**.

Futile or non-beneficial treatment is not defined in law, but is generally used to refer to treatment that **is of no benefit, cannot achieve its purpose, or is not in the person's best interests.**

Whether or not treatment is futile or non-beneficial is generally decided on a case-by-case basis by the person's treating doctor. Factors that may be considered in making this decision include:

- the person's treatment goals and the likelihood that they will be achieved by providing treatment;
- the risks, burdens and benefits of further treatment;
- treatment alternatives; and
- the person's prognosis and quality of life.

Hugh, Emma and their colleagues consider that continuing Victor's ventilation would be of no benefit, and unlikely to result in significant improvement due to the extent of his injuries and pre-existing conditions. They believe that continuing treatment would carry risks and burdens, including that it would be invasive, and could result in Victor enduring further pain and suffering. They conclude that even if Victor's condition improved and he could breathe without ventilation, his quality of life would be impacted by significant cognitive impairment and immobility, with little prospect of further improvement.

These factors suggest that continuing Victor's ventilation would be futile and non-beneficial. In these circumstances it would be lawful for the clinical team to withdraw Victor's ventilation.

In Queensland however, the clinical team would need consent from Victor's substitute decision-maker to lawfully withdraw the ventilation. The law on consent and futile and non-beneficial treatment is discussed in the next section.

2. If Patrick disagreed with the clinical team's decision to withdraw treatment, and insisted that Victor continue to be ventilated, does that request have to be followed?

A health professional is not required to provide treatment they consider to be futile or non-beneficial, even if a person, their family member or substitute decision-maker requests that it be provided. A person also cannot require in their Advance Care Directive that futile treatment be given. Therefore, if Patrick requests that ventilation continue, the clinical team has no legal obligation to ventilate Victor if they believe it would be futile or non-beneficial, or not in his best interests to do so.

Similarly, **a health professional does not need to obtain consent from a person or a substitute decision-maker to withhold or withdraw futile treatment**. However, **Queensland law is different when the person does not have capacity.** There, a health professional must obtain consent from the person's substitute decision-maker to withdraw or withhold treatment that is considered futile.

Learn more about Queensland's laws on futile or non-beneficial treatment at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws/queensland#QLDfutile)

Though consent is not required (except for in Queensland if the person has impaired capacity), it is still good practice for health professionals to involve the person or, if the person does not have capacity, their substitute decision-maker in discussions about futile treatment, to reach a shared decision. Shared decision-making enables:

- the person's values, preferences and goals of treatment, or the substitute decision-maker's understanding of these, to be known,
- communication of the risks, benefits and burdens of continuing or commencing treatment,
- the clinical team to explain why they believe treatment is futile, and
- those involved to reach a shared view about the options.

If Patrick insisted Victor continue to be ventilated, the clinical team would most likely meet with him again later to try to reach consensus about Victor's treatment, before engaging in other dispute resolution options.

Learn how to manage disagreements about medical treatment in the **End of Life Law Toolkit's *Managing Disputes about Medical Treatment Decision-Making* resources**. **(https://www.eldac.com.au/Toolkits/End-of-Life-Law/Managing-Disputes-about-Medical-Treatment-Decision-Making)**

Final legal observations

The clinical team are able to lawfully withdraw Victor's ventilation on the basis that continuing to provide it would be non-beneficial and futile. They do not require consent to withdraw the ventilation (except in Queensland where a substitute decision-maker's consent would be required), and may proceed to do so even if Patrick requested that it continue. However, it would be good practice for the clinical team to involve Patrick in discussions about Victor's treatment, and to try to reach consensus. If there is disagreement between Patrick and the clinical team, dispute resolution, such as mediation, could be undertaken.

Urgent Medical Treatment

There are times when a decision about life-sustaining medical treatment must be made in an emergency. Sometimes there is not enough time to obtain a treatment decision from a person's substitute decision-maker. This factsheet explains the law on urgent (or emergency) medical treatment. It also discusses whether a person should be transferred to hospital for urgent treatment.

Clarifying the law

This factsheet explains:

- When urgent treatment can be provided
- Whether consent to that treatment is required, and who can consent
- Whether a person can refuse treatment in an emergency
- The law relating to resuscitation plans and orders

When can urgent treatment be provided?

Decisions about treatment in emergencies occur regularly in aged care, particularly when a person is approaching the end of life. Many of these decisions relate to providing life-sustaining treatment i.e. treatment that is needed to prolong a person's life. Common examples of this type of treatment in an emergency situation include cardiopulmonary resuscitation, assisted ventilation, and blood transfusions.

In aged care, a decision may also be needed urgently about whether a person should be taken to hospital for treatment.

When consent cannot be obtained

The law about when urgent treatment can be provided if neither a person nor their substitute decision-maker can consent differs between States and Territories.

Generally, it is **lawful for a health professional or personal care worker to provide treatment without consent to a person who does not have capacity if there is an urgent need for treatment e.g. to save a person's life, prevent serious damage to health, or prevent significant pain and distress**.

The treatment given must be necessary to protect the person's life or health at that time.

When consent can be obtained

It may still **be possible in an emergency, before treatment is provided, to obtain consent** either from a **person with capacity, or their substitute decision-maker if the person does not have capacity**.

Consent to treatment may also be given before an emergency situation arises e.g. in a person's Advance Care Directive, or noted on a resident's file. The guardianship and medical treatment decision-making legislation in some States and Territories requires a **health professional to make reasonable efforts (if practical) to find out whether the person has an Advance Care Directive** before giving urgent treatment.

In **South Australia, Western Australia**, the **Northern Territory**, and in some circumstances in **Queensland**, where a person does not have capacity and needs treatment urgently, health professionals must **seek consent from the person's substitute decision-maker if it is possible to do so (e.g. a decision-maker can be located and is available and willing)**.

Though not required by the legislation of other States and Territories, it is still **good practice to obtain a substitute decision-maker's consent if possible**.

If there is a reasonable opportunity to obtain consent and a health professional does not do so, treating the person could result in civil or criminal liability.

Learn more about consent to treatment and capacity in the **End of Life Law Toolkit factsheet Overview:** ***Capacity and Consent to Medical Treatment***. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment)

Can urgent treatment be refused?

Urgent treatment **cannot be provided if it has been lawfully refused**:

- by the person if they have capacity (this may be done verbally),
- in a valid Advance Care Directive, or
- by a substitute decision-maker.

A health professional who provides treatment contrary to a lawful refusal commits an assault on the person.

The guardianship and medical treatment legislation in some States and Territories requires health professionals to consider whether the person has previously refused the treatment.

If it is an emergency situation and a health professional does not know whether a refusal of treatment is valid, treatment may be provided while this is being checked.

The law on urgent treatment differs across Australia. Learn more about the law in your **State or Territory** at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws)

Urgent treatment and transfers to hospital

In emergency situations it is not uncommon for health professionals or personal care workers to be uncertain about **whether or not an older person should receive treatment, and/or be transferred to hospital**. This dilemma may occur when, for example:

- A **person with capacity** states they do not want to go to hospital, and/or refuses treatment.
- A **person does not have capacity** and their substitute decision-maker:
  - demands treatment be provided, despite an earlier decision that treatment should not be given; and/or
  - instructs an aged care facility to transfer the resident to hospital for treatment, despite previously deciding the resident should not be transferred.

Remember!

Hospital transfers and treatment provided against the wishes of a person (or which is not in their best interests) may result in unwanted, burdensome or non-beneficial treatment, and can cause distress to the person, their family, and health professionals.

Treatment against a person's wishes may be an assault and can also lead to criminal or civil liability for the health professionals involved.

What you can do

It is important to know how to act in an emergency situation by doing the following:

Aged care facilities

- Upon the resident entering aged care, **have a conversation about Advance Care Planning** with them, or, if the resident does not have capacity, their substitute decision-maker.
- **Discuss what treatment the resident wants or does not want** if an emergency situation arises.
- If the resident wants to **document their end of life decision, learn how this can be done** by reading the End of Life Law Toolkit *Advance Care Directives* factsheet (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives) or visiting *Advance Care Planning Australia* (https://www.advancecareplanning.org.au/#/).
- **If the person already has Advance Care Planning documentation** (e.g. an Advance Care Directive or a resuscitation plan) **ensure it is made known to staff, it is placed in the resident's records, and can be easily located**.

Health professionals and personal care workers

- **Know if the residents you care for have an Advance Care Directive, a resuscitation plan, and/or substitute decision-maker**, and what the residents' documentation says about treatment.
- **Respect the person's treatment decision**. Remember that it is lawful for a person with capacity to refuse to go to hospital or to receive life-sustaining treatment even if it will result in their death.
- **Know your workplaces' policies and procedures** in relation to emergency situations.
- **Know what the law says about providing treatment**. The following End of Life Law Toolkit factsheets can assist: (https://www.eldac.com.au/Toolkits/End-of-Life-Law):
  - Overview: Capacity and Consent to Medical Treatment
  - Advance Care Directives
  - Substitute Decision-Making
  - Withholding and Withdrawing Life-Sustaining Medical Treatment
  - Legal Protection for Administering Pain and Symptom Relief
  - Futile or Non-Beneficial Treatment
  - Managing Disputes about Medical Treatment Decision-Making
  - Overview of Voluntary Assisted Dying.

Resuscitation plans and the law

Some States and Territories have **forms to guide clinical decision-making about cardiopulmonary resuscitation (CPR) in emergencies**. Examples include Resuscitation Plans (New South Wales) and Acute Resuscitation Plans (Queensland).

These forms are generally completed by hospital clinicians (following discussions with a person or their substitute decision-maker while a person is in hospital) to communicate whether emergency CPR would be futile or burdensome, or whether the person does not want that treatment.

If a resident has a resuscitation plan or similar order which refuses treatment, **whether or not you are required to follow it will depend on the laws of your State or Territory, what decisions are being made about CPR, and by whom**. For example, a form recording a person's refusal of CPR could be evidence of a Common Law Advance Care Directive.

For more information read the End of Life Law Toolkit *Advance Care Directives* factsheet. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives)

If you are unsure about following a resuscitation plan, ask questions!

If you are unsure about whether or not you should follow a Resuscitation Plan:

- **Discuss your concerns with your manager**. They may wish to seek legal advice about the appropriate course of action.
- **General Practitioners** can seek advice from their medical insurer or medical defence organisation.
- **Learn more about resuscitation plans in your State or Territory** by reading the End of Life Law Toolkit *Urgent Medical Treatment* resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Emergency-Medical-Treatment/Resources)

Key points to remember

1. Although the law differs between States and Territories, generally treatment can be given in an emergency without consent if neither the person nor their substitute decision-maker can consent and there is an urgent need for the treatment e.g. to save the person's life, prevent serious damage to health, or prevent significant pain or distress.
2. In South Australia, Western Australia, the Northern Territory, and in some circumstances in Queensland, the law requires that consent to urgent treatment be sought from a substitute decision-maker if possible (e.g. where a decision-maker is available). It is good clinical practice in all States and Territories to seek consent from a substitute decision-maker if they are available.
3. In some emergency situations it may still be possible to obtain consent to treatment e.g. from a person with capacity. If a health professional could have obtained consent and did not, they may be liable under civil or criminal law.
4. Urgent treatment can be lawfully refused either by a person with capacity; in an Advance Care Directive; or by a person's substitute decision-maker.
5. A person may have a resuscitation plan which provides instructions about resuscitation in an emergency. The law on this is different in each State and Territory.

Mythbusters: Urgent Medical Treatment

Myth 1: Urgent treatment cannot be provided to a person without capacity unless a substitute decision-maker consents.

No. *If a person does not have capacity, and it is not possible to obtain consent from the person's substitute decision-maker, the law allows treatment to be given without consent if it is needed urgently to save a person's life, prevent serious damage to health, or prevent significant pain and distress.*

Myth 2: A health professional can provide urgent treatment to a person with capacity without their consent.

No. *If a person has capacity, a health professional or personal care worker should obtain consent from the person prior to providing that treatment, even in an emergency situation.*

Myth 3: If a person does not have capacity and requires treatment urgently to save their life, a health professional or personal care worker must arrange to transfer them to hospital for treatment.

No. *A person is able (when they have capacity) to refuse treatment, including life-sustaining treatment, even if it will result in their death. A person is also able to refuse to go to hospital if they do not want to receive treatment.*

If a person does not have capacity, a decision about transfer will depend on:

- *whether the person's preferences about hospital transfer or treatment are known (e.g. documented in an Advance Care Directive, or previously stated), or*
- *if they have a substitute decision-maker, the decision of that person.*

The law in Victoria is different. There, consent is not required to transfer a person to hospital in an emergency.

If the person without capacity has previously decided they do not want to receive treatment, their decision should be respected.

If it is not possible to obtain consent to treatment from either the person or their substitute decision-maker, the law allows treatment to be given urgently to save the person's life, prevent serious damage to health, or prevent significant pain and distress. In this case a hospital transfer may occur if it is necessary to enable the person to receive treatment (so long as they haven't previously refused being transferred to hospital).

ELDAC
End of Life Directions for Aged Care

Urgent Medical Treatment

Case Study

Maria's story

Maria is a resident of the Nampara Aged Care Home. She has almost total vision impairment as a result of macular degeneration, and a history of hypertension and breast cancer (in remission). She does not have an Advance Care Directive.

Recently Maria complained to nursing staff that she had nausea, vomiting and abdominal pain. Following medical investigations she was diagnosed with advanced pancreatic cancer. Her oncologist advised that surgery and invasive treatment would be unlikely to significantly improve her condition, and recommended palliative management to control Maria's symptoms and quality of life. On returning to Nampara she was reviewed by Dominic, her GP, and a palliative care plan was established.

A few weeks after her cancer diagnosis, Maria starts experiencing chest pain. Josef, a nurse on duty at the home, finds her in discomfort, reaching for her chest. He is concerned and asks a colleague to call an ambulance. Maria overhears this discussion and says: 'I don't want to go to hospital. I have made my peace and maybe this is my time'.

The paramedics arrive and examine Maria who repeats her request not to go to hospital. She states that she does not want treatment. The paramedics suspect she is having a non-ST-elevation myocardial infarction and is at risk of cardiac arrest. She requires urgent Percutaneous coronary intervention to treat the narrowing of her coronary arteries, and to save her life. They advise Maria that she may die if she does not receive this treatment immediately but she replies: 'I'm dying anyway, I'm ready to go, I don't want any more treatment.' While the paramedics are confident that Maria has decision-making capacity, they are also worried about her not receiving treatment.

Ultimately, the paramedics decide not to transfer Maria to hospital, and with her consent give her some aspirin and other anticoagulant pain relief to help manage the pain. Maria is transferred back to her room, but continues to experience chest pain. She is reviewed by Dominic, who prescribes further pain and symptom relief. Maria dies the following day, with her family by her side.

Points for reflection

1. Was it appropriate for Maria not to be transferred to hospital, and not to receive urgent medical treatment?
2. If Maria did not have decision-making capacity, could hospital transfer occur and medical treatment be given without her consent?
3. What steps could you take to ensure you know the preferences of the people you care for if they require urgent treatment?

1. Was it appropriate for Maria not to be transferred to hospital, and not to receive urgent medical treatment?

It is not uncommon for health professionals and personal care workers to be unsure about whether to provide urgent medical treatment when a person they care for refuses it. This uncertainty can also arise where a person refuses to be transferred to hospital.

If a person with capacity refuses to go to hospital it is lawful not to transfer them, even if the person requires medical examination and/or treatment urgently, and refusing to go may cause serious harm or death.

Similarly, **a person with capacity can refuse medical treatment, including life-sustaining treatment, even if it is clinically indicated and urgently needed (e.g. in an emergency)**. This is because the law recognises an individual's right to consent or refuse consent to medical treatment, even if it results in an adverse outcome e.g. death.

Transferring a person to hospital or treating them without their consent is considered an assault.

Maria is presumed (by law) to have capacity to make medical treatment decisions. In addition, the paramedics are confident from their examination that Maria has capacity. Therefore, it was appropriate for the paramedics to comply with Maria's lawful refusal and not transfer her to hospital, or provide medical treatment to her, even though it is an emergency situation.

Visit the **End of Life Law Toolkit** for further information on the law about:

- *Capacity and Consent to Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Capacity-and-Consent-to-Medical-Treatment)
- *Withholding and Withdrawing Life-Sustaining Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Withholding-and-Withdrawing-Life-Sustaining-Medical-Treatment)
- *Hospital transfers and Urgent Medical Treatment.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Urgent-Medical-Treatment)

It was also appropriate and good practice for the paramedics to seek Maria's consent prior to giving her aspirin and other pain relief.

2. If Maria did not have decision-making capacity, could hospital transfer occur, and medical treatment be given without her consent?

Generally it is lawful for a health professional to provide treatment without consent to a person without capacity if it is needed urgently to save the person's life, prevent serious damage to their health, or prevent significant pain and distress.

Treatment cannot be provided in an emergency if it has been refused by the person in their valid Advance Care Directive. If there is no Advance Care Directive it may still be possible to obtain consent from the person's substitute decision-maker. Indeed, the legislation in some States and Territories requires health professionals to make reasonable efforts (if practical) to seek a substitute decision-maker's consent (and/or to find out whether the person has an Advance Care Directive) before giving urgent treatment. If there is an opportunity to obtain consent and a health professional does not do so, treating the person could result in civil or criminal liability.

If Maria does not have decision-making capacity, the paramedics should find out whether she has an Advance Care Directive that contains a relevant decision about treatment and/or hospital transfer. As she does not have a Directive, the paramedics should consider whether Maria's substitute decision-maker can provide consent.

The law on obtaining a substitute decision-maker's consent in an emergency varies by State and Territory:

- If Maria were in **Western Australia, South Australia** or the **Northern Territory**, the law requires that her substitute decision-maker be contacted to make a decision, if it is practical to do so.
- In **Tasmania, Victoria, New South Wales** and the **Australian Capital Territory,** a substitute decision-makers' consent would not be required for Maria to be treated or transferred.

- In **Queensland**, Maria could be transferred or treated without a substitute decision-maker's consent if there was an imminent risk to her life or health. However, consent would be needed if the treatment was required to prevent her suffering significant pain and distress.

Though consent is not required in some States and Territories, it would still be good clinical practice in those jurisdictions to try to contact Maria's substitute decision-maker for consent, if time and circumstances permit.

