



5 February 2013

## **Advance Care Directives Bill 2012**

The doctors of *Medicine with Morality* have serious concerns with this bill.

1. It would allow refusal of medical treatment for a treatable condition in a non-dying patient, such refusal then resulting in death.
2. The bill also forces attending medical practitioners to comply with such an instruction or hand over care to another doctor willing to comply with such instruction. Effectively, the attending doctor is then in a forced euthanasia/physician assisted suicide situation.
3. In the absence of a directive a decision can be made by a person responsible for care of a patient that the patient has lost decision making capacity and make directives on their behalf.
4. The bill is unworkable in its present format which would lead to great uncertainty for attending medical practitioners.

Advance care *planning* is part of good end-of-life care and palliative care. Discussion of such care is also a part of good medicine best enhanced in a good doctor/patient relationship.

But problems result when such plans become *directives* particularly if they become “binding” directives – as in this bill where the directive to not administer life-saving treatment is binding.

This bill in its attempts to overcome some of the other problems inherent in advance care planning has with its many qualifications made the bill more complex to interpret, creating uncertainty for attending medical staff and potentially interfering with good medical decision-making care. Such qualifications include “subject to this act”, “nothing in this act”, “is not invalid merely because”, “however, nothing in this section”, including the particularly confusing and apparently conflicting qualifications in Part 5, 36 (2) “despite subsection (1)” and (3) “subsection (2) does not apply” and 37 (1) “despite any other provision” and (2) “however, if”.

It is this section of the bill that spells out that a directive to withhold potentially life-saving medical care is a “binding” directive 36 (2) (3). Other sections detailing that refusal of medical care is “binding” are 6 (1) (2) protecting compulsion of a doctor *except* in the “withholding” of health care, and 19 (1) “refusal” of health care.

The compulsion of an attending medical practitioner is further detailed in 37 (1) (2) where, “if a health practitioner refuses to comply” he must refer to another “health practitioner” who he

believes will not refuse to comply. Liberty of conscience in not wishing to be the agent of a patient's unnecessary death by being barred from administering life-saving treatment in a non-dying patient – or even complicit in the process of such refusal – is thereby effectively overruled.

The provision in the bill for a substitute decision maker in the instance of an Advance Care Directive not having been completed is fraught with danger as it would, for instance, facilitate a nursing home director being able to make binding medical decisions on behalf of a patient deemed to no longer have decision-making capacity.

This is also spelt out in the Amendments to *Consent to Medical Treatment and Palliative Care Act 1995*, Part 2A 14 (1) person responsible (d) “an adult who is charged with overseeing the ongoing day-to-day supervision... and willing to make a decision”.

Given certain circumstances/conditions and people responsible for care this bill would allow for the withdrawing of life-sustaining measures with the intention of death in patients no longer deemed to have decision-making capacity and who are not at the stage where death is both imminent and inevitable. This scenario could conceivably take place in a nursing home situation.

The resulting cultural shift of a doctor being perceived as the ultimate defender and carer of the patient to the very end of their life to being a possible collaborator to ending that life prematurely has the potential to alter the fundamental doctor/patient relationship and engender fear.

Equally dangerously, the bill would also allow for a suicidal – even relatively young – patient to draw up an Advance Care Directive refusing life-saving treatment in the event of loss of decision-making capacity (however that may be interpreted) and then deliberately inducing such capacity e.g. by stopping his insulin or by a deliberate overdose of certain medications or drugs. In the event of such action taken not actually resulting in death of its own accord, further treatment to resuscitate would effectively be prohibited.

The doctors of *Medicine with Morality* believe that this bill is fundamentally flawed and dangerous and should be rejected in its entirety.



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## Appendix: General Comments re Advance Care Planning

This bill is also subject to other problems inherent in attempts to make advance care planning legally binding.

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.

Ideally, 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 plan 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 is thus actually hindered. Fear of commitment to a written statutory directive may be a factor in low uptake of such directives.

In any future proposed bill we recommend that to overcome these problems and increase community uptake that advance care directives be advisory rather than binding.

Lachlan Dunjey.