

Submission

on the

Acts Amendment (Consent to Medical Treatment) Bill 2006

to the

Legislation Committee

Legislative Council
Parliament of Western Australia
Perth WA 6000

By

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I write as a medical practitioner in my 40th year of general practice and with special interests in end-of-life care and depression. I am also the founder of *Medicine With Morality*, an organisation of medical practitioners concerned with medical ethics, but this submission has not yet had the opportunity of being endorsed by members and is submitted on my own behalf. I have also been the representative on the *Coalition for the Defence of Human Life* (CDHL) for the *Christian Democratic Party* and I am aware of the submission made to the Legislation Committee by the CDHL.

I acknowledge that I cannot make recommendations opposing bill policy. Implementation of my recommendations would I submit have the following benefits

1. To make the bill more workable and valuable for caring doctors in both obtaining declarations and their implementation
2. To increase the uptake of declarations.

The difficulties with advance care directives have been clearly defined by others and are recognised by any medical practitioner concerned with primary care. These relate to

1. The impossibility of true informed consent in planning treatment recommendations for unknown circumstances
2. The problems for doctors in obtaining such informed consent and in certification that the consent was truly informed
3. The difficulty for treating doctors in interpretation when instructions have been too specific or not specific enough and where there is disagreement over that interpretation, either between doctors or between doctor and relative or agent
4. The legal implications for the doctor in these instances particularly when treatment options for significantly enhancing quality of life or preservation of life are available and also when a request is made for treatment to be withheld in the context of the patient not actually dying
5. Changing social and medical circumstances for the patient
6. Decisions made in the context of depressive illness
7. Changing patient views as perspective on sanctity of life changes
8. Changing medical practice with improving outcomes that can alter treatment decisions.

The effect of the bill in encouraging discussion with patients of end-of-life issues is to be applauded. Such *advance care planning* is already part of good end-of-life care and palliative care. It enhances real communication in the doctor-patient relationship and between patient and loved ones and carers. It enhances both the feeling and expression of normal grief in all its varied components. It enhances the medical management of the dying process. It makes a huge difference to quality.

When a patient seems unwilling to discuss these issues the presentation of a document or directive may help to introduce the subject "we need to know how we are going to treat you – we need to discuss some of these issues as listed here". Voluntary and willing completion of such a document may benefit the ongoing process but is not an essential part of this process.

Advance care planning is to be seen as a work in progress and re-visited as the medical condition of the patient changes, as views on preciousness and quality of life change with differing circumstance and age, and as medical treatment previously thought impossible becomes not only possible but desirable.

The use of a document or directive can also facilitate ongoing discussion: "this is how you were thinking 2 years ago, is this how you still think?" However if such directives were to be binding then they can be an impediment to further discussion when impression is formed that no further thought is required ("there, I've done that"), and it can create a hassle in the changing of it.

Some patients, because of what they perceive as the binding nature of such directives and fear of commitment to a poorly perceived set of circumstances, may refuse to even engage in a discussion involving end-of-life issues and *advance care planning* is thus actually hindered. Fear of commitment to a written statutory directive may be a factor in the low uptake of such directives.

To overcome these problems and increase the general community uptake it is recommended that advance care directives be advisory rather than binding.

Likewise treatment decisions made by enduring guardians, guardians or persons responsible should be advisory and not binding.

The advantages of such declarations being advisory are huge:

1. The facilitation of discussion of end-of-life issues with well patients, such discussion – as well as expressing personal wishes about treatment options – having the effect of enhancing every-day quality of life
2. The facilitation of ongoing discussion with ill patients, particularly those with terminal illness
3. Reduced fear of commitment by patients resulting in increased uptake
4. Reduced fear for doctors involved in the interpretation of declarations.

These advantages would enhance uptake by the general community, the result being a successful outcome of this legislation and a significant advance in community health care.

I am in agreement with the recommendations made by the CDHL with respect to these matters. I am also in total agreement with the first recommendation as would be the medical practitioners of *Medicine With Morality*.

I am willing to appear before the Committee in support of this submission.

The recommendations therefore are as follows

RECOMMENDATION 1: Treatment decisions intentionally or recklessly causing death not to be implemented

Page 25, after line 26 insert new subsection:

(4) A health professional is not to take treatment action to give effect to a treatment decision in (a) an advance health directive made by the patient or (b) made by the patient's guardian or enduring guardian or the person responsible for the patient under section 110ZD if:

(i) the treatment decision is made with the intention of ending the patient's life or

(ii) the treatment decision will have the effect of ending the patient's life and is not in accordance with good medical practice.

RECOMMENDATION 2: Advance health directives advisory

Page 17, lines 9-12: omit all terms and expressions and substitute the following:

(b) must be taken into account by a health professional before taking any treatment action to which the treatment decision applies

RECOMMENDATION 3: Treatment decisions advisory – Persons responsible

Page 23, lines 8-12 delete all the terms and expressions on these lines and substitute the following:

110ZD (8) A treatment decision made by the person responsible for the patient must be taken into account by a health professional before taking any treatment action to which the treatment decision applies.

Page 27, line 16 delete the words “by the person responsible” and substitute the following:

“only after taking into account any treatment decision made by the person responsible.”

RECOMMENDATION 4: Treatment decisions advisory – Enduring guardians

Page 26, line 30 delete the words “by the enduring guardian” and substitute the following:

“only after taking into account any treatment decision made by the enduring guardian.”

RECOMMENDATION 5: Treatment decisions advisory – Guardians

Page 27, line 10 delete the words “by the guardian” and substitute the following:

“only after taking into account any treatment decision made by the enduring guardian.”