If it were not possible to obtain consent from Maria's substitute decision-maker (e.g. a decision-maker could not be contacted or was not willing to make a decision), the laws in each State and Territory would enable her to be transferred and/or receive medical treatment without consent.

Learn more in the **End of Life Law Toolkit's *Urgent Medical Treatment* resources.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Urgent-Medical-Treatment)

3. What steps could you take to ensure you know the preferences of the people you care for if they require urgent treatment?

Knowing the treatment and care preferences of the people you care for can help:

- ensure their treatment preferences are followed,
- prevent unnecessary hospital admissions,
- prevent provision of treatment that they do not want, is not in their best interests, or is futile or burdensome, and
- reduce distress to the person, their family and the health professionals involved in their care.

The **ELDAC End of Life Law Toolkit** contains useful tips for health professionals, personal care workers, and aged care providers about knowing how to act in an emergency situation. These include:

- Have a conversation about Advance Care Planning with the person or their substitute decision-maker upon the person entering aged care, or receiving home care.
- Discuss what treatment the person wants or does not want if an emergency situation arises.
- Know if the people in your care have an Advance Care Directive or resuscitation plan, and what it says.
- Know who the person's substitute decision-maker is (if they do not have capacity), or would be (if they do have capacity), and how to contact them.
- Respect the person's treatment decision.
- Know what the law says about providing, withholding and withdrawing life-sustaining treatment.

Learn more in the **End of Life Law Toolkit's *Urgent Medical Treatment* factsheet.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Urgent-Medical-Treatment)

Final legal observations

The paramedics acted lawfully by respecting Maria's refusal to be transferred to hospital, and her refusal of an urgent Percutaneous coronary intervention. If Maria did not have decision-making capacity, it would be good practice to seek consent to hospital transfer and medical treatment from her substitute decision-maker, though the law on this varies by State and Territory. If it were not possible to obtain consent from Maria's substitute decision-maker, the urgent treatment laws in those jurisdictions would enable her to be transferred and/or receive medical treatment without consent.

Managing Disputes about Medical Treatment Decision-Making

End of life decision-making can be challenging for everyone involved in a person's care, and sometimes disagreements can arise. This factsheet explores what legal and other avenues are available to manage conflict that arises in aged care about medical treatment decision-making. It focuses on managing disputes between health professionals (or aged care workers) and a person (or their families).

Clarifying the law

This factsheet discusses:

- How disputes can be resolved within aged care
- If a dispute cannot be resolved, what legal avenues are available
- The role of Public Advocates and Public Guardians, tribunals and courts in medical treatment disputes

Medical treatment disputes in aged care

As a person nears the end of their life, disagreements sometimes occur about their medical treatment. In aged care, these disputes generally arise when there is **disagreement between an aged care worker (or health professional) and a person (or, if the person lacks capacity, their family or substitute decision-maker) about a medical treatment decision.**

Examples include:

- An aged care worker believes a resident's family or substitute decision-maker is making treatment decisions contrary to the resident's preferences or best interests.
- Conflict with residents or families about types and doses of medication.
- Disputes about hospital transfers, or when medical treatment should be provided.
- Disputes about provision of pain and symptom relief.
- Requests from families for treatment to be provided, even if it would be futile or non-beneficial for the person.
- Disputes between family members about who is the person's substitute decision-maker.

Learn who may be a person's substitute decision-maker in the End of Life Law Toolkit's *Substitute Decision-Making* factsheet. (https://www.eldac.com.au/tabid/4963/Default.aspx)

Managing disputes in aged care

Communication about treatment

Communication with the person and their family about future treatment and care, including the person's values and preferences, is essential. **Early, proactive communication can avoid future conflict, and ensure the person's preferences and needs are met.**

This can occur by residents, families, aged care workers and health professionals meeting early, preferably when the person enters aged care, to discuss advance care planning. The person can also choose to record their **treatment decisions and preferences in an Advance Care Directive**.

Learn about Advance Care Directives in the **End of Life Law Toolkit's *Advance Care Directives* resources.** (https://www.eldac.com.au/tabid/4968/Default.aspx)

For practical tips on how to undertake advance care planning with a person visit *Advance Care Planning Australia* (https://www.advancecareplanning.org.au/) or read *How to do Advance care planning: A quick guide for health professionals* (https://end-of-life.qut.edu.au/__data/assets/pdf_file/0016/1040209/How-to-do-Advance-Care-Planning.pdf)

It is important for aged care workers and health professionals **to involve the person, and their family (provided the person consents) or, if the person lacks capacity, their family or substitute decision-maker in all discussions about the person's care and treatment**. This is particularly important for conversations about withholding and withdrawing life-sustaining treatment or futile or non-beneficial treatment. This can help to achieve consensus about treatment, and allows any problems to be addressed as early as possible.

> *Wherever end of life conflicts occur, they need to be managed in a timely manner which focuses on the … best outcome for the patient. Delays and protracted discussions with family may defer decision-making for the patient and prolong the patient's discomfort, distress or pain in the dying phase of their illness.*
>
> Executive Summary, *NSW Health Conflict Resolution in End of Life Settings Final Working Group Report*, 2010. (https://www.health.nsw.gov.au/patients/acp/Publications/conflict-resolution.pdf)

Preventing disputes

Disputes can be avoided by aged care organisations and workers:

- **Providing information to residents and their families about palliative care and end of life decision-making**, and the role and obligations of substitute decision-makers.
- **Providing education for staff on recognising a person's deterioration** so appropriate and timely palliative and end of life care can be provided, and families or substitute decision-makers advised.
- **Obtaining the person's medication orders, prescriptions and instructions from the person's GP early** to enable timely access to and provision of end of life care and treatment.
- **Respecting the person's treatment decision**. Remember that it is lawful for a person with capacity to refuse to go to hospital or to receive life-sustaining treatment even if it will result in death.
- **Knowing what the law says about providing treatment** by reading the following End of Life Law Toolkit factsheets:
  - Capacity and Consent to Medical Treatment
  - Advance Care Directives
  - Substitute Decision-Making
  - Withholding and Withdrawing Life-Sustaining Medical Treatment
  - Legal Protection for Administering Pain and Symptom Relief
  - Futile or Non-Beneficial Treatment
  - Emergency Medical Treatment.

What to do if a dispute arises

When a dispute arises, **early resolution can prevent it from escalating. In most situations it is rare for the legal system to become involved**. Most conflict can be managed within the aged care setting by **applying your aged care organisation's complaints or disputes management policies and procedures**.

It is important to **know what those policies or procedures say** so that you can take appropriate action if a dispute arises. This includes knowing who is responsible at each point of the process, relevant timeframes for reporting and addressing complaints, and what documentation must be completed.

Most organisations will require an **aged care worker to advise their manager as soon as possible about the dispute**. In most cases a manager will determine the appropriate course of action, based on the nature of the dispute. This action may include:

- Meeting with the aged care worker to obtain information about the dispute;
- Asking an aged care worker to complete a complaint, incident or feedback form outlining the issues; and/or
- Arranging an informal meeting or case conference with the resident or their family to discuss the issues. A formal conference may be arranged for more serious disputes.

Every situation is different, so the action taken will depend on the circumstances, the severity of the issue, and the nature of the medical treatment or care.

When a dispute cannot be resolved, a manager may advise their senior manager or CEO, or seek advice from a lawyer or their State or Territory's Public Advocate or Public Guardian.

Practice tip

If you are a GP involved in a dispute, you can also seek advice from your medical insurer or medical defence organisation.

Aged Care Quality and Safety Commissioner

In some cases where there is a dispute, a complaint may be made to the *Aged Care Quality and Safety Commission*. (https://www.agedcarequality.gov.au/making-complaint/complaints-process). The Commission is responsible for dealing with complaints about Australian Government-funded aged care services. It provides a free service for anyone to raise concerns about the quality of care or services delivered. All complaints are taken seriously and they can be made openly, confidentially or anonymously.

Disputes and the legal system

If a dispute cannot be resolved within the aged care system, the guardianship or legal system may become involved.

What is the role of the Public Advocate or Public Guardian?

The Public Advocate or Public Guardian are independent statutory bodies in each State and Territory. They have **powers relating to guardianship and end of life decision-making for people who lack capacity**. Aged care services and workers, or health professionals may contact these bodies when:

- a dispute about treatment for a person who lacks capacity cannot be resolved internally;
- they disagree with a decision of a substitute decision-maker;
- there is no substitute decision-maker appointed or available; or
- there is a disagreement about who is the appropriate substitute decision-maker, or a conflict between joint substitute decision-makers.

The powers of the Public Advocates and Public Guardians vary by State and Territory, but they may be able to provide advice about dispute resolution options; mediate disputes; apply to a court or tribunal to be appointed as a substitute decision-maker (if no one else is available or appropriate); or make a treatment decision (in limited circumstances only).

Learn more about the role of the Public Advocate or Public Guardian in your State or Territory at *End of Life Law in Australia* (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws), or visit their website using the links on the End of Life Law Toolkit *Disputes about Medical Treatment Decision-Making* resources page (https://www.eldac.com.au/tabid/5285/Default.aspx).

What can be done if a dispute remains unresolved?

If a treatment dispute remains unresolved, a health professional, aged care worker or service, the person, their family or substitute decision-maker may **apply to a State or Territory tribunal or the Supreme Court** for an order.

There is no legal requirement to refer an unresolved dispute to a tribunal or court. However, it is good practice to seek legal advice about this when appropriate (e.g. from an aged care facility's lawyer), and also to tell the person's family or substitute decision-maker about this option.

How do tribunals and courts address medical treatment disputes?

State and Territory tribunals

Tribunals in each State and Territory have **powers to decide medical treatment disputes involving adults who lack capacity**. These tribunals are like courts but are designed to be quicker, cheaper and easier to use.

The **types of matters tribunals may decide and the orders they may make differ depending on State and Territory laws**. These might include deciding whether or not a person has decision-making capacity; or appointing or revoking the appointment of a substitute decision-maker e.g. a guardian. Depending on the State or Territory, tribunals may also have power to decide whether to consent or refuse consent to medical treatment, or whether life-sustaining treatment should be withheld or withdrawn.

In making decisions, tribunals must consider a range of factors outlined in State or Territory guardianship and medical treatment legislation. This generally includes the person's best interests, and what the person would have wanted for themselves.

The laws about tribunals and their powers differ across Australia. Learn about the law in your State or Territory at *End of Life Law in Australia* (https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws), or visit their website using the links on the End of Life Law Toolkit *Disputes about Medical Treatment Decision-Making* resources page (https://www.eldac.com.au/tabid/5285/Default.aspx).

The Supreme Court

The Supreme Court in each State and Territory has **broad powers to resolve disputes about medical treatment,** and to **confirm whether or not providing, withholding or withdrawing treatment would be lawful**.

Practice tip

Generally cases are bought before courts and tribunals by aged care services rather than individual health professionals or aged care workers. Before instigating court proceedings, legal advice should be sought.

When making a decision a **Supreme Court must consider the person's best interests**. There are no established criteria for determining this, but the courts will consider factors including:

- medical evidence regarding the person's diagnosis, prognosis and treatment options;
- whether the requested treatment is overly burdensome (so that the burdens of treatment outweigh any possible benefits);
- views and wishes of the person about treatment (and, to a lesser extent, views of the person's family); and
- quality of life of the person if they receive treatment (which the courts have considered particularly when the person has significant cognitive impairment).

In most cases, the courts have agreed with medical opinion about whether or not providing life-sustaining treatment was in the person's best interests. However, this is not always the case.

Key points to remember

1. Most disagreements about medical treatment can be resolved through good communication and timely dispute resolution processes within aged care settings.
2. When a dispute cannot be resolved within aged care, advice or assistance may be sought from the Public Advocate or Public Guardian.
3. State and Territory tribunals are able to hear disputes about end of life medical treatment. Their powers, the orders they may make, and how they make decisions vary depending on the guardianship and medical treatment legislation of the State or Territory.
4. The State and Territory Supreme Courts also have powers to resolve disputes about medical treatment at the end of life. When making a decision for adults who lack capacity, the Courts' paramount consideration is the person's best interests.

Mythbusters: Managing Disputes about Medical Treatment Decision-Making

Myth: When there is a medical treatment dispute with a resident or their family, a court or tribunal must be involved.

No. *The legal system rarely becomes involved in disputes relating to aged care as most conflict is able to be resolved through communication, and following internal dispute and conflict management policies and processes. If a medical treatment dispute cannot be resolved, the aged care organisation or health professional can seek legal advice, or contact their State or Territory Public Advocate or Public Guardian for information and advice.*

Managing Disputes about Medical Treatment Decision-Making

Case Study

Samir's story

Samir has Chronic Obstructive Pulmonary Disease. He requires therapeutic oxygen via a nasal cannula, and uses routine and prn inhalers to manage his condition. He can quickly become short of breath after walking short distances, and has recently had a prolonged hospital stay due to complications arising from his condition. Samir resides at the Redvale Aged Care Lodge, and has an Advance Care Directive that refuses life-saving treatment. A copy of the Advance Care Directive is filed in Redvale's records, but it is not noted elsewhere at the facility and the nursing and care staff are not aware that Samir has one. Samir has told his daughter Amali that he does not want to go to hospital if he becomes unwell again.

One afternoon Samir feels short of breath after returning from the bathroom and presses his call button. Felicity, a Registered Nurse, attends on him. She assists Samir to administer his inhaler (in accordance with his medication plan). After 5 minutes Samir tells her that his breathing has slightly improved but not fully resolved, and that he feels fatigued. Felicity assumes that this will resolve with further rest, and tells Samir that she will return to check on him shortly.

Felicity commences her rounds and becomes preoccupied assessing another resident and then attending an emergency situation. She does not mention Samir's condition to her colleagues or Nurse Manager. When Felicity returns to Samir's room an hour later she finds him experiencing breathing difficulties, feverish and unable to communicate. Felicity immediately calls an ambulance. Samir is transferred to hospital, where he is diagnosed with pneumonia and treated with IV antibiotics.

While Samir is at the hospital Christine, Redvale's Manager, calls Amali, Samir's daughter. On hearing about Samir's deterioration and transfer to hospital Amali becomes upset that Samir is receiving treatment despite his Advance Care Directive, and that she was not contacted earlier. She says her father will be distressed to be in hospital, and that she will be making a formal complaint about Samir's care.

Points for reflection

1. What steps can Christine take to manage this situation?
2. What can Christine do to prevent similar incidents at Redvale in the future?
3. What options are available to Samir and Amali if they remain unsatisfied?

1. What steps can Christine take to manage this situation?

Meeting with Samir and Amali

Early, proactive communication by Christine may be able to resolve Samir and Amali's concerns, and prevent escalation.

Christine should invite Samir and Amali to meet with her, as the manager of the staff involved, as soon as possible. Prior to meeting with them Christine should conduct an investigation, including speaking with the staff who were involved in Samir's care to ascertain the details of the incident. This is discussed further below.

The meeting (or case conference) with Samir and Amali would enable further exploration of their concerns, and discussion of improvements to better manage Samir's future care. Christine should advise them of actions she is taking to identify and address systemic issues emerging from the incident e.g. reviewing Redvale's system for managing residents' Advance Care Directives and planning documents, to make them more accessible.

Christine could also, on behalf of the staff involved, offer an apology to Samir and Amali.

Meeting with Redvale staff

All aged care providers are required to have **policies and procedures on complaints and dispute management**. These policies would require an investigation into the incident, and that Christine meet with Felicity and the Nurse Manager to determine what events took place that led to Samir's deterioration and hospitalisation. They may also need to complete a complaint or incident form.

When meeting with those staff members, Christine could explore:

- Whether Felicity is familiar with relevant **policies on managing deteriorating residents**, and require that she undertake training on this if necessary. Escalating Samir's condition to the Nurse Manager may have resulted in more frequent assessments of Samir before he significantly deteriorated. It may also have led to discussions with Samir, while he had capacity, about his Advance Care Directive and preferences around hospital transfer. Further information about recognising and responding to deterioration is available in **ELDAC's Residential Aged Care Toolkit** (https://www.eldac.com.au/Toolkits/Residential-Aged-Care/Clinical-Care/Respond-to-Deterioration) and **Primary Care Toolkit.** (https://www.eldac.com.au/Toolkits/Primary-Care/Clinical-Action/Respond-to-Deterioration)
- Why Amali was not contacted prior to Samir's hospital transfer, and involved in decision-making around transferring and treating him. When Samir was discovered by Felicity he could not communicate, indicating that he did not have capacity to make a decision about transfer to hospital or treatment. **If a person does not have capacity, it is important for aged care staff and health professionals to involve the person's family or substitute decision-maker in all discussions about the person's care and treatment, including going to hospital**.

In this case, a staff member should have contacted Amali to inform her about the situation (for example, while the ambulance was on route, or while the paramedics were attending to Samir at Redvale). Contacting Amali would likely have revealed the existence of Samir's Advance Care Directive refusing treatment, as well as his wishes not to be transferred to hospital.

Learn more about refusal of hospital transfer and treatment in the **End of Life Law Toolkit *Urgent Medical Treatment* factsheet.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Urgent-Medical-Treatment/Factsheet)

2. What can Christine do to prevent similar incidents at Redvale in the future?

Ways in which Christine could prevent similar incidents in the future include:

- **Improving recording, awareness and accessibility of residents' Advance Care Directives.** As Samir's Advance Care Directive was not sufficiently visible in Redvale's records Felicity was not aware of his treatment refusal, or his preference not to go to hospital. It is important that aged care providers have appropriate systems in place to ensure their staff:
    - are aware the person they care for has a Directive or other advance care planning documents,
    - understand the person's care and treatment preferences, and
    - can easily access those documents, particularly in urgent situations.

