



***ACL Submission on the  
Acts Amendment (Consent to Medical Treatment) Bill 2006***

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## **Executive Summary**

The Australian Christian Lobby (ACL) sees value in Advanced Healthcare Directives (AHDs) if there are suitable protections in place for both doctor and patient.

ACL believes that the current common law arrangements adequately address the needs of both patient and doctor. If specific legislation is to be introduced, then suitable protections need to be in place to protect both doctor and patient (see the amendments recommended in [Appendix 1](#)). These are lacking in the proposed Bill in WA. ACL therefore opposes the proposed Acts Amendment (Consent to Medical Treatment) Bill 2006 unless certain minimum safeguards are addressed. If these amendments are not made, there is a strong possibility that the AHD can and will be used as a method of euthanasia.

ACL affirms the unique value of each person regardless of their physical or mental state and therefore opposes all forms of euthanasia. ACL expresses gratitude to doctors, nurses and others who care for people approaching death.

ACL has undertaken considerable consultations with doctors about the concept and practicalities of Advanced Healthcare Directives (AHDs) and the specific legislation proposed in WA as well as the operation of AHDs under common law. It is clear that there are both benefits and risks involved and that much depends on the precise wording of the legislation and the directive itself.

Advanced directives can be very helpful in directing decision making at the end of life. They enable patients to express their preferences for treatment and in this way, address the fears they may have of losing control at the end of life. Advanced directives allow a patient to have some sense of dying with dignity and therefore neutralise the arguments for euthanasia by giving patients an alternative way to retain control over their dying. However, stringent safeguards are needed to ensure that AHDs allow for natural death, rather than themselves being used as a means of euthanasia.

However, expressing one's desires in the event of unpredictable situations is easier said than done and safeguards must be in place to prevent misuse of advance directives, either to overrule or misinterpret the patient's requests or to allow them to express suicidal intent. The AHD should only come into force in a limited set of circumstances in which natural death could be expected to occur within a certain timeframe if medical assistance were unavailable. Patients should not be able to refuse basic nursing or palliative care, such as the provision of food and water.

It must also be ensured that the treating doctor is not prevented from providing the most appropriate treatment alternatives for the patient in question. While legislation is not required for this to happen (common law provides an alternative), it is possible to use the means suggested to facilitate the process.

ACL WA requests the opportunity to address the Committee and speak to our suggested amendments (shown at Appendix 1) in order to ensure that safeguards are built into the legislation.

**ACL WA**  
**September 2007**

## **What is an Advanced Healthcare Directive?**

An Advanced Healthcare Directive (sometimes referred to as a Living Will) allows a person to make anticipatory decisions about future medical care in the event that he is not able to communicate his wishes at the time. People voluntarily prepare the document in order to express their wish to avoid artificially prolonging their life and make clear that they would rather die naturally, receiving palliative care that provides comfort and pain relief.

Typically, the Advanced Healthcare Directive is a legal document that must be signed in the presence of witnesses. Proposed models in Australia usually attempt to specify the kind of circumstances in which a person would rather die a natural death than live with extensive medical needs. This can be problematic because it is so difficult to anticipate the details of an unknown future situation, and because patient's wishes may change. Some British doctors have begun to move away from this model to outline instead a person's beliefs, attitudes and values; a more flexible model that provides an insight to the person whilst allowing doctors leeway to determine the most appropriate course of treatment (example at [Appendix 2](#)).

If a patient is able to communicate, the doctor would ask a series of questions about his preferences for treatment and quality of life. The patient's responses would guide decisions on the treatment provided. An AHD allows patients to do this in advance but only comes into effect if they cannot communicate at the time (if the patient can communicate, doctors must talk to them about their current wishes).

This puts a heavy responsibility on a person who signs a directive. Its legal significance should not be underestimated, nor the consequences for the attending doctor. Choosing to make an AHD in some way forces people to discuss their intentions for end of life care with loved ones now. The process of making a directive should involve considerable reflection and consultation with a medical practitioner.

In ACL's view, an Advanced Healthcare Directive is only of real value when made by a person with a diagnosed terminal condition, which is likely to enter its terminal phase in the near future. Many variables remain in this scenario but, because the patient has a known condition that is reaching its terminal phase, it is possible to make some predictions about its progression and the possible treatment options. The patient therefore has a certain amount of reasonably reliable information on which to base decisions about future wishes. Given the complexity of the situation, an AHD should only be made with the close involvement of a medical practitioner.

