

Frequently Asked Questions

Q. I have dementia. Can I still make my own medical treatment decisions?

A. You can still make your own decisions while you have the ability (capacity) to communicate and make your decisions. If your dementia is in the early stages, you may still be able to make all your healthcare decisions. As your dementia progresses, you may be able to make some decisions, but maybe not more complex decisions. Gradually, you may lose the ability to make any decisions. Because dementia is known to affect a person's thinking ability, this is a condition where it is possible to do Advance Care Planning before the ability to think is too greatly affected.

Q. I don't have anyone on the list of who can be a Medical Treatment Decision Maker. Can I appoint a friend?

A. Yes, you can.

Q. What if I won't have a Medical Treatment Decision Maker?

A. Less serious decisions will be made by your Health Practitioner. For more serious decisions, consent or refusal of treatment will need to be given by the Office of the Public Advocate (Victoria). This excludes emergency decisions where consent is not required.

If you won't have a Medical Treatment Decision Maker, it is particularly important to consider writing down things that are important for you in an Advance Care Directive – this will be your voice if there is ever a time you cannot directly participate in decision-making.

Q. My father wants to appoint me as his Medical Treatment Decision Maker, but I don't want this role. We have very different values and beliefs, and I would find it difficult to follow what I know he would want. Do I have to accept the role of Medical Treatment Decision Maker?

A. You don't have to accept an appointment as a Medical Treatment Decision Maker if you don't want this role. It can be very difficult to make decisions for someone who has different values and beliefs to yourself. Some people can manage this, but it is difficult. This is why it is important for the person making the appointment to think carefully about whom to appoint. The most suitable person may not be the person who has the closest family relationship.

Q. Can I write my preferences for medical treatment in my Will?

A. No, a Will only has an effect after a person dies. It may not be looked at until some weeks after a person dies, which would be too late if there was information there about your medical treatment preferences.

Q. Is an Advance Care Directive or an Appointment of a Medical Decision Maker completed in another Australian state, recognised in Victoria?

A. All Australian states and territories have different legislation for Advance Care Planning.

- An Advance Care Directive completed in another state or territory will be recognised as a Values Directive.
- A properly completed appointment of a Medical Treatment Decision Maker (sometimes called Substitute Decision Maker) in another state or territory will be recognised as a Medical Treatment Decision Maker in Victoria.

Q. Can someone write an Advance Care Plan for someone who has already lost the ability (capacity) to do their own Advance Care Planning?

A. Only a person with capacity can appoint someone as a Medical Treatment Decision Maker or complete a Victorian Advance Care Directive.

Advance Care Directives are intended to be completed by a person for themselves. Even if a person lacks the capacity to complete an Instructional Directive, they may be quite able to communicate what is important to them using a Values Directive.

In practice, there are documents called Advance Care Plans that are completed on behalf of a person lacking the capacity to do so. The person completing them should be trying to write down what they already know about the person's preferences and values. At Northern Health, our preference would be to use the Victorian Form, ['What I understand to be the person's preferences and values'](#).

Q. What does it mean to have capacity?

A. Having the capacity to make decisions is a necessary part of making your own decisions. Capacity means that you have the ability to make a decision. Making a decision that others think is unwise does not mean that you lack capacity.

The law assumes adults have capacity unless proven otherwise. Capacity is specific to a decision. For example, you may be able to make simple decisions about your healthcare, but if you need a big operation, you might not be able to understand this.

To have Capacity, you must:

- Understand the information relevant to the decision and the effect of the decision;
- Retain that information to the extent necessary to make the decision;
- Use or weigh that information as part of the process of making the decision;
- Communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

Information must be provided in a way that optimises a person's ability to understand. e.g. use of an interpreter, use of diagrams, optimal timing when the person is not sleepy after medication.

A person may be able to make their own decision if given appropriate support. Even if a person cannot make their own decision, they should still be included in the decision-making as much as they are able or wish to be involved.

Q. I know what I want for my future healthcare, but I can't physically write or type into the form or even sign it. How can I plan?

A. There is a Victorian form called '[Advance Care Directive for Adults for someone signing on your behalf](#)'. The person the form is about must have the capacity (ability) to make their own decisions. However, if they can't physically sign the form, someone else can complete the form and sign it as directed by the person.

Q. What is a Goals of Care form? Is this different from an Advance Care Directive?

A. Goals of Care can have several meanings. It may be about what the person's own goals are for health and medical treatment.

In hospital, Residential Aged Care Facilities or the community, there is a Goals of Care form used, which is a quickly accessible summary of the medical treatment plan, including any limitations to how far the treatment should be escalated.

It brings together what is possible for the person's illness and what they would consent to or refuse out of what might be medically possible.

It is common to have Goals of Care discussions following admission to the hospital or RACF. Although some people might find this difficult, it is important that we don't provide treatment that the person would not want to receive or could not benefit them. Thinking about this by doing Advance Care Planning before becoming ill can help when important decisions need to be made.