  A useful guide for implementing advance care planning within aged care organisations can be found at *Advance Care Planning Australia.* (https://www.advancecareplanning.org.au/__data/assets/pdf_file/0031/179293/advance-care-planning-in-aged-care-implementation-guide.pdf)

  As Samir also had a prolonged hospital stay prior to the incident it would have been good practice for the facility to revisit advance care planning and/or review his Advance Care Directive with him after his return. This would have helped ensure his treatment and care decisions and preferences were up to date, and that staff were aware of his Directive.
- **Providing information, education, training and support to staff about advance care planning, end of life decision-making, substitute decision-making, and consent in emergencies.** This would support Redvale's staff to undertake advance care planning; know what to do when situations like Samir's arise; and identify who to involve in decision-making e.g. substitute decision-makers, family members. Further information on these topics is available from the **End of Life Law Toolkit.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law)

More practical tips: Advance Care Directives and planning

It is important to remember that:

- A person can only make an Advance Care Directive if they have decision-making capacity. If they do not have capacity, generally a substitute decision-maker e.g. a family member or friend must be called upon to make a decision.
- Only the person can make an Advance Care Directive – family members, carers, health professionals, and aged care staff cannot make a Directive for the person.
- Making an Advance Care Directive is voluntary – a person may choose not to make a Directive, and cannot be required by an aged care provider to do so.
- Advance care planning discussions can occur early e.g. when a resident enters aged care, or can be undertaken with residents (and if the person consents, their family) at any time.
- It is good practice after a person experiences deterioration e.g. is hospitalised and returns to a facility, or experiences a significant change to their health, to revisit advance care planning discussions and/or review existing documents.

For more practical tips and information visit:

- *Advance Care Planning Australia* (https://www.advancecareplanning.org.au/__data/assets/pdf_file/0031/179293/advance-care-planning-in-aged-care-implementation-guide.pdf)
- the **End of Life Law Toolkit *Advance Care Directives* resources.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Advance-Care-Directives)

3. What options are available to Samir and Amali if they remain unsatisfied?

If Samir and/or Amali are unsatisfied after meeting with Christine they could consider contacting the Aged Care Quality and Safety Commission, a free service for anyone to raise concerns about the quality of care or services delivered by an aged care provider. A complaint can be made openly, confidentially or anonymously.

For further information visit the ***Aged Care Quality and Safety Commission.*** (https://www.agedcarequality.gov.au/contact-us/complaints-concerns)

If after the meeting the incident remains unresolved, Christine could advise the facility's CEO, or seek advice from Redvale's lawyer.

It is likely that the incident involving Samir could be resolved without the involvement of a court or tribunal. In most situations it is rare for the legal system to become involved and conflict can be managed within the aged care setting. Where this is not possible and the dispute relates to medical treatment decision-making or guardianship for a person without capacity, some State and Territory bodies (e.g. the Public Advocate or Public Guardian) have powers to undertake dispute resolution and/or make decisions for the person. On rare occasions tribunals and courts may become involved.

Learn more in the **End of Life Law Toolkit's *Managing Disputes about Medical Treatment Decision-Making* factsheet.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Managing-Disputes-about-Medical-Treatment-Decision-Making/Factsheet)

Final legal observations

It is possible for the incident involving Samir to be resolved in a timely manner, without further escalation, if Christine meets with Samir and Amali early and communicates openly with them about the incident. This meeting would allow Samir and Amali to discuss their concerns, and be informed about the steps Redvale will take to ensure optimal care is provided to Samir and other residents in the future.

Meeting with the staff who cared for Samir during the incident and reviewing current practice would enable Christine to promptly identify systemic issues and areas for improvement at Redvale. These include improving recording, accessibility and awareness of Advance Care Directives and planning documents, and providing education to staff about recognising deterioration, advance care planning, consent to treatment, and other aspects of end of life decision-making. Implementing these improvements would not only assist in preventing future incidents but support delivery of person-centred care that reflects residents' treatment preferences.

Overview of voluntary assisted dying

Voluntary assisted dying (VAD) is lawful in all Australian States and the Australian Capital Territory. The laws in each jurisdiction are similar but there are key differences.

Clarifying the law

This factsheet explains:

- Common features of the laws across jurisdictions, including eligibility criteria, processes to access VAD, and safeguards
- Obligations of health professionals and institutions in relation to VAD

The information in this factsheet is an overview only. For detailed information about the law on VAD in your State visit *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

What is voluntary assisted dying?

Voluntary assisted dying (VAD) is the assistance provided by a health practitioner to a person with a terminal illness, disease or medical condition to end their life. It includes:

- **self-administration**, where the person takes the VAD medication themselves, and
- **practitioner administration**, where the person is given the medication by a health practitioner.

'Voluntary' means it is the person's voluntary choice. The person must have decision-making capacity to decide to access VAD.

Is voluntary assisted dying legal in Australia?

VAD is legal in all Australian States. It is available in limited circumstances to people who meet the eligibility criteria (discussed on the next page).

VAD laws have been passed in the **Australian Capital Territory** (ACT) and will commence on 3 November 2025.

VAD is illegal in the **Northern Territory**.

Learn more about the law on VAD at *End of Life Law in Australia*. (https://www.end-of-life.qut.edu.au/assisteddying)

Providing appropriate pain and symptom relief with the intention of relieving a person's pain and suffering is not VAD.

It is lawful (and good clinical practice) to provide pain relief to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain relief in the **End of Life Law Toolkit factsheet *Legal Protection for Administering Pain and Symptom Relief.*** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief)

VAD laws in Australia

The VAD laws in each State and the ACT are similar, but there are some key differences.

Though VAD will not be available in the Australian Capital Territory until 3 November 2025, this factsheet discusses the ACT's laws as though they have commenced.

Eligibility criteria

To access VAD **the person must meet all of the eligibility criteria** in their jurisdiction. A person is eligible if they:

- **are aged 18 years or over**;
- **are an Australian citizen or permanent resident**, who has been resident in the State for at least 12 months when they first request VAD (these criteria can be met in other ways in Tasmania, Queensland and New South Wales). This is not a requirement in the ACT.

  In all States, the person must also have been **ordinarily resident in the State for at least 12 months** when they first request VAD. In the ACT, the person must have lived in the ACT for at least the previous 12 months.
- **have decision-making capacity** for VAD;
- **are acting voluntarily and without coercion**;
- have an **enduring request** for VAD (i.e. their request is ongoing); and
- have a **disease, illness or medical condition** that is:
  - **advanced and will cause death**. In all States except Tasmania it must also be **progressive** (i.e. the person experiences active deterioration),
  - **incurable** (Victoria, South Australia and Tasmania only), and **irreversible** (Tasmania only),
- **expected to or will cause death within:**
  - six months, or 12 months if a person has a neurodegenerative condition (Victoria, Western Australia, South Australia, New South Wales, and Tasmania),
  - 12 months (Queensland), or
  - no time frame (ACT); and
  - **causing suffering that cannot be relieved in a way that the person finds tolerable**. The person's suffering may be physical or non-physical e.g. psychological, existential.

A person will not be eligible for VAD based on having a disability or mental illness (or in New South Wales, dementia) alone – they must meet all of the criteria above to access VAD.

Learn more about the VAD eligibility criteria in your State at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

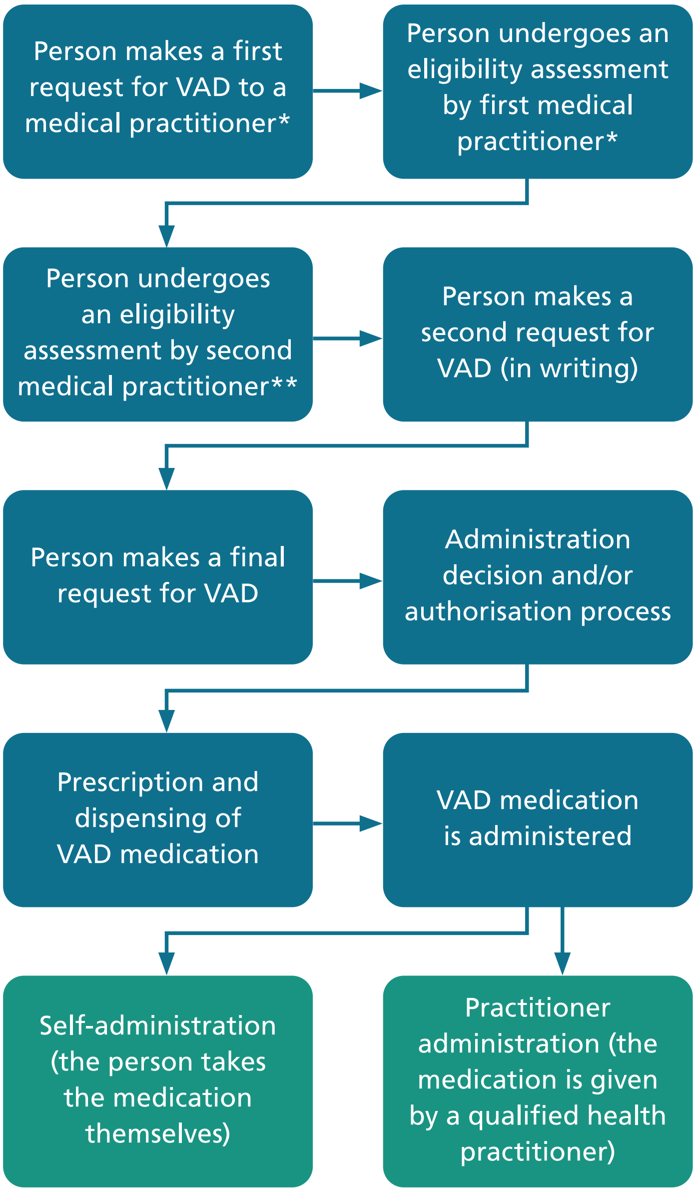
Accessing VAD

To access VAD, each State **requires a person to undergo a request and assessment process**. It generally involves a person:

- making **at least three requests** for VAD; and
- being **assessed as eligible by at least two independent practitioners**.

The person can withdraw their request for VAD at any time.

The diagram following shows the basic VAD request and administration process in each jurisdiction. Tasmania's process is similar but has additional requirements.



* *In the ACT, this person can be a medical or nurse practitioner.*

** *In the ACT, a nurse practitioner may also be a consulting practitioner so long as the first practitioner is a medical practitioner.*

The two doctors who assess VAD eligibility must both have undertaken specialised VAD training in the jurisdiction where they practise.

> The process for requesting VAD is different in each jurisdiction. Learn more about the process in your jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Administration of VAD medication

The **VAD medication can be administered by the person (self-administration), or, in some cases, a health practitioner (practitioner administration)**. The situations in which a practitioner can give the medication, and which health practitioners are permitted to do this differ in each jurisdiction.

> Learn about practitioner administration in your jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

The person may take the VAD medication at a time and place of their choosing. Other people (e.g. family and friends) may be present, if the person wishes. There is no requirement for other people to attend, but a witness must be present for practitioner administration in all jurisdictions except Tasmania.

Safeguards

Each State has safeguards to ensure that VAD is only accessed by eligible people. Some of the key safeguards in all jurisdictions are:

- **Restrictions on when health professionals can initiate a discussion or provide information** to a person about VAD.
- Requirements in some cases for **additional specialist opinions** to be obtained to determine if a person is eligible for VAD. An example is where it is unclear that a person has capacity.
- Strict protocols governing the **prescription, dispensing and disposal of VAD medications**.
- Any **unused or remaining VAD medication must be returned** (e.g. to the dispensing pharmacist).
- **Offences** for anyone who induces another person to request VAD, or take the VAD medication.
- **Oversight** by independent Boards or Commissions in all States. Their roles include monitoring, reporting, and research.

Legal rights and obligations of health professionals

Health professionals e.g. medical practitioners, registered nurses, allied health professionals, enrolled nurses and personal care workers have rights and obligations under VAD laws. These differ depending on the person's profession, the jurisdiction they work in, and whether they choose to be involved with VAD. Some key obligations are discussed here.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses, and personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

Discussing VAD and providing VAD information

There are **restrictions on when VAD can be discussed, and which health professionals can do this**. There are also **restrictions on providing information about VAD.**

Victoria and South Australia

Medical practitioners, nurses and other registered health practitioners cannot start VAD discussions with a person. All health professionals and personal care workers can provide VAD information if the person requests it.

Western Australia, Tasmania, Queensland, New South Wales, and the ACT

In these jurisdictions, all registered health practitioners and personal care workers may provide information about VAD if a person or resident requests it.

In **Western Australia**, **Tasmania, Queensland** and **New South Wales**, a medical practitioner can initiate VAD discussions, but must also provide information about treatment and palliative care options. A nurse practitioner in Western Australia and Queensland can also do this.

In **Tasmania**, all registered health practitioners other than a medical practitioner can initiate VAD discussions but must inform the person that a medical practitioner is the best person to discuss VAD with.

In **New South Wales**, all registered health practitioners other than a medical practitioner, other health professionals and personal care workers can initiate VAD discussions but must inform the person that they have palliative care and treatment options available, and should discuss these with the person's medical practitioner.

In the **ACT**, a medical practitioner or nurse practitioner can initiate VAD discussions as long as they also inform the person about their treatment and palliative care options, and their likely outcomes. Registered nurses, social workers, counsellors and other health practitioners may also raise VAD with a patient. When initiating VAD discussions, each of these health professionals must also comply with other legal requirements.

Learn more about the law on discussing VAD and providing VAD information in your jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Participating in VAD

Health professionals e.g. medical practitioners, nurses and allied health professionals working in aged and home care **can decide whether or not to participate in VAD**. Personal care workers can also choose not to be involved with VAD. However, in some jurisdictions, objecting health professionals, as well as non-participating residential facilities e.g. RACFs, nursing homes still have certain legal obligations.

Conscientious objection by health professionals

Health professionals can conscientiously object to participating in VAD. Personal care workers can also choose not to be involved with VAD. In all jurisdictions they may refuse to:

- accept a VAD request;
- participate in VAD assessment processes or administration decisions;
- prescribe, supply or administer a VAD medication; or
- be present during administration of VAD medication.

In **Victoria, South Australia, Queensland, and New South Wales**, a person with a conscientious objection can also refuse to provide information about VAD.

In Western Australia, Queensland and New South Wales, a medical practitioner who refuses to accept a first request for VAD because of a conscientious objection must let the person know immediately. In **Western Australia, Tasmania, Queensland, and the ACT**, they must also provide contact details of a service which provides VAD assistance.

The obligations of health professionals who conscientiously object to VAD differ in each jurisdiction. Learn more about the law in your jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Participation by RACFs and other institutions

Generally, institutions such as **residential facilities may decide whether to provide VAD, and what level of support they offer to residents seeking VAD**. The laws differ in each jurisdiction.

Victoria, Western Australia and Tasmania

The VAD laws do not discuss institutional participation in VAD. Institutions including residential facilities may decide what level of involvement they have.

South Australia, Queensland, New South Wales, and the ACT

Institutions may choose not to participate in VAD. However, **residential facilities who decide not to participate have certain obligations so that a resident can access VAD if they wish**.

The law on institutional obligations relating to VAD is complex. Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Residential facilities in Victoria, Western Australia and Tasmania*, and *South Australia, Queensland, New South Wales, and the Australian Capital Territory*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

Key points to remember

1. VAD is legal and operating in all Australian States. VAD laws have been passed in the Australian Capital Territory and will commence on 3 November 2025. It is currently illegal in the Northern Territory.
2. To be eligible to access VAD, a person must meet a range of criteria including:
    - they are an adult with decision-making capacity;
    - they have a disease, illness or medical condition which will cause death within 6 months (12 months in Queensland and in other States for a neurodegenerative disease). There is no time frame in the ACT; and
    - their condition is advanced, and is causing intolerable suffering. In all jurisdictions except Tasmania the condition must also be progressive.
3. To access VAD, a person must undergo a request and assessment process that includes making (at least) three separate requests for VAD, and eligibility assessments by (at least) two independent health practitioners.
4. The VAD medication will be administered either by the person (self-administration) or by a health practitioner (practitioner administration).
5. A range of safeguards apply to the VAD process, including requirements relating to oversight and reporting, and prescription, disposal and safe storage of VAD medication.
6. There are restrictions on when health professionals can discuss VAD or provide VAD information to a person, and which health professionals can do so.
7. Health professionals can conscientiously object to participating in VAD, but in some jurisdictions they will still have legal obligations to ensure patients and residents can access VAD.
8. Generally institutions e.g. RACFs and hospitals may decide whether to provide VAD, and the support they offer those wanting to access VAD. Institutions in South Australia, Queensland, New South Wales, and the ACT have specific obligations to allow people to access VAD if they wish.

For more information about VAD laws and policies in Australia visit:

- ELDAC End of Life Law Toolkit factsheets: *Voluntary assisted dying in aged care:*
  - *Roles and obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses, and personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
  - *Residential facilities in South Australia, Queensland, New South Wales, and the Australian Capital Territory*, and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
  - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

Current at August 2024

ELDAC
End of Life Directions for Aged Care

Voluntary assisted dying in aged care: Roles and obligations of medical practitioners

Voluntary assisted dying (VAD) is legal in all Australian States. VAD laws have been passed in the Australian Capital Territory and will commence on 3 November 2025. The Northern Territory does not currently have VAD laws.

Under each jurisdiction's VAD laws, medical practitioners may have specific roles, and legal rights and obligations.

This factsheet explains:

- **the roles medical practitioners may have in VAD, and**
- **medical practitioners' legal rights and obligations relating to VAD.**

This factsheet is for medical practitioners working across health settings, including in residential aged care facilities (RACFs), home care, palliative care, primary care, hospitals, and other health services. The focus, however, is on VAD in the context of aged care and home care. VAD laws are discussed as though they have commenced in all jurisdictions.

Important information about VAD laws

VAD laws in each jurisdiction are similar, but there are key differences. As a starting point, read the **End of Life Law Toolkit factsheet** *Overview of Voluntary Assisted Dying* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview) to understand:

- the eligibility criteria for a person to access VAD,
- processes to access VAD,
- administration of VAD medication, and
- VAD safeguards.

Learn more about the law on VAD in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

ELDAC is funded by the Australian Government Department of Health and Aged Care

How does VAD fit into aged care, palliative care and other end of life care?

VAD is an end of life option that a person receiving aged care services e.g. residential aged care, home care may choose provided they meet the eligibility criteria set out in their jurisdiction's VAD legislation.

Many people who choose to access VAD also receive palliative care. A person accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, and/or spiritual care up until their death.

VAD is distinct from palliative care. If a person's death unintentionally results from providing medication e.g. morphine, this is not VAD. This is because the health professional's intention was to relieve the person's pain and symptoms, not hasten death. It is always good clinical practice to provide pain relief to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit factsheet** *Legal Protection for Administering Pain and Symptom Relief*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief/Factsheet)

What roles do medical practitioners have in VAD?

Medical practitioners play important roles in the VAD process. Their roles and legal obligations depend on whether they choose to participate in VAD. However, in some jurisdictions, medical practitioners who choose not to be involved in the practice still have legal obligations (discussed further below).