ACL believes that Advanced Directives can be very helpful in directing decision making at the end of life. A living will enables a patient to express their preferences for treatment and in this way, addresses the fears they may have of losing control at the end of life. Further consideration of the arguments for and against their use is provided in Appendix 3.

## **ACL Position**

### **Care for dying patients**

Doctors are not obliged to provide treatment on every occasion (though basic care should always be provided). Withdrawal or withholding of specific treatment in a dying patient whose death is both imminent and inevitable is good medical practice if the burden of treatment outweighs its benefits and the intention is to relieve suffering rather than hasten death.

ACL believes that it is always in the interests of a dying patient<sup>1</sup> to receive basic care. This would include nutrition and hydration (in clinically appropriate amounts), palliative care and basic nursing care. As well as upholding basic human rights, this reassures patients and loved ones that the patient has not been abandoned. Palliative care is never to be refused. Patients should never be able to use an AHD to refuse food and water. However, there is no set formula for what constitutes a clinically appropriate amount of food and water for a dying patient: nutrition and hydration should therefore be provided in clinically appropriate amounts according to the clinician's judgment.

### **Value of human life**

Each person has a unique value and is of intrinsic worth. Human beings, even in the agony of suffering or in a twilight mental state, deserve respect, empathy and protection from abuse, harm, manipulation or willful neglect. Every patient, no matter how deformed the body, deranged the mind or diminished the personality should receive equal protection and medical care<sup>2</sup>.

There is a fundamental difference between making treatment decisions and making value of life decisions. Doctors are qualified to make treatment decisions: to decide which treatment is worthwhile and which is not. They are not qualified to make value of life decisions: to decide which life is worthwhile and which is not. They may determine that a treatment is futile but not that a life is futile<sup>3</sup>.

ACL understands the concerns that advanced healthcare directives could provide a method of euthanasia. In ACL's view, advanced directives should allow for natural death to occur without prolonged medical intervention to help the patient cling to life. Advanced directives allow a patient to have some sense of dying with dignity and therefore help to neutralise the arguments for euthanasia by giving patients an alternative way to retain control over their dying.

However, stringent safeguards are needed to ensure that AHDs allow for natural death, rather than themselves being used as a means of euthanasia. Advanced directives that allow a patient to refuse basic nursing or palliative care (e.g. food, water, antibiotics) are akin to voluntary euthanasia and should be invalid under law. In many cases, the critical factors are the precise wording of the AHD and the operation of the law in practice, something that should be tested through the courts and reviewed as required.

Expressing one's desires in the event of unpredictable situations is easier said than done and safeguards must be in place to prevent misuse of advance directives, either to overrule or misinterpret the patient's requests or to allow them to express suicidal intent. It must also be ensured that the treating doctor is not prevented in providing the most appropriate treatment alternatives for the patient in question. While legislation is not required for this to happen (common law provides an alternative), it is possible to use the means suggested to facilitate the process.

### **Common law approach versus specific legislation**

Is it better for doctors to simply be guided by the directive (made under Common Law) or to be legally bound to follow it (if made under specific legislation)? ACL leans towards the benefits of a Common Law approach. Though not without its problems, this option seems to offer the best of both worlds: it allows a patient to make clear his wishes about end of life care but allows doctors the scope to

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<sup>1</sup> As previously noted, AHDs should only come into force when in a limited set of circumstances in which natural death could be expected to occur within a certain timeframe if medical assistance were unavailable.

<sup>2</sup> Christian Medical Fellowship (UK) *Submission to the Department of Constitutional Affairs on the Mental Capacity Act Code of Practice*. [www.cmf.org.uk/ethics/submissions](http://www.cmf.org.uk/ethics/submissions)

<sup>3</sup> Ibid

exercise their clinical judgment in the patient's best interests. It is imperative to avoid a situation in which the AHD brings the doctor into conflict with basic medical ethics by forcing them to act against the patient's best interests. It is the ACL view that the current common law system seems to address the concerns of the proponents of the Bill.

If specific legislation is to be passed, then it must contain appropriate safeguards to protect both doctor and patient. Both of the proposed bills fall short of the necessary safeguards. Based on the current bill, ACL opposes the proposed Acts Amendment (Consent to Medical Treatment) Bill 2006. A critique of the WA bill is provided in [Appendix 1](#).

