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House Standing Committee on Legal and Constitutional Affairs
Inquiry into older people and the law
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AMA Submission to the Inquiry into older people and the law

The AMA would like to thank the Government and the Attorney General, the Hon Phillip Ruddock MP, for the opportunity to make a submission on the adequacy of current legislative regimes in addressing the legal needs of older Australians.

The AMA submission addresses the area of general and enduring 'power of attorney' provisions in the Inquiry's Terms of Reference, with specific comment on the adequacy of the legislative framework that exists for advance care across States and Territories.

In August 2006, the AMA endorsed its position statement on *The Role of the Medical Practitioner in Advance Care Planning (2006)* (Attachment 1).

The AMA supports Advance Care Planning as a way to provide a competent patient with the means to participate in future health care decisions, should he/she lose decision-making capacity in the future.

As part of the Advance Care Planning process, the AMA supports the use of advance directives by patients, and/or the designation of a surrogate decision-maker, such as an Enduring Power of Attorney.

At the foundations of our policy is the desire to protect the rights of patients and the care they want to receive. However, the AMA believes every unforeseen possibility, option or health care scenario cannot be encompassed in a single document.

Whilst respecting the role of patient autonomy in the advance care planning process, doctors' clinical independence must be protected in order for them to act in the best interests of their patients, whether following an advance care plan or deciding not to comply if they have reasonable grounds to believe it is inconsistent with good medical practice.

The AMA is calling for clear, nationally consistent legislation across all jurisdictions in Australia that recognises this, and for the development of clear, nationally consistent guidance for the preparation, notification and storage of advance directives, including a consistent proforma.

The current legislative environment is fragmented and unclear, and offers little certainty for both patients and heath care professionals.

The AMA calls for all States and Territories to enact legislation that recognises advance care directives as legally binding, protecting the rights of the patient to specify future health care treatment preferences while they still have the capacity to do so, while providing equal protection for doctors and other health care professionals who both follow that advance direction or who do not for clearly defined and valid reasons.

The AMA acknowledges that the legislative situation is different in each State and Territory in Australia. Some State and Territory Governments already have legislation in place or are considering legislation in this area where none exists: where legislation does exist, it is inconsistent in many ways across jurisdictions.

Not every piece of legislation recognises an advance directive made in another state, not every piece of legislation provides protection for a health provider who does not comply where there are reasonable grounds to believe that an advance direction is uncertain or inconsistent with good medical practice.

To this extent the AMA encourages the use of the Queensland legislation in this area as 'best practice' legislation, and considers this should be used as the framework for establishing nationally consistent legislation in this area.

The AMA urges this Committee to become familiar with the key points of the AMA position statement on *The Role of the Medical Practitioner in Advance Care Planning (2006)*, and to take this into account as it considers the issues around advance care planning, and the adequacy of current legislative regimes across the nation.

I look forward the outcomes of this Inquiry into older people and the law, and to working with the Federal Government to achieve the best possible political, social and health care outcomes on this issue for all Australians.

Yours sincerely

Dr Mukesh Haikerwal
President

1 December 2006

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The Role of the Medical Practitioner in Advance Care Planning

2006

1. Preamble

1.1 The AMA recognises that Advance Care Planning (ACP) plays an important role in patient self-determination. ACP provides a competent individual with a means to articulate their current health care goals and values. This may be done through the preparation of an advance directive (AD) (or similar instrument), which may include the designation of a surrogate decision-maker such as an Enduring Power of Attorney (EPA), to assist in health care decision-making in the event that the individual loses decision-making capacity in the future.

1.2 The AMA believes that ACP is likely to become more prevalent as the population ages, the ability to maintain life following a catastrophic event improves, and as more people want the ability to record in advance their views on their future health care.

1.3 While providing patients with a means to participate in future health care decision-making, the AMA considers that ADs, in particular, pose ethical and legal challenges to the health care team.

1.4 As such, the AMA recommends that all States and Territories enact legislation that establishes advance directives as legally enforceable, whilst ensuring that the same legislation provides statutory protection for doctors who comply with an AD, or who do not comply if they have reasonable grounds to believe it is inconsistent with good medical practice or advances in medical science, thereby preserving doctors' clinical judgement and discretion.
1.5 The AMA will lobby State and Territory governments accordingly.

1.6 The AMA's position statement on ACP is an extension of the AMA position statement on Care of Severely and Terminally Ill Patients, and serves to complement rather than replace that position.

2. Definitions

2.1 The AMA defines **Advance Care Planning (ACP)** as a process that allows a competent individual to express their views in relation to future health care decisions when the capacity to express those views is lost, and believes it can play a critical role in reducing the stress to families that participation in health care decisions can cause.

2.2 The outcome of an ACP process is an **advance care plan** that may include:

(a) an **Advanced (Health or Care) Directive (AD)** (or other similar instruments);
(b) an **Enduring Power of Attorney (EPA)** (or other similar instruments);
(c) a letter to the person who will be responsible for this decision-making;
(d) an entry in the patient medical record;
(e) a verbal instruction or other communication which clearly enunciates a patient's view or
(f) any combination of the above.

2.3 The AMA defines an **AD** as a statement that allows patients who understand the implications of their choices to state in advance how they wish to be treated when they are no longer capable, as a consequence of physical or cognitive incapacity, of making such health care decisions in a particular circumstance.