Medical practitioners who are trained to provide VAD

In each jurisdiction, medical practitioners who have decided to provide VAD must meet requirements about their type of registration and years of experience. They must also undertake mandatory training provided by their jurisdiction's health department. In **South Australia**, **Tasmania and Victoria**, medical practitioners must also have expertise in the person's illness or medical condition.

The roles of participating medical practitioners may include:

Assessing a person's eligibility for VAD	This might involve visiting a person receiving home care, or a resident in a residential aged care facility (RACF) to conduct an eligibility assessment.
Prescribing VAD medication	A medical practitioner may prescribe VAD medication to a person who has been assessed as eligible.
Administering VAD medication to a person	This might involve visiting a person in an RACF or at their home to administer VAD medication.
Complying with VAD reporting requirements	A Board or Commission oversees VAD in each jurisdiction. Participating medical practitioners must submit forms to the relevant Board or Commission for each step of the process they are involved in.
Disposing of VAD medications if necessary	A medical practitioner who administers VAD medication to a person is responsible for returning any unused or remaining medication (e.g. to the dispensing pharmacist).

Medical practitioners can decide which of these roles they want to perform. For example, a medical practitioner might be willing to conduct eligibility assessments, but not administer VAD medication.

All medical practitioners

Medical practitioners can perform some roles associated with VAD even if they have not undertaken mandatory VAD training. These roles may include:

Providing information to a person about VAD	For example, a medical practitioner may be asked for information about VAD during a routine consultation with a resident.
Receiving a person's initial request for VAD	For example, a person receiving home care might make an initial request for VAD to their medical practitioner who has attended their home for routine care.
Assessing whether the person meets specific eligibility criteria for VAD	For example, a participating medical practitioner might be unsure if a resident in an RACF who has requested VAD has decision-making capacity. They might request another medical practitioner e.g. a geriatrician consult with the resident to assess the person's decision-making capacity.
Being present (if the person chooses) when the person self-administers the VAD medication	For example, a person receiving home care might self-administer the VAD medication. The person might ask their medical practitioner to be present in their home when they do this.
Arranging the person's transfer to another practitioner or institution to access VAD	This might happen where a RACF has chosen not to participate in VAD. A medical practitioner may support a resident who wishes to access VAD by arranging their transfer from the RACF to a place e.g. a hospital or health service where they can access VAD services.

Medical practitioners may also certify that the person's death has occurred following VAD.

In some jurisdictions other health care professionals can also provide or participate in VAD. Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and legal obligations of:*

- *registered nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-registered-nurses.pdf)
- *allied health professionals and enrolled nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-allied-health-professionals-and-enrolled-nurses.pdf)
- *personal care workers.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-personal-care-workers.pdf)

Conscientious objection

Some medical practitioners might not want to be involved in VAD due to their personal beliefs or values. In all jurisdictions medical practitioners have the right to conscientiously object to participating in VAD. The VAD laws allow medical practitioners to refuse to:

- accept a person's request for VAD,
- participate in the VAD assessment processes or administration decisions,
- prescribe, supply, or administer the VAD medication, and
- be present during the administration of the VAD medication.

In all jurisdictions, medical practitioners who have a conscientious objection to VAD still have legal obligations. For example, objecting medical practitioners have specific obligations if they receive a person's first request for VAD:

- In **Western Australia, Queensland and New South Wales**, a medical practitioner who refuses to accept a VAD first request because of a conscientious objection must let the person know immediately of their objection to the practice. Medical practitioners in **Victoria and South Australia** have up to seven days to let the person know, and four business days in the **ACT**. Medical practitioners in **Tasmania** have up to two days to decide whether to accept or refuse the request. If they refuse the request, they must advise the person within seven days of their refusal.
- In **Queensland, Tasmania, and the ACT**, medical practitioners who receive a first request must refer the person to a medical practitioner or service who may be able to assist with their request. There is no legal requirement to refer in **Victoria, South Australia, New South Wales and Western Australia**, but it is good medical practice for objecting medical practitioners in those States to do so.

In some jurisdictions objecting medical practitioners also have legal obligations to provide information (discussed further below).

Learn more about conscientious objection to VAD in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Good medical practice and conscientious objection

Good medical practice requires that a conscientious objection does not impede a person's right to access lawful treatments or negatively impact their dignity and right to choose.

The Medical Board Ahpra's *Good medical practice: a code of conduct for doctors in Australia* (https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx) and the Australian Medical Association's *Position Statement on Conscientious Objection* (https://www.ama.com.au/position-Statement/conscientious-objection-2019) acknowledge the right of medical practitioners to conscientiously object, but also recognise that as part of good clinical practice medical practitioners should:

- inform their patients and (if relevant) their colleagues of their objection;
- not use their objection (or personal views) to impede individuals accessing medical care and treatments that are legal; and
- refer the patient to someone who may assist them, where required by law.

The Victorian Department of Health (https://www.health.vic.gov.au/patient-care/health-practitioner-information) advises that though practitioners have no obligation to refer a person for VAD assistance, practitioners should not inhibit a person's access to treatment, and should inform the person as soon as possible that they will not assist them.

It can also be a criminal offence for medical practitioners to persuade a person to withdraw their request for VAD, or persuade a person to ask for VAD.

Communicating about VAD

A person who is considering VAD should receive appropriate information about VAD and be supported to discuss this information with a medical practitioner. However, there are restrictions on when medical practitioners can discuss VAD.

Can medical practitioners initiate discussions about VAD?

There are restrictions on when medical practitioners can initiate discussions with a person about VAD. In some jurisdictions, doing so is unprofessional conduct. These restrictions are designed to ensure a person is not pressured to request VAD.

The laws on when a medical practitioner can initiate a discussion about VAD differ between States:

- In **Victoria and South Australia**, medical practitioners cannot initiate discussions about VAD with a person.
- In **Western Australia, Tasmania, Queensland, New South Wales, and the ACT**, medical practitioners can initiate discussions about VAD. However, they can only do this if, at the same time, they discuss the person's available treatment and palliative care options, and their likely outcomes. In the **ACT**, there are also other requirements that must be met.

An overview of the law in each jurisdiction is in the table below.

Can medical practitioners provide information about VAD?

It is lawful for medical practitioners to provide information if a patient or resident requests it. In these circumstances the above restrictions do not apply.

Medical practitioners in **Western Australia, Tasmania, Queensland, New South Wales, and the ACT** who receive a first request for VAD have additional obligations to provide specific information to the person. In **Tasmania, Queensland, and the ACT** this includes providing information about where the person can seek assistance or support. An overview of the law in each jurisdiction is in the table below.

A patient or resident's family, friend or carer may ask a medical practitioner for information about VAD. Medical practitioners can provide information about VAD or direct them to other sources of information. However, family members, substitute decision-makers, carers and others cannot request VAD on behalf of the person – VAD must be the person's voluntary decision.

Learn more about what information medical practitioners must provide in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying).

Medical practitioners with a conscientious objection

VAD laws in **Victoria, South Australia and Queensland** specifically allow a medical practitioner to conscientiously object to providing information about VAD. Though the VAD laws in **Western Australia, Tasmania, New South Wales, and the ACT** do not specifically discuss this, objecting medical practitioners in those States also have the right not to provide information.

Despite this, medical practitioners might still be required to provide information in certain situations:

- In **Western Australia and Tasmania**, any medical practitioner who refuses a person's first request for VAD (whether they have a conscientious objection or not), must provide the person with specified information so the person can learn more about or access VAD.
- In **Queensland**, the law allows a medical practitioner to conscientiously object to providing information about VAD to a person. However, a medical practitioner who refuses a person's first request for VAD or refuses to be involved in other aspects of the VAD process must provide contact details of a support service or a medical practitioner who may be able to assist the person.
- In **New South Wales**, objecting medical practitioners are not required to provide information about VAD. Medical practitioners who do not have a conscientious objection but choose not to be involved must provide the person with approved information.
- In the **ACT,** medical practitioners with a conscientious objection to any part of the VAD process must give the person, in writing, the contact details of the approved care navigator service. If they refuse a first request, they may alternatively provide contact details of a health practitioner who may be able to assist the person.

An overview of the law in each jurisdiction is in the table below.

Table: Communicating about VAD – Medical practitioners

Type of communication		Vic	WA	Tas	SA	Qld	NSW	ACT
Initiating discussions about VAD	Cannot initiate discussions.	X			X			
	Can initiate discussions but must also tell the person about treatment and palliative care options and their likely outcomes.		X	X		X	X	*X
Providing information about VAD	Can provide information about VAD where the person requests it.	X	X	X	X	X	X	X
	When a person makes a first request for VAD, specified information about VAD must be provided by all medical practitioners, even those with a conscientious objection.		X	X		X		X

In the **ACT, a medical practitioner must also know or believe the person has a disease, illness or condition that is progressive, advanced and expected to cause death, and be satisfied they have the expertise to appropriately discuss treatment and palliative care options.*

Additional legal obligations when caring for people in residential facilities

Generally, residential facilities e.g. RACFs and nursing homes can decide whether to participate in VAD, and the type of support they offer to residents wanting to access VAD. Some residential facilities might choose not to provide VAD services or allow VAD processes to occur at the facility. However, in some jurisdictions, residential facilities that choose not to participate will still have some legal obligations.

Jurisdictions regulate the VAD obligations of residential facilities in different ways. In **South Australia, Queensland, New South Wales and the ACT**, the VAD laws and health department policies determine residential facilities' obligations. In **Victoria, Western Australia and Tasmania**, policies alone determine residential facilities' obligations. These laws may impact medical practitioners and other health professionals working in residential facilities, and residents who want to access VAD.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Residential facilities in*:

- *South Australia, Queensland, New South Wales, and the Australian Capital Territory.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-RACFs-SA-QLD-NSW.pdf)
- *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-Victoria-WA-TAS.pdf)

Practical tips for medical practitioners

- **Know your obligations under your jurisdiction's VAD laws and health department policies.**
  - Learn about your jurisdiction's VAD laws at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)
  - Access your jurisdiction's health department's VAD policies from the End of Life Law Toolkit Voluntary Assisted Dying Resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- **Find out whether the aged and home care services you work with are participating in VAD and familiarise yourself with their VAD policies.** Some services might have a staff member who manages and oversees all VAD enquiries.
- **Consider what role, if any, you wish to have in providing VAD.** If you have a conscientious objection to VAD, it is good clinical practice to advise the services you work with as early as possible that you do not wish to be involved with VAD.
- **If a person seeks information from you about VAD, consider what obligations you have to that person.** Depending on your jurisdiction, you may be required to provide certain information to the person or refer them to another practitioner or service, even if you have a conscientious objection.
- **If a person makes a request for VAD to you:**
  - Advise the person as soon as possible that you refuse their request if you have a conscientious objection, to limit any interruption to the person's care.

  - Consider providing the person with information about VAD or where they can seek further support e.g. from a participating medical practitioner or the jurisdiction's VAD Care Navigation Service (discussed below).
  - If you are willing and able to accept the person's request, the VAD process can start. You will need to undertake the mandatory training in your jurisdiction to provide VAD.
- **Contact the VAD Care Navigation Service in your jurisdiction for further support or to clarify your obligations.** These services provide information and support to health professionals, service providers, people considering or accessing VAD, and their families. The contact details for these services are available from your jurisdiction's health department. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)

Key points to remember

1. Medical practitioners can choose whether to participate in VAD.
2. Only medical practitioners who have undertaken mandatory training and meet requirements about type of registration, years of experience and expertise (in some jurisdictions) can provide VAD.
3. Medical practitioners can conscientiously object to participating in VAD. However, in some jurisdictions they will still have legal obligations. In all jurisdictions, medical practitioners have ethical obligations when they have a conscientious objection.
4. In all jurisdictions, there are restrictions on medical practitioners initiating discussions about VAD. In some jurisdictions, medical practitioners also have specific legal obligations to provide information about VAD.
5. Generally residential facilities may decide whether to provide VAD, and the support they offer to residents wanting to access VAD. In some jurisdictions, residential facilities that choose not to participate will still have some legal obligations which impact the medical practitioners who work there.

For more information and guidance about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
  - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
  - *Voluntary assisted dying in aged care:*
    - *Roles and obligations of registered nurses, allied health professionals and enrolled nurses,* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
    - *Residential facilities in South Australia, Queensland, New South Wales, and the Australian Capital Territory,* and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
  - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

ELDAC
End of Life Directions for Aged Care

Voluntary assisted dying in aged care: Roles and obligations of registered nurses

Voluntary assisted dying (VAD) is legal in all Australian States. VAD laws have been passed in the Australian Capital Territory and will commence on 3 November 2025. The Northern Territory does not currently have VAD laws.

Under each jurisdictions' VAD laws, registered nurses may have specific roles, and legal rights and obligations.

This factsheet explains:

- **the roles registered nurses may have in VAD, and**
- **registered nurses' legal rights and obligations relating to VAD.**

This factsheet is for all **nurse practitioners and registered nurses** working across health settings, including in residential aged care facilities (RACFs), home care, palliative care, primary care, hospitals, and other health services. The focus, however, is on VAD in the context of aged care and home care. VAD laws are discussed as though they have commenced in all jurisdictions.

In this factsheet the term **registered nurses refers to nurse practitioners and registered nurses other than enrolled nurses**. Where nurse practitioners have different roles or obligations to other registered nurses, they are specifically referred to.

VAD laws relating to enrolled nurses are different. Enrolled nurses should read the End of Life Law Toolkit factsheet *Voluntary assisted dying in aged care: Roles and obligations of allied health professionals and enrolled nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-allied-health-professionals-and-enrolled-nurses.pdf)

Important information about VAD laws

VAD laws in each jurisdiction are similar, but there are key differences. As a starting point, read the End of Life Law Toolkit factsheet *Overview of Voluntary Assisted Dying* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview) to understand the eligibility criteria a person must meet to access VAD, processes to access VAD, administration of VAD medication, and VAD safeguards.

Learn more about the law on VAD in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

ELDAC is funded by the Australian Government Department of Health and Aged Care

How does VAD fit into aged care, palliative care and other end of life care?

VAD is an end of life option that a person receiving aged care services e.g. residential aged care, home care may choose provided they meet the eligibility criteria set out in their jurisdiction's VAD legislation.

Many people who choose to access VAD also receive palliative care. A person accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, and/or spiritual care up until their death.

VAD is distinct from palliative care. If a person's death unintentionally results from providing medication e.g. morphine, this is not VAD. This is because the health professional's intention was to relieve the person's pain and symptoms, not hasten death. It is always good clinical practice to provide pain relief to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit factsheet *Legal Protection for Administering Pain and Symptom Relief*.** (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief/Factsheet)

What roles do registered nurses have in VAD?

Before a person can receive assistance to die they must be assessed as eligible and go through a formal process. Medical practitioners are the main health practitioners involved in this process. In all jurisdictions except the **ACT**, only medical practitioners can receive a person's request for VAD and assess the person's eligibility. In the **ACT**, a nurse practitioner may also assess the person's eligibility, and act as the person's coordinating or consulting practitioner.

In **Western Australia, Tasmania, Queensland, New South Wales and the ACT**, both medical practitioners and nurse practitioners may administer VAD medication. In **Queensland, Tasmania, and the ACT**, registered nurses may also administer VAD medication. Nurses who perform this role are known as an administering practitioner.

Nurse practitioners' and registered nurses' roles in VAD depend on the jurisdiction they practise in, their type of registration, and whether they choose to participate in VAD. However, in **Queensland and the ACT**, registered nurses who refuse to participate in VAD still have legal obligations (this is discussed below).

Registered nurses who are trained to provide VAD

In **Western Australia, Tasmania, Queensland, New South Wales, and the ACT**, nurse practitioners and registered nurses who have decided to participate in providing VAD must meet requirements about their type of registration and years of experience. They must also undertake mandatory training provided by their jurisdiction's health department.

The roles of participating registered nurses include:

Depending on the jurisdiction, administering VAD medication to a person who can access practitioner administration	This might involve entering a RACF and administering VAD medication to a person assessed as eligible for VAD by a medical practitioner. All registered nurses in **Tasmania, Queensland, and the ACT** may perform this role. In **Western Australia and New South Wales**, only nurse practitioners can administer VAD medication.

Before administering VAD medication, assessing whether the person has decision-making capacity, and is acting voluntarily and without coercion	Before practitioner administration of VAD medication can occur, a nurse practitioner or registered nurse who is the person's administering practitioner must conduct this assessment.
Complying with VAD reporting requirements	A Board or Commission oversees VAD in each jurisdiction. Participating nurse practitioners and registered nurses must submit forms to the relevant Board or Commission for each step of the process they are involved in.
Disposing of VAD medications if necessary	A nurse practitioner or registered nurse who administers the VAD medication to a person must return any unused or remaining medication (e.g. to the dispensing pharmacist).

In **Victoria and South Australia**, registered nurses cannot participate in the formal VAD process.

All registered nurses

Registered nurses can perform some roles associated with VAD even if they have not undertaken mandatory VAD training. These roles may include:

Providing information to a person about VAD	A registered nurse may be asked for information about VAD in a routine discussion with a resident.
Providing routine care while the person is going through the VAD process	This might include providing comfort care, or other care or treatment to a person during the VAD process e.g. on the day of a VAD assessment.
Being present (if the person chooses) at the time of self-administration or practitioner administration of VAD	This might involve: • being present and providing comfort care while a person receiving home care self-administers the VAD medication, or • providing support to a practitioner who is administering VAD medication to the person.
Witnessing a person's formal written request for VAD, or being a witness to practitioner administration of VAD	This would involve being present when the VAD medication is administered and signing forms which are sent to the relevant jurisdiction's VAD Board or Commission.
Arranging the person's transfer to another health professional or institution to access VAD	This might happen where a RACF has chosen not to participate in VAD. A registered nurse may support a resident who wishes to access VAD by arranging their transfer from the RACF to another health professional or place e.g. a hospital or health service to access VAD.

In some jurisdictions other health professionals can also provide or participate in VAD. Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and legal obligations* of:

- *medical practitioners.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-medical-practitioners.pdf)
- *allied health professionals and enrolled nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-allied-health-professionals-and-enrolled-nurses.pdf)
- *personal care workers.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-personal-care-workers.pdf)

Conscientious objection

Some nurse practitioners and registered nurses might not want to be involved in VAD due to their personal beliefs or values. In all jurisdictions, nurse practitioners and registered nurses have the right to conscientiously object to participating in VAD. The VAD laws allow them to refuse to:

- administer VAD medication to a person, and
- be present during the administration of VAD medication.