### **What safeguards are needed in AHDs?**

- Doctors' rights of conscientious objection must be protected and preserved. They should not be forced to act against what they consider to be the patient's best interests. An AHD should be set aside if it is explicitly suicidal;
- Must protect physicians involved in emergency care. The opportunity to save life should not be lost by trying to ascertain whether or not an AHD is in place;
- Clear, tight and precise definitions of what constitutes 'life sustaining measure,' 'palliative care,' 'persistent vegetative state,' 'terminal illness<sup>4</sup>,' 'terminal phase of a terminal illness' or 'unable to make a reasonable judgment;'
- AHD must not lead to the withdrawal of the basic nursing or palliative care, in particular the necessities of life such as food, liquid and warmth<sup>5</sup>. Provision of food and water and the amount of each, must be at the clinical discretion of the doctor;
- AHD should not interfere with the highest quality palliative care to relieve pain and suffering.
- The AHD must be drawn up with the involvement of a medical practitioner to make sure the patient understands what s/he is stating. Specifying this process is better than stating that the directive is invalid if the patient is deemed not to have understood – this leaves doctors too vulnerable to challenge by relatives claiming the patient had told them something different.
- Independent expert to provide a second opinion on the diagnosis of a condition where the AHD would apply;
- Legislation must enforce regular review and update of the AHD, taking into account changes in medical science and changes in the person's personal beliefs and circumstances. If not updated within this timeframe, the AHD lapses;
- Early and detailed review of the practical working of the Act is essential.

Many of these safeguards are missing in the WA Bill.

### **Recommendations for the WA Bill**

ACL has identified significant concerns with the proposed WA bill and cannot support the bill in its current form. [Appendix 1](#) contains a list of the safeguards and provides a pass or a fail depending on whether or not they are addressed in the bill. Where the safeguard fails, ACL suggests possible amendments.

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<sup>4</sup> The Tasmanian bill currently defines terminal illness as an illness or condition likely to result in death. This is far too vague and could include many chronic conditions such as diabetes or cerebral palsy.

<sup>5</sup> There are circumstances where it is clinically appropriate to withhold or withdraw artificial nutrition and hydration but doctors should not be forced to withhold such measures where it is clinically appropriate to provide them.

## Appendix 1 - Detailed assessment of proposed legislation in WA

### Acts Amendment (Consent to Medical Treatment) Bill 2006

#	Safeguard	Fail / pass	Action needed
1.	AHD must be made with the involvement of a medical practitioner	Fail	New clause needed to ensure AHD is made with involvement of medical practitioner.  This may simplify some of the clauses relying on interpretation of whether or not an AHD was valid (e.g. 110R and parts of 110S).
2.	AHD must be signed by the maker, a medical practitioner and an independent witness	Fail	Need to include medical practitioner.
3.	AHD only comes into force in a limited set of circumstances in which natural death could be expected to occur within a certain timeframe if medical assistance were unavailable	Fail	Insert new clause specifying when AHDs apply. At present AHDs could be used for almost any circumstances when the patient was not able to communicate his or her wishes clearly.
4.	Clear, tight and precise definitions of what constitutes 'life sustaining measure,' 'palliative care,' 'unable to make a reasonable judgment.'	Fail	Clause 5(2) to be amended as follows:  'life sustaining measure'- specify that ordinary provision of food and water does not constitute 'maintaining a vital bodily function'.  'palliative care'- clarify that if the purpose of the intervention is to relieve symptoms, it is allowed to use medications (e.g. antibiotics to the reduce the unpleasant odour of smelly wound) which could be used as a life-sustaining measure under different circumstances. Also that it does not include food and water given by ordinary means.  'treatment' must not include palliative care. Palliative care can involve the provision of the same drugs as for 'treatment' but with a different intent (e.g. to relieve pain and suffering rather than to prolong life).  Clause 110F indicates that the advanced directive is