In some jurisdictions, VAD laws also recognise that registered nurses have a right to conscientiously object to providing information (discussed further below).

Learn more about conscientious objection to VAD in each State at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Good clinical practice and conscientious objection

Good clinical practice requires that a conscientious objection does not impede a person's right to access lawful treatments or negatively impact their dignity and right to choose.

The Nursing and Midwifery Board Ahpra's ***Code of conduct for nurses*** (https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx) recognises the right of nurses not to provide or directly participate in treatments to which they conscientiously object. It also recognises that as part of good clinical practice nurses should:

- respectfully inform their patients and (if relevant) their colleagues of their objection;
- ensure the patient has alternative care options; and
- not use their objection (or personal views) to impede individuals accessing medical care and treatments that are legal.

The Victorian Department of Health (https://www.health.vic.gov.au/patient-care/health-practitioner-information) advises that though nurses have no obligation to refer a person for assistance, they should not inhibit a person's access to treatment, and should inform the person as soon as possible that they will not assist them.

It can be a criminal offence for nurse practitioners and registered nurses to persuade a person to withdraw their request for VAD, or persuade a person to ask for VAD.

Communicating about VAD

A person who is considering VAD should receive appropriate information about VAD and be supported to discuss this information with a medical practitioner. However, there are restrictions on when health professionals, including nurse practitioners and registered nurses, can discuss VAD.

Can registered nurses initiate discussions about VAD?

There are restrictions on when nurse practitioners and registered nurses can initiate discussions with a person about VAD. In some jurisdictions, doing so is unprofessional conduct. These restrictions are designed to ensure a person is not pressured to request VAD.

The laws on when a registered nurse can initiate a discussion about VAD differ between jurisdictions. Also, in some jurisdictions, the laws have different rules for nurse practitioners and registered nurses:

- In **Western Australia and Queensland, only nurse practitioners** can initiate a discussion about VAD with a person. However, they can only do this if, at the same time, they discuss the person's available treatment and palliative care options, and their likely outcomes.
- In **Tasmania and New South Wales, registered nurses** can initiate a VAD discussion if they also inform the person that a medical practitioner is the most appropriate person to discuss VAD and their other treatment and palliative care options with.
- In the **ACT, nurse practitioners and registered nurses** can initiate a VAD discussion with a person, so long as they also inform the person, at the same time, about treatment and palliative care options, and their likely outcomes. There are also other legal requirements that must be met.
- In **Victoria and South Australia, registered nurses** cannot initiate a VAD discussion.

An overview of the law in each jurisdiction is in the table below.

Can registered nurses provide information about VAD?

In all jurisdictions, nurse practitioners and registered nurses can provide information if a patient or resident requests it. An overview of these laws is in the table below.

A patient or resident's family, friend or carer may ask a registered nurse for information about VAD. Registered nurses can provide information about VAD or direct them to other sources of information. However, family members, substitute decision-makers, carers, and others cannot request VAD on behalf of the person – VAD must be the person's voluntary decision.

Registered nurses with a conscientious objection

VAD laws in **Victoria, South Australia and Queensland** specifically allow a registered nurse to conscientiously object to providing information about VAD. Though the VAD laws in **Western Australia, Tasmania and New South Wales** do not specifically discuss this, objecting nurse practitioners and registered nurses in those States also have the right not to provide information.

In **Queensland, and the ACT**, registered nurses who conscientiously object to participating in VAD must provide information about where the person can seek assistance or support.

In **Queensland**, these obligations exist despite Queensland's laws allowing nurse practitioners and registered nurses to conscientiously object to providing information about VAD.

An overview of the law in each jurisdiction is in the table below.

Table: Communicating about VAD – Nurse practitioners and registered nurses

Type of communication		Vic	WA	Tas	SA	Qld	NSW	ACT
Initiating discussions about VAD	Cannot initiate discussions.	X			X			
	Can initiate discussions but must also tell the person about treatment and palliative care options and their likely outcomes.		NP			NP		*NP
	Can initiate discussions but must also tell the person that a medical practitioner is the most appropriate person to discuss VAD and their other treatment and palliative care options with.			NP RN			NP RN	RN
Providing information about VAD	Can provide information about VAD where the person requests it.	X	X	X	X	X	X	X
	Must provide the person with certain information even if they have a conscientious objection.					X		X

** X = Nurse practitioners and registered nurses; NP = Nurse practitioners; RN = Registered nurses.*

** In the **ACT**, a nurse practitioner must also know or believe the person has a disease, illness or condition that is progressive, advanced and expected to cause death, and be satisfied they have the expertise to appropriately discuss treatment and palliative care options.*

Additional legal obligations when caring for people in residential facilities

Generally, residential facilities e.g. RACFs and nursing homes can decide whether to participate in VAD, and the type of support they offer to residents wanting to access VAD. Some residential facilities might choose not to provide VAD services or allow VAD processes to occur at the facility. However, in some jurisdictions, residential facilities that choose not to participate will still have some legal obligations.

Jurisdictions regulate the VAD obligations of residential facilities in different ways. In **South Australia, Queensland, New South Wales, and the ACT**, the VAD laws and health department policies determine residential facilities' obligations. In **Victoria, Western Australia and Tasmania**, policies alone determine residential facilities' obligations. These laws may impact registered nurses and other health professionals working in residential facilities, and residents who want to access VAD.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Residential facilities in*:

- *South Australia, Queensland, New South Wales, and the ACT.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-RACFs-SA-QLD-NSW.pdf)
- *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-Victoria-WA-TAS.pdf)

Practical tips for registered nurses

- **Know your obligations under your jurisdiction's VAD laws and health department policies.**
  - Learn about your jurisdiction's VAD laws at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)
  - Access your jurisdiction's health department's VAD policies from the End of Life Law Toolkit Voluntary Assisted Dying Resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- **Find out whether the aged and home care services you work with are participating in VAD and familiarise yourself with their VAD policies.** Some RACFs or services might have a staff member who manages and oversees all VAD enquiries.
- **Consider what role, if any, you wish to have in providing VAD.** If you have a conscientious objection to VAD, it is good clinical practice to advise the facility or service you work with as early as possible that you do not wish to be involved with VAD.
- **If a person seeks information from you about VAD, consider what obligations you have to that person.** If you are in Queensland and the ACT, you may be required to provide certain information to the person or provide them with the contact details of another practitioner or service, even if you have a conscientious objection.
- **If a person makes a request for VAD you may wish to consider:**
  - Advising the person that a request for VAD must be made to a medical practitioner.
  - Providing the person with information about VAD or where they can seek further support e.g. from a participating medical practitioner or your jurisdiction's VAD Care Navigation Service (discussed below).
- **If a medical practitioner or patient asks you to be the administering practitioner advise them as soon as possible if you have a conscientious objection**, to limit any interruption to the person's care. If you are willing and able to be the administering practitioner, you will need to undertake the mandatory training in your jurisdiction.
- **Contact the VAD Care Navigation Service in your jurisdiction for further support or to clarify your obligations.** These services provide information and support to health professionals, service providers, people considering or accessing VAD, and their families. The contact details for these services are available from your jurisdiction's health department. (https://www.eldac.com.au/tabid/5756/Default.aspx)

Key points to remember

1. Registered nurses can choose whether to participate in VAD.
2. In some jurisdictions, nurse practitioners and registered nurses who have undertaken mandatory training and meet requirements about type of registration and years of experience can administer VAD medication to eligible patients.
3. Registered nurses can conscientiously object to participating in VAD. In Queensland and the ACT, objecting nurse practitioners and registered nurses still have legal obligations. In all jurisdictions, nurses have ethical obligations when they have a conscientious objection.
4. In all jurisdictions there are restrictions on registered nurses initiating discussions about VAD.
5. Registered nurses in all jurisdictions can provide information about VAD if a person requests it.
6. Generally residential facilities may decide whether to provide VAD, and the support they offer to residents wanting to access VAD. In some jurisdictions, residential facilities that choose not to participate will still have some legal obligations which impact the registered nurses who work there.

For more information and guidance about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
  - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
  - *Voluntary assisted dying in aged care:*
    - *Roles and obligations of medical practitioners, allied health professionals and enrolled nurses,* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
    - *Residential facilities in South Australia, Queensland, New South Wales, and the ACT,* and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
  - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

ELDAC
End of Life Directions for Aged Care

Voluntary assisted dying in aged care: Roles and obligations of allied health professionals and enrolled nurses

Voluntary assisted dying (VAD) is legal in all Australian States. VAD laws have been passed in the Australian Capital Territory and will commence on 3 November 2025. The Northern Territory does not currently have VAD laws.

Under the State and ACT VAD laws, allied health professionals and enrolled nurses may have specific roles, and legal rights and obligations.

This factsheet explains:

- **the roles allied health professionals and enrolled nurses may have in VAD, and**
- **allied health professionals' and enrolled nurses' legal rights and obligations relating to VAD.**

These roles and obligations differ depending on the type of health professional, whether they are a registered health practitioner or not, and the State or Territory (jurisdiction) they practise in.

This factsheet is for:

- **allied health professionals who are registered under the *Health Practitioner Regulation National Law*** e.g. psychologists, paramedics, Aboriginal and Torres Strait Islander health practitioners, physiotherapists, occupational therapists, and pharmacists ('registered allied health professionals'),
- **non-registered allied health professionals** e.g. speech pathologists, dietitians, social workers, and Aboriginal and Torres Strait Islander health workers, and
- **enrolled nurses.**

It is relevant to allied health professionals and enrolled nurses working across health settings, including in residential aged care facilities (RACFs), home care, palliative care, primary care, hospitals, and other health services. The focus however is on VAD in the context of aged care and home care. VAD laws are discussed as though they have already commenced in the ACT.

ELDAC is funded by the Australian Government Department of Health and Aged Care

Important information

VAD laws in each jurisdiction are similar, but there are key differences. As a starting point, read the **End of Life Law Toolkit factsheet** *Overview of Voluntary Assisted Dying* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview) to understand the eligibility criteria a person must meet to access VAD, processes to access VAD, administration of VAD medication, and VAD safeguards.

Learn more about the law on VAD in each State at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

How does VAD fit into aged care, palliative care and other end of life care?

VAD is an end of life option that a person receiving aged care or home care may choose, provided they meet the eligibility criteria set out in their jurisdiction's VAD legislation.

Many people who choose to access VAD also receive palliative care. A person accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, spiritual care up until their death.

VAD is distinct from palliative care. If a person's death unintentionally results from providing medication e.g. morphine, this is not VAD. This is because the health professional's intention was to relieve the person's pain and symptoms, not hasten death. It is always good clinical practice to provide pain relief to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit factsheet** *Legal Protection for Administering Pain and Symptom Relief*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief/Factsheet)

What roles do allied health professionals and enrolled nurses have in VAD?

Before a person can receive assistance to die they must be assessed as eligible and go through a formal process. Medical practitioners are the main health practitioners involved in this process. Only medical practitioners can receive a person's request for VAD and assess the person's eligibility.

In some jurisdictions medical practitioners, nurse practitioners and registered nurses may be able to administer VAD medication. To do these things, they must undertake mandatory training and meet other requirements about their registration and years of experience.

Allied health professionals' and enrolled nurses' roles in VAD depend on whether they are registered or non-registered health practitioners, the jurisdiction they practise in, and whether they choose to participate in VAD.

Allied health professionals and enrolled nurses are not required to complete any training to participate in VAD, except for **pharmacists** authorised to dispense and dispose of VAD medication.

The roles of participating allied health professionals and enrolled nurses might include:

Assessing whether a person meets specific criteria for VAD	If a medical practitioner is unsure whether a person meets one of the VAD criteria, they might ask an allied health professional to assess the person. For example: • A **psychologist** might visit a resident or a person receiving home care to assess whether the person has decision-making capacity for VAD. • A **social worker** might consult with a person to determine whether their request for VAD is voluntary and without coercion. • A **speech pathologist** might be asked to assess a person's swallowing, to help the medical practitioner decide which method of administration of the VAD medication is best for the person.
Providing information to a person about VAD	For example, an **enrolled nurse** might be asked for information about VAD while carrying out routine care.
Supporting a person prior to and during the VAD process	• **Psychologists** and **social workers** might provide counselling, suggest other supports to a person or their family, discuss the person's end of life preferences, and provide bereavement support. • A **speech pathologist** might recommend communication strategies or aids for a person so they can discuss VAD with a medical practitioner and undergo assessments. • An **Aboriginal and Torres Strait Islander health worker** might provide cultural and social support to a person considering or accessing VAD, and their family and community members.
Providing routine care to a person considering or accessing VAD	For example, a **physiotherapist** might provide exercises and other interventions to a person considering VAD, as part of routine care to manage the person's symptoms or the quality of life.
Being present (if the person chooses) when the person self-administers or is given the VAD medication	• A **speech pathologist** might be present to support the person to communicate. • An **Aboriginal and Torres Strait Islander health worker** may provide cultural and social support to the person or their family. • An **enrolled nurse** may act as a witness when VAD is administered to a person.

Pharmacists and paramedics

Pharmacists and paramedics play unique roles in relation to VAD.

In each jurisdiction, specially trained **pharmacists can possess, prepare, supply and dispense VAD medications**. In all States, there is a central government pharmacy service which prepares and dispenses the VAD medication. Pharmacists involved in dispensing VAD medication must **give specific information about the medication** to the person they are dispensing it to. A broader range of pharmacists can dispose of unused or surplus VAD medications.

Paramedics might be contacted to attend an RACF or a person's home to **provide palliative and comfort care** to a person who has taken or been administered VAD medication. They might also **provide support** to the person's family. Paramedics are legally protected if they do not give life-saving treatment to the dying person, so long as they act in good faith and the dying person has not requested treatment.

In some jurisdictions other health professionals can also provide or participate in VAD. Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and legal obligations* of:

- *medical practitioners.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-medical-practitioners.pdf)
- *registered nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-registered-nurses.pdf)
- *personal care workers.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-personal-care-workers.pdf)

Conscientious objection

Some health professionals might not want to be involved in VAD due to their personal beliefs or values. **All allied health professionals and enrolled nurses** can conscientiously object to participating in any part of the VAD process.

In **Queensland,** and the **ACT, registered allied health professionals, and enrolled nurses** who conscientiously object to participating in VAD still have some legal obligations. In Queensland, objecting speech pathologists also have some legal obligations. These are discussed further below.

In some jurisdictions, VAD laws also recognise that allied health professionals and enrolled nurses have a right to conscientiously object to providing information (also discussed further below).

Learn more about conscientious objection to VAD in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Good clinical practice and conscientious objection

Good clinical practice requires that a conscientious objection does not prevent a person accessing lawful treatments or negatively impact their dignity and right to choose. The codes of conduct governing your profession might provide important guidance on good practice in relation to VAD.

Allied health professionals

The Ahpra & National Boards *Shared Code of conduct* (https://www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx) that applies to **pharmacists, paramedics, physiotherapists, occupational therapists** and **Aboriginal and Torres Strait Islander health practitioners** recognises their right not to provide or participate in care to which they conscientiously object. It also recognises that good practice includes:

- respectfully informing their patients (where relevant), employer and relevant colleagues of their objection;
- not allowing their objection to deny residents access to healthcare; and
- ensuring the person has alternative care options.

The Victorian Department of Health (https://www.health.vic.gov.au/patient-care/health-practitioner-information) advises that although allied health professionals are not required to participate in VAD, they should not prevent a person from accessing a lawful medical treatment.

Enrolled nurses

The Nursing and Midwifery Board Ahpra's *Code of conduct for nurses* (https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx) recognises the right of enrolled nurses not to provide or directly participate in treatments to which they conscientiously object. It also recognises that as part of good clinical practice enrolled nurses should:

- respectfully inform their patients and (if relevant) their colleagues of their objection;
- ensure the patient has alternative care options; and
- not use their objection (or personal views) to prevent individuals accessing medical care and treatments that are legal.

It can be a criminal offence for allied health professionals and enrolled nurses to persuade a person to withdraw their request for VAD, or persuade a person to ask for VAD.

Communicating about VAD

A person who is considering VAD should receive appropriate information about VAD and be supported to discuss this information with a medical practitioner. However, there are restrictions on when allied health professionals and enrolled nurses can discuss VAD.

Can allied health professionals and enrolled nurses initiate discussions about VAD?

There are restrictions on when allied health professionals and enrolled nurses can initiate discussions with a person about VAD. In some jurisdictions, doing so is unprofessional conduct. These restrictions are designed to ensure a person is not pressured to request VAD.

The laws on when these health professionals can initiate a discussion about VAD differ between jurisdictions. Also, in some jurisdictions, the laws have different rules for enrolled nurses and registered and non-registered allied health professionals:

- In **Victoria and South Australia, registered allied health professionals and enrolled nurses** cannot initiate a VAD discussion. **Non-registered allied health professionals** in these States are not prohibited from initiating these discussions.
- In **Western Australia and Queensland, all allied health professionals and enrolled nurses** are prohibited from initiating VAD discussions.
- In **Tasmania, registered allied health professionals and enrolled nurses** can initiate a VAD discussion. They must however inform the person that a medical practitioner would be the most appropriate person to discuss the VAD process and care and treatment options with. **Non-registered allied health professionals** are not prohibited from initiating these discussions.
- In **New South Wales, all allied health professionals and enrolled nurses** can initiate VAD discussions. They can only do this if they inform the person that they have palliative care and treatment options available, and that they should discuss these with their medical practitioner.
- In the **ACT, registered allied health professionals, enrolled nurses, and some other health professionals and social workers prescribed by regulation** can initiate a VAD discussion with a person, so long as they also take reasonable steps to ensure the person knows that treatment and palliative care options are available, and that the person should discuss these with their treating doctor. There are also other legal requirements that must be met.

An overview of the law in each jurisdiction is in the table below.

Can allied health professionals and enrolled nurses provide information about VAD?

All allied health professionals and enrolled nurses can provide information about VAD if a person requests it. An overview of the laws in each jurisdiction is in the table below.

A person's family, friend or carer may ask an allied health professional or enrolled nurse for information about VAD. The health professional can provide information about VAD or direct them to other sources of information. However, family members, substitute decision-makers, carers and others cannot request VAD on behalf of the person – VAD must be the person's voluntary decision.

Allied health professionals and enrolled nurses with a conscientious objection

VAD laws in **Victoria, South Australia and Queensland** specifically allow **registered allied health professionals and enrolled nurses** to conscientiously object to providing information about VAD. Though the VAD laws do not specifically discuss **non-registered allied health professionals**, they also have the right not to provide information if they conscientiously object.

VAD laws in **Western Australia, Tasmania and New South Wales** do not specifically discuss conscientious objection to providing information, but **all objecting allied health professionals and enrolled nurses** have the right not to provide information.

In **Queensland, registered allied health professionals, enrolled nurses and speech pathologists** who conscientiously object to participating in VAD still have certain legal obligations. If a person seeks information or assistance about VAD from:

- a **registered allied health professional or an enrolled nurse** with a conscientious objection, they must tell the person help is available, and provide the contact details of a VAD provider or QVAD-Support (Queensland Voluntary Assisted Dying Support Service).
- a **speech pathologist** with a conscientious objection, they must:
    - tell their employer or the person about their objection,
    - give the person information about another speech pathologist or service that may be able to assist, and
    - not prevent the person from accessing speech pathology services in relation to VAD.

These obligations exist despite Queensland's laws allowing these health professionals to conscientiously object to providing information about VAD.

In the **ACT**, registered allied health professionals and non-registered persons providing health services who have a conscientious objection must, within 2 business days, provide contact details for the approved care navigator service.

An overview of the law in each jurisdiction is in the table below.

Table: Communicating about VAD – Allied health professionals and enrolled nurses

Type of communication		Vic	WA	Tas	SA	Qld	NSW	ACT
Initiating discussions about VAD	Cannot initiate discussions.	R EN	All		R EN	All		
	Can initiate discussions.	NR		NR	NR			
	Can initiate discussions if other essential information is provided to the person, including that they should discuss VAD with a medical practitioner.			R EN			All	R EN O
Providing information about VAD	Can provide information about VAD where the person requests it.	All	All	All	All	All	All	All

**All = All allied health professionals and enrolled nurses; R = Registered allied health professionals; NR = Non-registered allied health professionals; EN = Enrolled nurses; O = Other Health Professionals prescribed by regulation.*

Additional legal obligations when caring for people in residential facilities

Generally, residential facilities e.g. RACFs, nursing homes can decide whether to participate in VAD, and the type of support they offer to residents wanting to access VAD. Some residential facilities might choose not to provide VAD services or allow VAD processes to occur at the facility. However, in some jurisdictions, residential facilities that choose not to participate will still have some legal obligations.

States regulate the VAD obligations of residential facilities in different ways. In **South Australia, Queensland, New South Wales, and the ACT**, the VAD laws and State health department policies determine residential facilities' obligations. In **Victoria, Western Australia and Tasmania**, policies alone determine residential facilities' obligations. These laws may impact health professionals working in residential facilities, and residents who want to access VAD.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Residential facilities in*:

- *South Australia, Queensland, New South Wales, and the ACT.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-RACFs-SA-QLD-NSW.pdf)
- *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-Victoria-WA-TAS.pdf)

Practical tips for allied health professionals

- **Know your obligations under your jurisdiction's VAD laws and health department policies.**
  - Learn about your jurisdiction's VAD laws at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)
  - Access your jurisdiction's health department's VAD policies from the End of Life Law Toolkit Voluntary Assisted Dying Resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- **Find out whether the aged and home care services you work with are participating in VAD and familiarise yourself with their VAD policies.** Some services might have a staff member who manages and oversees all VAD enquiries.
- **Consider what role, if any, you wish to have in providing VAD.** If you have a conscientious objection to VAD, it is good clinical practice to advise the services you work with as early as possible that you do not wish to be involved with VAD.
- **If a person seeks information from you about VAD, consider what obligations you have to that person.** If you are in Queensland or the ACT, you may be required to provide certain information to the person or provide them with the contact details of another practitioner or service, even if you have a conscientious objection.
- **If a person makes a request for VAD, you may wish to consider:**
  - advising the person that a request for VAD must be made to a medical practitioner.
  - providing the person with information about VAD or where they can seek further support e.g. from a participating medical practitioner or the VAD Care Navigation Service in your jurisdiction (discussed below).
- **Contact the VAD Care Navigation Service** in your jurisdiction for further support or to clarify your obligations. These services provide information and support to health professionals, service providers, people considering or accessing VAD, and their families. The contact details for these services are available from your jurisdiction's health department. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)

Key points to remember

1. Allied health professionals and enrolled nurses can choose whether to participate in VAD.
2. Allied health professionals and enrolled nurses can conscientiously object to participating in VAD. However, in Queensland, and the ACT, registered health professionals, and enrolled nurses, and speech pathologists (Queensland only) will still have legal obligations.
3. In all jurisdictions there are restrictions on allied health professionals and enrolled nurses initiating discussions about VAD.
4. Allied health professionals and enrolled nurses in all jurisdictions can provide information about VAD if a person requests it.
5. Generally residential facilities may decide whether to provide VAD, and the support they offer to residents wanting to access VAD. In some jurisdictions, residential facilities that choose not to participate will still have some legal obligations which impact health professionals who work there.

For more information and guidance about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
    - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
    - *Voluntary assisted dying in aged care:*
        - *Roles and obligations of medical practitioners, registered nurses* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
        - *Residential facilities in South Australia, Queensland, New South Wales and the ACT* and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
    - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

ELDAC
End of Life Directions for Aged Care

Voluntary assisted dying in aged care: Roles and obligations of personal care workers

Voluntary assisted dying (VAD) is legal in all Australian States. VAD laws have been passed in the Australian Capital Territory and will commence on 3 November 2025. Northern Territory does not currently have VAD laws.

Under the States' and the ACT's VAD laws, personal care workers may have specific roles, and legal rights and obligations.

This factsheet explains:

- **the roles personal care workers may have in VAD, and**
- **personal care workers' legal rights and obligations relating to VAD.**

This factsheet is for **personal care workers who are not registered health practitioners e.g. aged care workers, disability care workers.** It is relevant to personal care workers in all health settings, including those working in residential aged care facilities (RACFs), home care, palliative care, primary care, hospitals, and other health services. The focus, however, is on VAD in aged care and home care. VAD laws are discussed as though they are currently operating in the ACT.

Important information about VAD laws

VAD laws in the States and ACT are similar, but there are key differences. As a starting point, read the End of Life Law Toolkit factsheet *Overview of Voluntary Assisted Dying* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview) to understand the eligibility criteria a person must meet to access VAD, processes to access VAD, administration of VAD medication, and VAD safeguards.

Learn more about the law on VAD in each State and the ACT at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

How does VAD fit into aged care, palliative care and other end of life care?

VAD is an end of life option that a person in a RACF or home care may choose if they meet the eligibility criteria set out in their jurisdiction's VAD law. Many people who choose to access VAD also receive palliative care. A person accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, and/or spiritual care up until their death.

VAD is different to palliative care. If a person's death unintentionally occurs after they are given medication e.g. morphine, this is not VAD. This is because the health professional intended to relieve the person's pain and symptoms, not hasten death. It is always good clinical practice to provide pain relief to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit factsheet** ***Legal Protection for Administering Pain and Symptom Relief***. (https://www.eldac.com.au/tabid/4985/Default.aspx)

What role do personal care workers have in VAD?

Before a person can receive assistance to die they must be assessed as eligible and go through a formal process. Medical practitioners are the main health practitioners involved in this process. In some States and the ACT, nurse practitioners and registered nurses might also be involved. Only medical practitioners can receive a person's request for VAD and assess the person's eligibility (a nurse practitioner in the ACT can also do this). In some States and the ACT, both medical practitioners and registered nurses may be able to administer VAD medication.

Personal care workers' roles in VAD depend on the State or Territory they work in, and whether they want to be involved with VAD. Their role might include:

Providing care and support to a person who has asked for VAD or is thinking about it	A **personal care worker** might provide routine personal care to a person seeking VAD.
Providing information about VAD	A **personal care worker** might be asked for information about VAD while providing routine care to a person.
Being present (if the person chooses) when the VAD medication is taken or given	A person might ask a **personal care worker** to be present when they take the VAD medication (this is known as self-administration).
Being a witness during the VAD process	For example: • in some States and the ACT, a **personal care worker** may be asked to witness a person signing their second request for VAD. • a **personal care worker** may be asked to be a witness to practitioner administration, which includes signing forms which are sent to a VAD Board or Commission.

In some States and the ACT, other health professionals can also provide or participate in VAD. Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and legal obligations* of:

- *medical practitioners.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-medical-practitioners.pdf)
- *registered nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-registered-nurses.pdf)
- *allied health professionals and enrolled nurses.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-allied-health-professionals-and-enrolled-nurses.pdf)

Conscientious objection

Some personal care workers might choose not to be involved with VAD because of their personal beliefs or values. If that is the case, they should advise their employer about this, and whether they are prepared to provide information about VAD, or support to a person seeking VAD.

Learn more about conscientious objection to VAD at *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)

Good clinical practice and conscientious objection

Good clinical practice requires that a conscientious objection does not prevent a person accessing lawful treatments or negatively impact their dignity and right to choose.

Codes of conduct for health care workers in **Victoria, New South Wales, Western Australia, South Australia, Queensland**, and **the ACT** require personal care workers to accept a person's right to make informed choices about their health care, and not dissuade them from seeking or continuing treatment.

It can be a criminal offence for personal care workers to persuade a person to withdraw their request for VAD or persuade a person to ask for VAD.

Communicating about VAD

A person who is considering VAD should receive appropriate information about VAD and be supported to discuss this information with a medical practitioner. However, there are restrictions on when personal care workers can discuss VAD.

Can personal care workers start discussions about VAD?

In some States, there are restrictions on when personal care workers can start a discussion about VAD with a person. These restrictions are to ensure that a person is not pressured to request VAD. These laws differ:

- In **Victoria, Tasmania and South Australia**, personal care workers can initiate discussions about VAD if they feel comfortable doing so. In **Western Australia and Queensland**, personal care workers are prohibited from initiating VAD discussions.

- In **New South Wales**, personal care workers can initiate VAD discussions. They can only do this if they inform the person that they have palliative care and treatment options and should discuss these with their medical practitioner.

An overview of the law in each State and the ACT is in the table below.

Can personal care workers provide information about VAD?

In all States and the ACT, personal care workers can provide information about VAD to a person who requests it, if they feel comfortable doing so. An overview of the law in each State and the ACT is in the table below.

A person's family, friend or carer may ask a personal care worker for information about VAD. Personal care workers can give information or direct them to other sources of information. However, family members, substitute decision-makers, carers, and others cannot request VAD on behalf of the person – VAD must be the person's voluntary decision.

Personal care workers with a conscientious objection

Personal care workers with a conscientious objection can refuse to provide information about VAD to a person.

Table: Communicating about VAD – Personal care workers

Type of communication		Vic	WA	Tas	SA	Qld	NSW	ACT
Initiating discussions about VAD	Cannot initiate discussions.		X			X		
	Can initiate discussions.	X		X	X			
	Can initiate discussions if other essential information is provided to the person, including that they should discuss VAD with a medical practitioner.						X	X
Providing information about VAD	Can provide information about VAD where the person requests it.	X	X	X	X	X	X	X

Additional legal obligations when caring for people in residential facilities

Generally, residential facilities e.g. RACFs and nursing homes can decide whether to participate in VAD, and the type of support they offer to residents wanting to access VAD. Some residential facilities might choose not to provide VAD services or allow VAD processes to occur at the facility. However, in some States and the ACT, residential facilities that choose not to participate will still have some legal obligations.

The States and the ACT regulate the VAD obligations of residential facilities in different ways. In **South Australia, Queensland, New South Wales, and the ACT**, the VAD laws and State health department policies determine residential facilities' obligations. In **Victoria, Western Australia and Tasmania**, policies alone determine residential facilities' obligations. These laws may impact personal care workers and health professionals working in residential facilities, and residents who want to access VAD.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Residential facilities:*

- *South Australia, Queensland, New South Wales, and the ACT.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-RACFs-SA-QLD-NSW.pdf)
- *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-Victoria-WA-TAS.pdf)

Practical tips for personal care workers

- **Know your obligations under VAD laws and health department policies.**
  - Learn about your State or Territories' VAD laws at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)
  - Access your health department's VAD policies from the End of Life Law Toolkit Resources. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- **Find out whether the RACFs or aged care services you work with are participating in VAD and familiarise yourself with their VAD policies.** Some RACFs or services might have a staff member who looks after all VAD enquiries.
- **Think about what involvement you want to have if a resident or patient is seeking VAD.** If you have a conscientious objection to VAD, it is good practice to advise the facility or service you work with as early as possible about whether you are prepared to provide information or support to a person seeking VAD.
- **If a person makes a request for VAD to you or seeks information about VAD, you can:**
  - Advise the person that a request for VAD must be made to a medical practitioner.
  - Give the person information about VAD or tell them where they can seek further support e.g. from a participating medical practitioner or the VAD Care Navigation Service in your State or Territory (discussed below).
- **Contact the VAD Care Navigation Service** in your State or Territory for further support or to clarify your obligations. These services provide information and support to health professionals, service providers, people considering or accessing VAD, and their families. The contact details for these services are available from your local health department. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)

Key points to remember

1. Personal care workers can choose whether to be involved with VAD.
2. In some States and the ACT there are restrictions on personal care workers initiating discussions about VAD.
3. Personal care workers in all States and the ACT can provide information about VAD if a person requests it.
4. Generally residential facilities may decide whether to provide VAD, and the support they offer to residents wanting to access VAD. In some States and the ACT, residential facilities that choose not to participate will still have some legal obligations which impact personal care workers.

For more information and guidance about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
    - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
    - *Voluntary assisted dying in aged care:*
        - *Roles and obligations of medical practitioners, registered nurses, and allied and other health professionals.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
        - *Residential facilities in South Australia, Queensland, New South Wales, and the Australian Capital Territory,* and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
    - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

ELDAC
End of Life Directions for Aged Care

Voluntary assisted dying in aged care: Residential facilities in South Australia, Queensland, New South Wales, and the Australian Capital Territory

Voluntary assisted dying (VAD) is legal in all Australian States. VAD laws have been passed in the Australian Capital Territory (ACT) and will commence on 3 November 2025. The Northern Territory does not currently have VAD laws.

Under each jurisdiction's VAD laws, residential facilities in **South Australia, Queensland, New South Wales, and the ACT** have legal obligations.

This factsheet explains:

- **residential facilities' legal obligations in relation to VAD, and**
- **practical tips to help residential facilities comply with their VAD obligations.**

This factsheet provides essential information about VAD for managers, directors, executives, and other operations staff at residential facilities in South Australia, Queensland, New South Wales, and the ACT.

VAD laws in **Victoria, Western Australia and Tasmania** do not discuss residential facilities' participation in VAD. Information for residential facilities in those States is discussed in the End of Life Law Toolkit factsheet *Voluntary assisted dying in aged care: Residential facilities in Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-Victoria-WA-TAS.pdf)

Residential facilities include:

- **residential aged care facilities (RACFs),**
- **nursing homes, hostels or other facilities providing accommodation, nursing or personal care, and**
- **retirement villages (South Australia only).**

Non-residential facilities such as public and private hospitals and hospices also have specific legal obligations in relation to VAD. These are not discussed in this factsheet. To learn more about VAD and health services visit *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

VAD laws are discussed as though they have commenced in all three States and the ACT.

ELDAC is funded by the Australian Government Department of Health and Aged Care

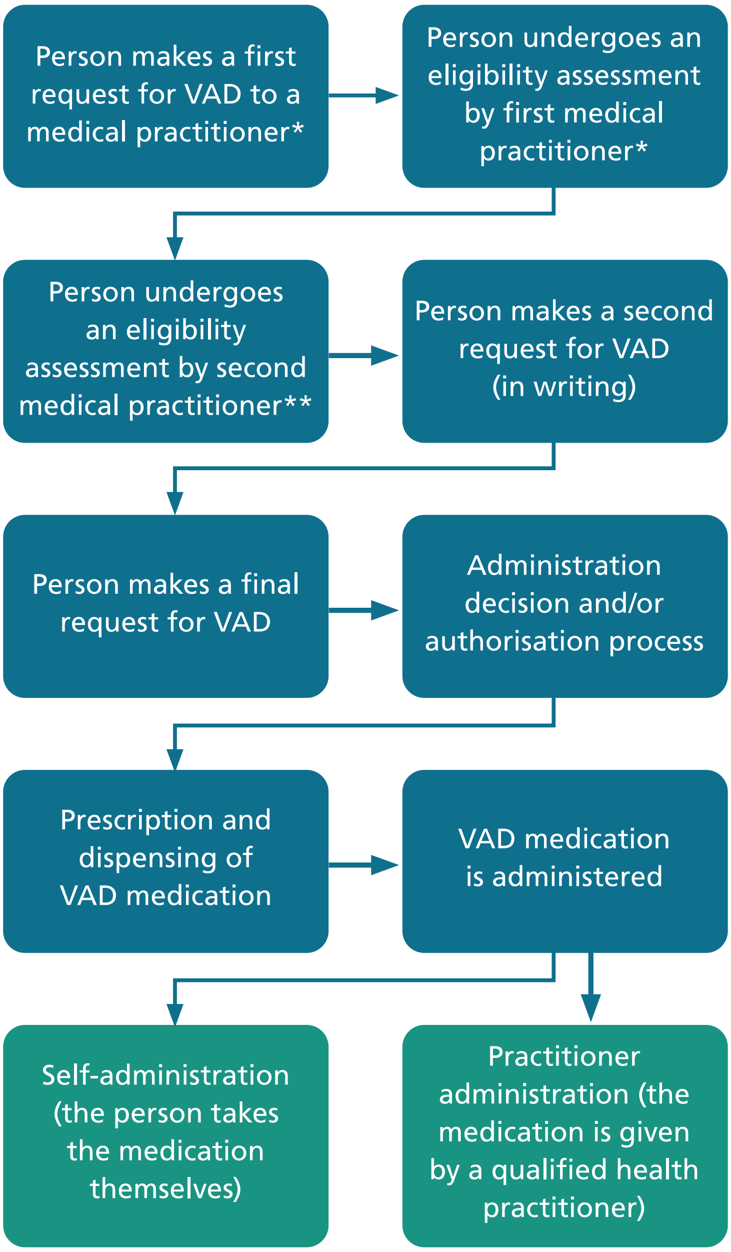
Important information about VAD laws

VAD laws in each State and the ACT are similar, but there are key differences. As a starting point, read the End of Life Law Toolkit factsheet *Overview of Voluntary Assisted Dying* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview) to understand the eligibility criteria a person must meet to access VAD, administration of VAD medication and VAD safeguards.