#	<i>Safeguard</i>	<i>Fail / pass</i>	<i>Action needed</i>
			operative when the patient is unable to make reasonable judgments. 'Reasonable' needs to be defined – perhaps by a standard mental state test which can be carried out by any medical practitioner. ACL recommends consulting a psychiatrist about the details of this.
5.	Independent expert to provide a second opinion on the diagnosis of a condition where the AHD would apply.	Fail	Make provision for independent expert to provide a second opinion before AHD comes into force.
6.	Legislation must enforce regular review and update of the AHD, taking into account changes in medical science and changes in the person's personal beliefs and circumstances. An AHD should lapse if not updated at least every 2 years.	Fail	<p>Ensure legislation specifies regular review and that AHD lapses if not updated at least every two years.</p> <p>The bill is rightly concerned that the wishes of the patient as expressed in the advance directive be correct and current. Instead of 110R, S and T, ACL would prefer that all advance directives be made with the assistance of a medical practitioner (possibly as a witness to the document to police the law and remove the risk of coercion), and reviewed on a regular basis. ACL recommends review at least every 2 years, and perhaps more frequently to take account changing health and personal circumstances.</p>
7.	Early and detailed review of the practical working of the Act is essential.	Pass	Legal challenge facilitated by sections 110R & 110S
8.	AHD must not lead to the withdrawal of the basic necessities of life such as food, liquid and warmth, or artificial food and hydration.	Fail	New clause needed to state that basic nursing and palliative care must be maintained for all patients regardless of their wishes. At present, this bill could lead to the withdrawal of basic nursing and palliative care,

#	<i>Safeguard</i>	<i>Fail / pass</i>	<i>Action needed</i>
			such as the refusal or food or water.
9.	Doctors' rights of conscientious objection must be protected and preserved. They should not be forced to act against what they consider to be the patient's best interests.	Fail	<p>Include right of conscientious objection.</p> <p>Risk that relatives will challenge doctors who follow an AHD, saying that it did not reflect what the patient would have wanted in those circumstances<sup>6</sup>.</p>
10.	Medical practitioners must be protected in law if they follow the patient's advance directive when it is in direct conflict with the wishes of the nearest relative.	Fail	There is no mention in the bill of the rights of medical practitioners to be protected in law if they follow the patient's advance directive when it is in direct conflict with the wishes of the nearest relative. Current wisdom suggests that doctors would be very unwise to go against the wishes of the relatives because they are the ones who will be around to sue later.
11.	Any treatment options which are not appropriate clinically at the time of decision-making need not be offered, regardless of the patient's stated desires AHD must not be made with explicitly suicidal intent.	Fail	<p>Specifically state that any treatment options which are not appropriate clinically at the time of decision-making need not be offered, regardless of the patient's stated desires.</p> <p>Make review available to treating clinicians if they deem an advanced directive to be suicidal in intent, (though this would be better done at the time of writing, hence the value of including a physician in that process).</p> <p>Withdrawal of active treatment in the context of a short prognosis (this should be specified: say, less than a year) should not be considered suicidal if the patient was mentally competent at the time of deciding.</p> <p>State that the AHD does not allow the patient to refuse basic needs such as food and water. This is close to a suicidal intent.</p>
12.	AHD should not interfere with the highest quality palliative	Fail	Amend definitions of palliative care and life sustaining

<sup>6</sup> It is not uncommon for relatives to challenge organ donation, even when the dead person has signed a form stating they wish to donate. Relatives usually win such cases.

#	<i>Safeguard</i>	<i>Fail / pass</i>	<i>Action needed</i>
	care to relieve pain and suffering.		measures and insert new clause stating protection for palliative care. At present, the bill does interfere by allowing refusal of basic necessities such as food, water or antibiotics prescribed with intention to relieve pain rather than prolong life.
13.	Must protect physicians involved in emergency care. The opportunity to save life should not be lost by trying to ascertain whether or not an AHD is in place.	Pass	No action needed as provides adequate protection. In emergency situation a doctor may provide urgent treatment if it is not practicable to determine if a patient has a health directive or to consult with an enduring guardian or person responsible.
14.	Must not give power over treatment decisions to anyone not authorized by the patient or who is not next of kin.	Fail	<p>Remove clauses 110ZD, ZE and ZJ. Unusual and problematic to specify list of people on patient's behalf. Each patient's circumstances are different. No-one should be able to make a treatment decision on patient's behalf unless specifically authorized and empowered by the patient (rather than by an arbitrary list).</p> <p>Furthermore, any mention of a 'person responsible' in an advance directive bill is inappropriate as the whole point of the process is to replace the current confusion of the 'person responsible' decision-making system currently in use.</p>

## Appendix 2 – Values Based Advanced Healthcare Directive

### ADVANCE STATEMENT<sup>78</sup>

This advance statement concerning my future medical and nursing care is made by XXXX

My General Practitioner is: YYY

I am very grateful for the care which my medical attendants have given me, both in the past and in the present.

Whenever I am physically and mentally capable of participating in discussions about my future medical treatment, I would like to receive full information about my diagnosis, prognosis and treatment options, and I would like my medical attendants to respect my wishes with regard to any future treatment.