That factsheet also discusses the **request and assessment process before a person may take or be given the VAD medication**. It generally involves a person making at least three requests for VAD (a first request, a second request (in writing) and a final request) and being assessed as eligible by at least two independent practitioners.

The process in **South Australia, Queensland, New South Wales and the ACT** is illustrated in the diagram below. You may wish to refer to this as you read this factsheet.

VAD request and administration process



* *In the ACT, this person can be a medical or nurse practitioner.*

** *In the ACT, a nurse practitioner may also be a consulting practitioner so long as the first practitioner is a medical practitioner.*

© Overview of Voluntary Assisted Dying factsheet, End of Life Law Toolkit, ELDAC, August 2024

Learn more about VAD laws and processes in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Staff working in residential facilities and home care also have specific roles, and legal rights and obligations in relation to VAD. The following **End of Life Law Toolkit factsheets** provide essential VAD information and support for facility staff – *Voluntary assisted dying in aged care: Roles and obligations of*:

- *medical practitioners*
- *registered nurses*
- *allied health professionals and enrolled nurses,* and
- *personal care workers.*

(https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

How does VAD fit into aged care, palliative care and other end of life care?

VAD is an end of life option that a person receiving aged care services in residential facilities or home care may choose provided they meet the eligibility criteria set out in their jurisdiction's VAD legislation.

Many people who choose to access VAD also receive palliative care. A person accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, and/or spiritual care up until their death.

VAD is distinct from palliative care. If a person's death unintentionally results from providing medication e.g. morphine, this is not VAD. This is because the health professional's intention was to relieve the person's pain and symptoms, not hasten death. It is always **good clinical practice for health professionals to provide pain relief** to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit factsheet** *Legal Protection for Administering Pain and Symptom Relief*. (https://www.eldac.com.au/tabid/4985/Default.aspx)

Do residential facilities have to participate in VAD?

Residential facilities **can decide whether to provide VAD services and what support they offer to residents who are seeking VAD**. However, residential facilities that choose not to provide VAD services still have legal obligations to enable a resident to access VAD if they wish. These are discussed further below.

Residential facilities that choose not to provide VAD services should inform all residents and families of this. They must also inform the public that they do not provide VAD and publish this information e.g. on the facility's website, to enable prospective residents to make an informed choice about whether to live there. If a resident requests VAD the facility should advise the person as soon as possible that they do not provide VAD.

Supporting residents' dignity and choice

Accessing VAD is a **person's voluntary choice**. Though residential facilities are not required to provide VAD, **a facility's values and beliefs should not impede a person's right to access lawful treatments, or negatively impact a resident's dignity and right to choose**. This is an important part of delivering optimal person-centred care, respecting residents' dignity and supporting residents to exercise their end of life choices (as required by the Aged Care Quality Standards (https://www.agedcarequality.gov.au/providers/standards)).

Residential facility staff who conscientiously object to VAD also have ethical obligations. As part of good clinical practice, staff should:

- not use their objection (or personal views) to prevent residents accessing lawful medical care and treatments; and
- consider referring the resident to someone who may assist them, or ensure the person has alternative care options.

It can be a criminal offence for health professionals and personal care workers to persuade a person to withdraw their request for VAD or persuade a person to ask for VAD.

Ethical obligations of staff are discussed further in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses*, and *personal care workers*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheet)

What legal obligations do residential facilities have in relation to VAD?

Residential facilities have important legal obligations in relation to VAD. All residential facilities must allow a resident to:

- **receive information about VAD when they request it**. This includes allowing a medical practitioner to visit the facility to provide information about VAD.
- **make a first or final request for VAD at the residential facility**. This is part of the process a person must undertake to access VAD.

These obligations are detailed in Table 1.

Table 1: Residential facilities - VAD obligations to all residents

Legal obligation	All residents: Residential facilities in South Australia, Queensland, New South Wales, and the ACT
Access to information	Not hinder the resident's access to information AND Allow a registered health practitioner and other relevant persons (e.g. a care navigator from the jurisdiction's VAD Care Navigation Service) reasonable access to the facility to provide information to the resident.
First and final requests	Allow a medical practitioner (and a relevant person in the ACT) access to the facility so the resident can make a first request or final request OR If the medical practitioner (or relevant person in the ACT) cannot attend the facility, transfer the resident to another place to make a first request or final request.

Accessing VAD services

Residential facilities also have **obligations to support residents to access VAD services** i.e. undertake eligibility assessments, make a formal written VAD request and take or be given the VAD medication (administration). These obligations differ depending on the jurisdiction. In South Australia, Queensland and New South Wales, some of these obligations also depend on whether a person is a permanent or non-permanent resident. In these States, residential facilities have greater obligations towards permanent residents because a residential facility is their home.

In the ACT, facilities must allow access to all aspects of VAD (including administration of the VAD substance) to all residents, regardless of whether a person is a temporary or permanent resident in the facility.

In SA, Qld and NSW, residential facilities must:

- **for permanent residents, allow health practitioners to enter the facility to undertake eligibility assessments and administer VAD medication**, and
- **transfer non-permanent residents to and from another place where they can receive VAD services**. However, if transferring the resident would be unreasonable e.g. it would cause the person additional discomfort or worsen their condition, the facility must allow a health practitioner to provide VAD services at the facility (including administration of VAD medication).

The tables below detail the obligations residential facilities have to residents in each jurisdiction.

Table 2: VAD obligations to permanent and non-permanent residents - Second request

Second request for VAD	South Australia and New South Wales	Queensland	ACT
Allow a medical practitioner, witnesses, an interpreter or other persons participating in the person's request e.g. a nurse practitioner (ACT) to access the facility so the resident can make the request OR If those people cannot attend the facility, transfer the resident to another place to make the request.	Permanent residents only	All residents	All residents
Transfer the resident to another place to make the request OR If transfer is not reasonable, allow a medical practitioner and other people participating in the person's request access to the facility so the resident can make the request.	Non-permanent residents	N/A	N/A

Table 3: VAD obligations to permanent and non-permanent residents – Assessments, decisions and administration

	South Australia and New South Wales and Queensland		ACT
	Permanent residents	**Non-permanent residents**	**All residents**
Eligibility assessments, *administration decision	Allow a medical practitioner access to the facility for consultation OR If the medical practitioner is unavailable, transfer the resident to another place for consultation.	Transfer the resident to and from a place for consultation with a medical practitioner OR If transfer is not reasonable, allow a medical practitioner access to the facility for consultation.	Allow a **relevant person access to the facility for a consultation. If a relevant person cannot attend, transfer the resident to and from another place for consultation. If transfer is not reasonable, allow a relevant person access to the facility for consultation.
Administration of VAD medication	Allow the VAD medication to come into the facility AND Allow access to the facility by a health practitioner and a witness participating in the administration of VAD medication. In South Australia and New South Wales, a facility must also allow other people to access the facility for administration e.g. a nurse, an interpreter or speech pathologist, if required.	Transfer the resident to a place for administration of VAD medication OR If transfer is not reasonable, allow a health practitioner and a witness access to the facility for administration. In South Australia and New South Wales, a facility must also allow other people to access the facility for administration e.g. a nurse, an interpreter or speech pathologist, if required.	Allow the VAD medication to come into the facility. Allow access to the facility by a relevant person participating in administration of the VAD medication. If a relevant person cannot attend, transfer the resident to a place for administration of the VAD medication. If transfer is not reasonable, allow a relevant person access to the facility for administration.

**Administration decision:* A decision about whether the VAD medication should be taken by the person (self-administration) or given by a health practitioner (practitioner administration).

**In the ACT, a *relevant person* includes a medical practitioner, a nurse practitioner, an agent, witnesses, and an interpreter.

Roles, rights and obligations of health professionals working in residential facilities

In each jurisdiction, **medical practitioners, nurse practitioners, registered nurses, allied health professionals, enrolled nurses, and personal care workers have specific roles and legal rights and obligations in relation to VAD.**

Residential facilities should be familiar with the roles, rights and obligations of staff working for them. These are discussed in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses,* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets).

Some important considerations for residential facilities are the legal rights and obligations of staff relating to conscientious objection, initiating VAD discussions and providing VAD information.

Conscientious objection

Some staff working at residential facilities may not want to be involved in VAD due to their personal beliefs and values. Medical practitioners, nurse practitioners, registered nurses, allied health professionals, and enrolled nurses have the **right to conscientiously object to participating in VAD**. Personal care workers can also choose not to be involved with VAD. However, in some jurisdictions, objecting health professionals may still have certain legal obligations. All health professionals also have ethical obligations if they have a conscientious objection.

Residential facilities should consider how to manage conscientious objections by staff to avoid any disruption to residents' care.

Discussing VAD and providing information

There are restrictions on when staff can **initiate discussions about VAD with a person**. Only some health professionals are permitted to do this. In some jurisdictions they must also provide other information prescribed by each jurisdiction's health departments (in addition to general information about VAD) to a person when they have discussions. These laws are different in each jurisdiction.

Health professionals and personal care workers in all jursidictions can **provide information about VAD to a resident**, or to a resident's family, friend, carer, or substitute decision-maker, if requested.

Guidance for residential facilities: State and Territory health departments

The departments of health in South Australia, Queensland and New South Wales have developed policies and guidelines about VAD for residential facilities. The ACT are still developing their policies and guidelines.

Queensland

- *Private entity guidance – Voluntary assisted dying, July 2022* (https://www.health.qld.gov.au/__data/assets/pdf_file/0034/1166569/private-entity-guidance.pdf)
- *Queensland Voluntary Assisted Dying Handbook, July 2022* (https://www.health.qld.gov.au/__data/assets/pdf_file/0027/1166184/qvad-handbook.pdf)

South Australia

- Voluntary Assisted Dying in South Australia (https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/primary+and+specialised+services/voluntary+assisted+dying/voluntary+assisted+dying+in+south+australia)

New South Wales

- *NSW Voluntary Assisted Dying Private Entity Guidance, October 2023* (https://www.health.nsw.gov.au/voluntary-assisted-dying/Publications/private-entity-guidance.pdf)

Australian Capital Territory

- *ACT Health* (https://www.act.gov.au/health/topics/health-services/end-of-life-and-palliative-care/making-choices-about-the-end-of-life)

Practical tips for residential facilities

- **Know the obligations of residential facilities under your jurisdiction's VAD laws and health department policies.**
  - Learn about your jurisdiction's VAD laws at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)
  - Access your jurisdiction's health department's VAD policies from the **End of Life Law Toolkit Voluntary Assisted Dying Resources**. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- **Decide what role, if any, the residential facility will have in providing VAD**. If the facility will not provide VAD, the public must be informed. This information must be published e.g. on the residential facility's website or in brochures.
- **Develop an organisational position statement** so that all staff, residents, families, and carers understand the facility's position or policy on providing VAD.
- **Develop policies, procedures and processes to manage VAD, and to meet the residential facility's legal obligations.** Facilities should develop policies whether they provide VAD or not.

Policies, procedures and processes might address:

- managing requests for information about and access to VAD
- providing VAD services
- how VAD is integrated into existing services and systems e.g. safety and quality frameworks; clinical deterioration, limitations of treatment and goals of care; and medical treatment decision-making e.g. assessment of decision-making capacity
- referral pathways for residents to access external support and providers
- support for people who are ineligible for VAD
- access to a facility by external practitioners or VAD services
- the physical environment, including place of care
- managing and disposing of VAD medication used within a facility
- conscientious objection
- support for families of residents accessing VAD, including bereavement support.

Residential facilities should ensure policies and procedures comply with their jurisdiction's laws and policies relating to:

- health professionals and personal care workers initiating VAD discussions, providing information, receiving first requests for VAD, and conscientiously objecting
- interpreter requirements
- facilities' obligations to provide access to VAD, including obligations to permanent and non-permanent residents.

Source: Queensland Health*, Private entity guidance – Voluntary assisted dying, July 2022 (pgs. 29 – 31).*

- **Provide education and training to staff on VAD and the facility's VAD policies.** Staff members should be aware of:
    - the facility's position on VAD, and its policies and processes relating to VAD e.g. providing information, responding to requests, making referrals, and documenting VAD discussions
    - their roles and legal rights and obligations in relation to VAD
    - supports available for staff e.g. support programs, clinical supervision, peer support networks, self-care assessments, and debriefing sessions.

  Visiting health professionals should also be informed of the facility's VAD policies, if appropriate.

- **Develop a system to manage requests for information about VAD from staff, residents and families.** For example, there could be one contact person to manage all VAD-related enquiries. Information resources could be developed or provided to people who request information. Each jurisdiction's health department also has useful resources about VAD that can be given to residents and families.

- **Contact the jurisdiction's VAD Care Navigation Service for further support or to clarify residential facilities' obligations**. These services provide information and support to residential facilities, health professionals, service providers, people considering or accessing VAD, and their families. The contact details for these services are available from each jurisdiction's health department (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources).

Key points to remember

1. Residential facilities in South Australia, Queensland, New South Wales, and the ACT can choose whether to participate in VAD. Non-participating facilities still have certain legal obligations to provide access to VAD for residents.
2. All residential facilities must allow residents to receive information about VAD when they request it, and to make a first or final request for VAD at the facility.
3. Residential facilities must also support a resident to access VAD. These obligations differ depending on the jurisdiction. In South Australia, Queensland and New South Wales, they also differ depending on whether the resident is a permanent or non-permanent resident.
4. Health professionals and personal care workers have specific roles and legal rights and obligations relating to VAD that residential facilities should be familiar with.
5. All residential facilities should develop a position statement, policies and guidelines on VAD, to support and guide residents and staff at the facility.

For more information and guidance about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
  - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
  - *Voluntary assisted dying in aged care:*
    - *Roles and obligations of medical practitioners, registered nurses* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
    - *Residential facilities in Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
  - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

ELDAC
End of Life Directions for Aged Care

Voluntary assisted dying in aged care: Residential facilities in Victoria, Western Australia and Tasmania

Voluntary assisted dying (VAD) is legal in all Australian States. VAD laws have been passed in the Australian Capital Territory (ACT) and will commence on 3 November 2025. The Northern Territory does not currently have VAD laws.

Unlike other States and the ACT, VAD laws in **Victoria, Western Australia and Tasmania** do not discuss or regulate residential facilities' participation in VAD. Instead, guidance is provided by policies issued by each State's health department.

In addition, VAD laws in all jurisdictions place legal obligations on health professionals and personal care workers working at residential facilities. It is important that facilities are familiar with the VAD obligations of their staff.

VAD laws in **South Australia, Queensland, New South Wales and the ACT** impose specific obligations on residential facilities. These are discussed in the End of Life Law Toolkit factsheet *Voluntary assisted dying in aged care: Residential facilities in South Australia, Queensland, New South Wales, and the Australian Capital Territory*. (https://www.eldac.com.au/Portals/12/Documents/Factsheet/Legal/VAD-aged-care-RACFs-SA-QLD-NSW.pdf)

This factsheet provides essential information about VAD for managers, directors, executives, and other operations staff at residential facilities in Victoria, Western Australia and Tasmania. It also includes practical tips to help facilities manage VAD.

Residential facilities include:

- **residential aged care facilities (RACFs), and**
- **nursing homes, hostels or other facilities providing accommodation, nursing or personal care.**

Important information about VAD laws

VAD laws in each State and the ACT are similar, but there are key differences. As a starting point, read the End of Life Law Toolkit factsheet *Overview of Voluntary Assisted Dying* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview) to understand:

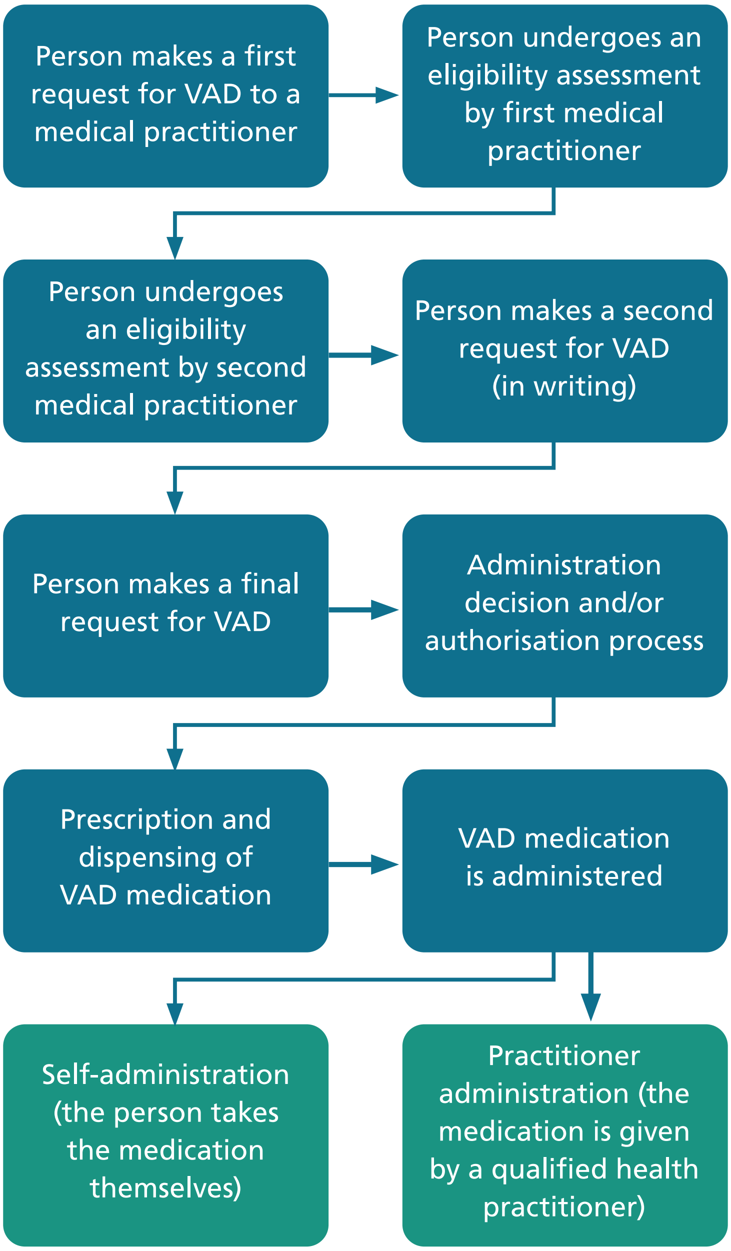
- the eligibility criteria a person must meet to access VAD
- administration of VAD medication
- VAD safeguards.

ELDAC is funded by the Australian Government Department of Health and Aged Care

That factsheet also discusses the **request and assessment process before a person may take or be given the VAD medication**. It generally involves a person making at least three requests for VAD (a first request, a second request (in writing) and a final request) and being assessed as eligible by at least two independent practitioners.

The process in **Victoria and Western Australia** is illustrated in the diagram below. You may wish to refer to this as you read this factsheet.

VAD request and administration process



© Overview of Voluntary Assisted Dying factsheet, End of Life Law Toolkit, ELDAC, October 2022

The process in **Tasmania** is similar but has additional requirements.

Learn more about VAD laws and processes in each jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

Staff working in residential facilities and home care also have specific roles, and legal rights and obligations in relation to VAD. The following **End of Life Law Toolkit factsheets** provide essential VAD information and support for facility staff – ***Voluntary assisted dying in aged care: Roles and obligations of***:

- *medical practitioners*
- *registered nurses*
- *allied health professionals and enrolled nurses,* and
- *personal care workers.*

(https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

How does VAD fit into aged care, palliative care and other end of life care?

VAD is an end of life option that a person receiving aged care services in residential facilities or home care may choose if they meet the eligibility criteria set out in their jurisdiction's VAD legislation.

Many people who choose to access VAD also receive palliative care. A person accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, and/or spiritual care up until their death.

VAD is distinct from palliative care. If a person's death unintentionally results from providing medication e.g. morphine, this is not VAD. This is because the health professional's intention was to relieve the person's pain and symptoms, not hasten death. It is always **good clinical practice for health professionals to provide pain relief** to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the **End of Life Law Toolkit factsheet** *Legal Protection for Administering Pain and Symptom Relief*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief/Factsheet)

Do residential facilities have to participate in VAD?

Residential facilities **can decide whether to provide VAD services and what support they offer to residents who are seeking VAD**. They have no obligation to provide VAD services or support.

Even if a residential facility does not provide VAD **all facility staff i.e. health professionals and personal care workers must comply with legal obligations set out in their jurisdiction's VAD laws** (these are discussed below).

Supporting residents' dignity and choice

Accessing VAD is a **person's voluntary choice**. Though residential facilities are not required to provide VAD, **a facility's values and beliefs should not impede a person's right to access lawful treatments, or negatively impact a resident's dignity and right to choose**. This is an important part of delivering optimal person-centred care, respecting residents' dignity and supporting residents to exercise their end of life choices (as required by the *Aged Care Quality Standards* (https://www.agedcarequality.gov.au/providers/standards).

Residential facility staff who conscientiously object to VAD also have ethical obligations. As part of good clinical practice, staff should:

- not use their objection (or personal views) to prevent residents accessing lawful medical care and treatments; and
- consider referring the resident to someone who may assist them, or ensure the person has alternative care options.

It can be a criminal offence for health professionals and personal care workers to persuade a person to withdraw their request for VAD or persuade a person to ask for VAD.

Ethical obligations of staff are discussed further in the **End of Life Law Toolkit factsheets** *Voluntary assisted dying in aged care: Roles and obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses*, and *personal care workers*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

Residential facilities that choose not to provide VAD services should inform all residents and families of this. This information should also be published e.g. on the facility's website, to enable prospective residents to make an informed choice about whether to live there. If a resident requests VAD the facility should advise the person as soon as possible that they do not provide VAD.

Roles, rights and obligations of health professionals working in residential facilities

In Victoria, Western Australia and Tasmania, **medical practitioners, nurse practitioners, registered nurses, allied health professionals, enrolled nurses, and personal care workers have specific roles and legal rights and obligations in relation to VAD**.

Residential facilities should be familiar with the roles, rights and obligations of staff working for them. These are discussed in the **End of Life Law Toolkit factsheets** *Voluntary assisted dying in aged care: Roles and obligations of*:

- *medical practitioners*
- *registered nurses*
- *allied health professionals and enrolled nurses,* and
- *personal care workers.*

(https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets).

Some important considerations for residential facilities are the legal rights and obligations of staff relating to conscientious objection, initiating VAD discussions and providing VAD information.

Conscientious objection

Some staff working at residential facilities may not want to be involved in VAD due to their personal beliefs and values.

Medical practitioners, nurse practitioners, registered nurses, allied health professionals, and enrolled nurses have the **right to conscientiously object to participating in VAD**. Personal care workers can also choose not to be involved with VAD. However, in some States, objecting health professionals may still have certain legal obligations. All health professionals also have ethical obligations if they have a conscientious objection.

Residential facilities should consider how to manage conscientious objections by staff to avoid any disruption to residents' care.

Discussing VAD and providing information

There are restrictions on when staff can **initiate discussions about VAD with a person**. Only some health professionals are permitted to do this. In some States they must also provide information prescribed by their State's health department (in addition to general information about VAD) to residents when they have discussions. These laws are different in each State.

Health professionals and personal care workers in all States can **provide information about VAD to a resident**, or to a resident's family, friend, carer, or substitute decision-maker, if requested.

How can residential facilities plan for and manage VAD?

State health department policies in **Victoria**, **Western Australia and Tasmania** provide useful guidance to residential facilities about managing VAD. The health departments in each State **encourage residential facilities to comply with these policies, which are consistent with good clinical practice**. Access these policies to support your facility's planning.

State health department policies for residential facilities

Victoria

The Victorian Department of Health advises residential facilities to implement one of three care pathways that aligns with their position on VAD and capacity to provide VAD. For more information visit:

- Voluntary assisted dying - Guidance for aged care providers
- Health service policy guidance for voluntary assisted dying
- Voluntary assisted dying - Health service participation
- Preparing for voluntary assisted dying
- Voluntary assisted dying - Model of care pathways for health services
- Voluntary assisted dying - Safety and quality guidance for health services

Available from: https://www.health.vic.gov.au/patient-care/health-services-information

Western Australia

The Western Australian Department of Health advises residential facilities to develop a position statement, policies and procedures to manage VAD, even if they are not providing VAD services. Western Australian health system entities are required to comply with the following policies, but organisations outside of WA Health may also use them.

- Voluntary Assisted Dying Safety and Quality Guidance for WA Health Services. (https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-Safety-and-Quality-Guidance.pdf)
- Western Australian Department of Health Managing Voluntary Assisted Dying Policy. (https://ww2.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Managing-Voluntary-Assisted-Dying-Policy/managing-voluntary-assisted-dying-policy.pdf)
- Western Australian Voluntary Assisted Dying Guidelines. (https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-guidelines.pdf)

Tasmania

The Department of Health (Tasmania) has developed the following policy to guide residential facilities' planning for VAD.

- Voluntary Assisted Dying in Tasmania: Planning for Voluntary Assisted Dying a. Health Service Establishments b. Residential Aged Care Facilities. (https://www.health.tas.gov.au/publications/minimum-requirements-health-service-establishments-facts-sheet)

These policies recommend key actions for residential services to manage VAD, including:

1. **Develop a clear organisational position statement** so that all existing and new staff, residents, families, and carers understand the facility's position on providing VAD.
2. **Develop policies, procedures and processes to manage VAD**. Residential facilities should develop policies whether they provide VAD or not.

Policies, procedures and processes might address:

- managing requests for information about and access to VAD
- providing VAD services
- how VAD is integrated into existing services and systems e.g. safety and quality frameworks; clinical deterioration, limitations of treatment and goals of care; and medical treatment decision-making e.g. assessment of decision-making capacity
- referral pathways for residents to access external support and providers
- support for people who are ineligible for VAD
- access to a facility by external practitioners or VAD services
- the physical environment, including place of care
- managing and disposing of VAD medication within the facility
- conscientious objection
- support for families of residents accessing VAD, including bereavement support.

Residential facilities should ensure policies and procedures comply with State laws and policies relating to:

- health professionals and personal care workers initiating VAD discussions, providing information, receiving first requests for VAD, and conscientiously objecting
- interpreter requirements
- facilities' obligations to provide access to VAD, including obligations to permanent and non-permanent residents.

Source: Queensland Health, *Private entity guidance – Voluntary assisted dying July, 2022 (pgs. 29 – 31).*

3. **Provide education and training to staff on VAD and the facility's VAD policies**. Staff members should be aware of:
    - the facility's position on VAD, and its policies and processes relating to VAD e.g. providing information, responding to requests, making referrals, and documenting VAD discussions
    - their roles and legal rights and obligations in relation to VAD
    - supports available for staff e.g. support programs, clinical supervision, peer support networks, self-care assessments, and debriefing sessions.

    Visiting health professionals should also be informed of the facility's VAD policies, if appropriate.

4. **Develop a system to manage requests for information about VAD from staff, residents and families**. For example, there could be one contact person to manage all VAD-related enquiries. Information resources could be developed or provided to people who request information. Each State's health department also has useful resources about VAD that can be given to residents and families.

VAD Care Navigation Services

In each State, these services can provide information and support to residential facilities, health professionals, service providers, people considering or accessing VAD, and their families. The contact details for these services are available from each State health department. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)

Key points to remember

1. Residential facilities in Victoria, Western Australia and Tasmania can choose whether to participate in VAD.
2. Health professionals and personal care workers in residential facilities have specific roles and legal rights and obligations relating to VAD that residential facilities should be familiar with.
3. All residential facilities should develop a position statement, policies and guidelines on VAD, to support and guide residents and facility staff.

For more information and guidance about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
  - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
  - *Voluntary assisted dying in aged care:*
    - *Roles and obligations of medical practitioners, registered nurses* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
    - *Residential facilities in South Australia, Queensland, New South Wales and the ACT* and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
  - *Frequently asked questions about voluntary assisted dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/FAQs)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)

ELDAC
End of Life Directions for Aged Care

Frequently asked questions about voluntary assisted dying

Note: This factsheet is for all health professionals working in aged and home care, aged care providers, and all aged care recipients, including people receiving home care. However, for ease the term ***resident*** *is used.*

Though VAD will not be available in the Australian Capital Territory (the ACT) until 3 November 2025, this factsheet discusses the ACT's laws as though they have commenced.

What is voluntary assisted dying?

Voluntary assisted dying (VAD) is the assistance provided by a health practitioner to a person with a terminal disease, illness or medical condition who wishes to end their life. It includes:

- self-administration, where the person takes the VAD medication themselves, and
- practitioner administration, where the person is administered the medication by a health practitioner.

Is VAD legal everywhere in Australia?

Yes. VAD is legal and operating in all Australian States. VAD laws have been passed in the **ACT** and will commence on 3 November 2025. VAD is illegal in the **Northern Territory**.

Is the law the same everywhere in Australia?

VAD laws in the States and the ACT are similar, but there are key differences.

For an overview of Australian VAD laws read the **End of Life Law Toolkit factsheet** ***Overview of Voluntary Assisted Dying***. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)

Learn more about the law on VAD in each jurisdiction at ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/assisteddying)

Can any resident with a terminal illness receive VAD?

No. A person can only access VAD if they are eligible. Each jurisdiction has its own eligibility criteria for VAD. In all jurisdictions, the person must:

- be an adult,
- have decision-making capacity,

- have a disease, illness or medical condition that is expected to cause death within a specified time period (except in the **ACT** where there is no timeframe until death), and
- have a condition that is advanced and causing intolerable suffering.

Learn more about eligibility criteria for VAD in your jurisdiction at *End of Life Law in Australia*. (https://end-of-life.qut.edu.au/assisteddying)

How close to death must the resident be to apply for VAD?

VAD is only available for people who are close to death. In most States, their condition must be expected to cause death within **six months, or 12 months if the person has a neurodegenerative disease** (such as motor neurone disease). In **Queensland**, a person must be expected to die within 12 months to be eligible. In the **ACT**, there is no time frame.

Can a resident with dementia access VAD?

A person will not be able to access VAD for dementia. This is because a person must have decision-making capacity to request VAD. In the States, a person with a neurodegenerative condition is not eligible for VAD unless their death is expected to occur within 12 months of the request. A person whose dementia is so advanced that they are within 12 months of death will not have decision-making capacity. In the **ACT**, the person's condition must be advanced, meaning they are approaching the end of their life. A person with advanced dementia is unlikely to have capacity to choose VAD.

A person who is in the early stages of dementia and also has a terminal illness (e.g. cancer) may be eligible for VAD if they have decision-making capacity and meet the other eligibility criteria.

Is VAD the same as providing pain and symptom relief?

No. VAD is different from providing pain and symptom relief, and palliative care. It is not VAD where a resident dies after receiving medication to relieve their pain e.g. morphine. This is because the health practitioner was intending to relieve pain, not hasten the person's death. It is always good clinical practice to provide pain relief to manage a person's pain and symptoms at the end of life.

Learn more about the law on providing pain and symptom relief in the End of Life Law Toolkit factsheet *Legal Protection for Administering Pain and Symptom Relief*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Legal-Protection-for-Administering-Pain-and-Symptom-Relief/Factsheet)

Can a resident who asks for VAD also receive palliative care and other treatment?

Yes. Many people who request VAD also receive palliative care. A resident accessing VAD will continue to receive palliative care and medical treatment, and access end of life care services e.g. specialist palliative care, social work, spiritual care up until their death.

Can a resident request VAD in an Advance Care Directive?

No. A person cannot request VAD in an Advance Care Directive or other advance care planning documents. This is because VAD cannot be requested after a person has lost capacity.

Can a resident's family, carer or substitute decision-maker request VAD for them?

No. A request for VAD must be made by the resident. It cannot be requested by another person e.g. a family member, carer or substitute decision-maker on their behalf. This is to ensure that a decision to access VAD is voluntary i.e. it is the resident's own choice, made of their own free will. There can be no pressure from another person to access VAD.

Can a resident change their mind after they ask for VAD?

Yes. A person who has requested VAD and started the process can change their mind at any time. They do not have to continue the VAD process. If a person has been prescribed or dispensed the VAD medication, they can choose not to take it.

Do health professionals and personal care workers have to participate in VAD?

No. Medical practitioners, nurse practitioners, registered nurses, allied health professionals, and enrolled nurses have the right to conscientiously object to participating in VAD. Personal care workers can also choose not to be involved with VAD. However, in some jurisdictions, objecting health professionals may still have certain legal obligations, such as to provide information to a person requesting VAD.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Roles and legal obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses* and *personal care workers*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

Do residential facilities have to provide VAD?

Residential facilities e.g. RACFs and nursing homes can decide whether to provide some, all or no VAD services to residents who are seeking VAD. However, in **South Australia, Queensland, New South Wales, and the ACT**, residential facilities who choose not to provide VAD services still have legal obligations to enable a resident to access VAD if they wish.

Learn more in the End of Life Law Toolkit factsheets *Voluntary assisted dying in aged care: Residential facilities in Victoria, Western Australia and Tasmania* and *South Australia, Queensland, New South Wales, and the Australian Capital Territory*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets).

Can health professionals discuss VAD with a resident, or give them information about VAD?

There are restrictions on when health care professionals can initiate discussions about VAD with a person. Only some health professionals can do this, and in some jurisdictions they must provide information set out by their jurisdiction's health department (in addition to general information about VAD) when they have discussions. These laws are different in each jurisdiction.

Health professionals and personal care workers in all jurisdictions can provide information about VAD to a resident, or to a resident's family, friend, carer, or substitute decision-maker, where requested.

Learn more in the **End of Life Law Toolkit factsheets** *Voluntary assisted dying in aged care: Roles and legal obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses*, and *personal care workers*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

Who can assess a resident's eligibility for VAD?

In all jurisdictions, medical practitioners can assess a person's eligibility for VAD. In the **ACT**, nurse practitioners may also do this. To assess a person's eligibility, practitioners must undertake mandatory training provided by their jurisdiction's health department and meet requirements about their registration and years of experience.

Who can provide VAD medication to a resident assessed as eligible for VAD?

Medical practitioners, nurse practitioners (in Western Australia, New South Wales, Queensland, Tasmania, and the ACT), and registered nurses (in Queensland, Tasmania, and the ACT only) may administer VAD medication to an eligible person. This is known as practitioner administration. To do this, medical practitioners and nurses must undertake mandatory training and meet other requirements about their registration and years of experience.

Contact your jurisdiction's health department to find out more about the training and requirements for your profession. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources) If you want to provide VAD, you should speak to the manager of your residential facility or aged care service to let them know this, and to find out the facility's or service's position on VAD.

Where can a resident have the VAD medication?

The answer to this will be different for each person. It depends on where they live (e.g. at home or in a residential facility) and in which jurisdiction, and how they will have the VAD medication.

A person receiving home care can choose to have the medication at home if circumstances permit. In some jurisdictions, a resident may be unable to take the VAD medication at their residential facility, if the facility chooses not to provide VAD. Also, if a person needs a practitioner to administer the VAD medication to them, this might have to take place in a particular location e.g. a hospital.

Learn more in the **End of Life Law Toolkit factsheets** *Voluntary assisted dying in aged care: Residential facilities in Victoria, Western Australia and Tasmania*, and *South Australia, Queensland, New South Wales, and the Australian Capital Territory*. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)

For more information about VAD visit:

- ELDAC End of Life Law Toolkit factsheets:
    - *Overview of Voluntary Assisted Dying.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview)
    - *Voluntary assisted dying in aged care:*
        - *Roles and obligations of medical practitioners, registered nurses, allied health professionals and enrolled nurses,* and *personal care workers.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
        - *Residential aged care facilities in South Australia, Queensland, New South Wales, and the Australian Capital Territory*, and *Victoria, Western Australia and Tasmania.* (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Factsheets)
- *End of Life Law in Australia.* (https://end-of-life.qut.edu.au/assisteddying)
- State and Territory health departments. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)
- End of Life Law for Clinicians online Module 11: Voluntary assisted dying. (https://ellc.edu.au)
- The **aged and home care services** you work with might have resources, policies and training on VAD.
- Contact the **VAD Care Navigation Service** in your jurisdiction. Contact details are available from your jurisdiction's health department. (https://www.eldac.com.au/Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Resources)