If my medical condition makes it impossible for me to participate in discussions about my treatment, then I ask that the following people are fully informed about my medical condition and treatment options, and I grant legal authority to them jointly and severally to be consulted by my medical attendants when considering what my intentions and wishes would be.

XXX

In all decisions about my future treatment and care I wish the following to be borne in mind by my medical attendants.

I greatly value the ability to think clearly, to be able to write, to be physically independent and to be able to meet and provide pastoral support to friends and contacts.

If I am suffering from a treatable condition in which it is likely that a relatively short period of medical treatment will restore me to my present health and mental functioning, then I would like to receive such treatment. However if it is likely that I will become permanently and severely disabled in such a way as to render me incapable of communication, then I do not wish to receive medical or surgical treatment aimed at prolonging or sustaining my life. In such an eventuality I wish that any distressing symptoms, including any caused by dehydration or lack of food, are fully controlled by appropriate pain relieving or other treatment, even though such treatment may shorten my life.

The reason that I do not wish to cling to life is that I have a living hope of a yet more glorious life beyond death, and I do not wish to be unnecessarily hindered from inheriting it.

I reserve the right to revoke this statement at any time, but unless I do so it should be taken to represent my continuing wishes.

Signed and dated  
Witnessed

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<sup>7</sup> This is an example from the UK of a values based directive rather than a prescriptive one. This is simply an example to inform discussions. An AHD should not be drawn up without appropriate legal and medical advice.

<sup>8</sup> With thanks to Professor John Wyatt, Professor of Neonatal Paediatrics at University College, London

## Appendix 3 - Arguments for and against Advanced Healthcare Directives

### Arguments for Advanced Healthcare Directives

- May make the patient feel more secure if they feel distrustful of doctors – they can make clear that under no circumstances do they wish to be left to die or they can make clear that they accept death in certain circumstances;
- Provide for natural death as a valid path, instead of desperate attempts to sustain life at all costs;
- Addresses some of the fears people have of being kept alive by all possible means may therefore reduce demand for euthanasia;
- Help a patient to have the maximum possible involvement in their care;
- Encourage discussion between the patient and the doctor about appropriate end of life care;
- Demonstrate respect for an individual's choices and desires;
- Mean the patient can be confident of avoiding degrading and drawn out treatment for a terminal illness;
- May make the doctors feel more secure if they are afraid of litigation from patients;
- Not compulsory. Therefore a patient who makes one clearly has firm wishes about their care, which should be respected.

### Arguments against Advanced Healthcare Directives

- Prognosis is a prediction but the prediction may be wrong (and often is). Many people recover against the odds;
- Prognosis presupposes a diagnosis of a particular condition. However, many medical conditions relevant to AHDs are very hard to diagnose. For example, only about 50% of cases of persistent vegetative state are correctly diagnosed. Similar difficulties exist in the diagnosis and prognosis of cancer;
- AHDs indicate the patient's past, not present, attitudes and can cause problems if they are not regularly updated:
  - It may be many years since the AHD was made. Medical science advances quickly and there may now be options for treatment that were not available when the directive was signed;
  - The patient's views and circumstances may have changed. There may have been a religious conversion, the birth of a new child, a remarriage etc, all of which may change the person's attitudes to living or dying;
  - The patient is now ill, which has a dramatic effect on their views of what is a life worth living. Most patients when confronted with the choice between death and a severely disabled life choose life;
- The patient may have felt coerced into signing the directive, or have done so from false guilt or the desire to 'avoid being a burden' to their family;
- Living wills limit the family's involvement in the patient's management because it is the doctor who decides when the living will comes into force;
- Doctors may follow the directive but find themselves challenged by family members who claim the patient would never have wanted such measures when he signed the directive;
- The Directive may tie a doctor's hands, even when the best interests of the patient would be served by ignoring it;
- No AHD can ever be specific about the clinical circumstances in which it would apply. It will never say, "If my blood pressure is X and my biochemistry results are Y and an initial trial for Z days with drug A has produced no improvement and there are no other drugs that might work then I ask that treatment be withdrawn understanding that this will lead to my death." This ambiguity means that doctors still have to consider the patient's best interests and whether the circumstances are the same or different to those envisaged by the patient when he made the AHD. How many patients die in circumstances totally unlike those they envisaged when signing the AHD?
- May complicate matters for emergency physicians who may be unsure whether or not there is an AHD they need to abide by;
- Often viewed as 'euthanasia by stealth.'