2.4 In this context, an **EPA** is a legal document that gives another person authority to make health care decisions on behalf of a person who has lost capacity. In relation to ACP, the attorney may have an important role in assisting in health care decisions that need to be made with the treatment team.

2.5 **Terminal illness** is defined as an illness which is inevitably progressive, the effects of which cannot be reversed by treatment (although treatment may be successful in relieving symptoms temporarily) and which will inevitably result in death within a few months at most (from AMA Position Statement on Care of Severely and Terminally Ill Patients 1997). **Terminal phase** of a terminal illness is defined as the phase of the illness reached when there is no real prospect of recovery, or remission of symptoms (on either a temporary or permanent basis).[1]

2.6 The AMA defines **life sustaining measures** as medical treatment that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation. This includes assisted ventilation, artificial nutrition and hydration and cardiopulmonary resuscitation but excludes measures of palliative care.[2]

2.7 **Palliative care** is defined as measures directed at maintaining or improving the comfort and dignity of a patient who is, or would otherwise be, in distress.[3] 2.8 **Good medical practice** is defined as having regard to:

(a) The recognised medical standards, practices and procedures of the medical profession in Australia; and
(b) The recognised ethical standards of the medical profession in Australia.[4]

3. The Doctor-Patient Relationship and ACP

3.1 The AMA upholds the (competent) patient's right to make health care decisions, including withholding and/or withdrawing life-sustaining measures (AMA *Code of Ethics 2004*, AMA *Position Statement on Care of Severely and Terminally Ill Patients 1997*) and supports the premise that the competent patient can have a role in anticipatory decision-making should he/she lose decision-making capacity in the future.

3.2 The AMA recognises that some individuals will prefer not to make decisions about the future, but rather make decisions about their health care as the need arises.

3.3 The AMA respects cultural diversity and encourages health care professionals to be sensitive to cultural and religious perceptions of how health care decisions are to be made and by whom.
3.4 The AMA endorses ACP as a process of reflection, discussion, and communication of health care preferences that respects the patient's right to take an active role in their health care, in an environment of shared decision-making between the patient and doctor. ACP can be part of a health care discussion with patients of all ages within the primary care environment or hospital setting.

3.5 The AMA endorses the key role of the doctor in providing guidance, advice and in discussing treatment issues related to incapacitating conditions and/or future health care options with patients,

1 Submission from Palliative Care Western Australia on Medical Treatment for the Dying. July 2005. pp4.

2 Submission from Palliative Care Western Australia on Medical Treatment for the Dying. July 2005. pp3.

3 Submission from Palliative Care Western Australia on Medical Treatment for the Dying. July 2005. pp3.

4 B White & L Willmott (2005), Rethinking Life-Sustaining Measures: Questions for Queensland: An Issues Paper reviewing the legislation governing withholding and withdrawing life-sustaining measures pp. 58-59.

as part of the therapeutic relationship. This process may involve family members, religious advisors, friends and other people the patient feels should be involved in the process.

3.6 When engaged in developing an ACP, doctors have a responsibility when possible to ensure that patients:

(a) are competent to do so;
(b) are fully informed and have had an adequate opportunity to receive advice on various health care options pertaining to their current and possible future condition/s;
(c) understand and appreciate the information, including medical concepts and terminology contained in the advance care document;
(d) have the capacity to understand the decisions they have made; and
(e) are acting voluntarily (as best as the doctor can determine this).

3.7 Advance care plans should be reviewed as the patient's condition, and possibly preferences, change. Accordingly, it is important to update plans on a regular basis with defined review points to ensure currency, and to encourage patients to explore all ACP options, including the appointment of an EPA.

3.8 The AMA would expect that ADs would be particularly useful in the following clinical settings:

(a) The patient is in the terminal phase of a terminal illness or condition that is incurable and progressive and is likely to die within a few months at most; or
(b) The patient is in a persistent vegetative state or coma, or
(c) The patient has an illness or an injury of such severity that there is no reasonable prospect that he or she will recover to the extent that his or her life can be sustained without the continued application of life-sustaining measures, and/or has no reasonable prospect of regaining decision-making capacity.

3.9 It is the responsibility of the patient or advocate to make the contents of an AD known. Patients should be encouraged to give a copy of their documents to their doctor, the attorney, to a trusted family member or friend, and to their solicitor. It is important for staff in all health care settings to be aware that the patient has made an advance care document, and where it can be obtained. The patient may therefore wish to carry notification on their person, stating that they have made a document or directive, and where it can be found.

4. Dilemmas in Patient Care

4.1 The AMA recognises that ADs may play an important role in the ACP process and enhance patient self-determination, however, the direct application of an AD under certain circumstances may pose the following serious ethical, clinical challenges to the health care team:

(a) The circumstances that existed at the time the AD was made may have changed. It may then be impossible to determine the extent to which the AD may still apply. Health care decisions arising from an AD are based on the information relevant to the medical condition (if any) and treatment options available, as well as the patient's attitude and values around health care, at the time the AD was made;
(b) Patients may use ambiguous terms in ADs such as 'heroic measures' or 'extraordinary treatment' that make interpretation and application of the AD difficult. The patient's view of what constitutes 'extraordinary treatment' may be quite different to that of their family members, surrogate decision-makers, and/or the health care team;

(c) When preparing an AD, a patient cannot predict and account for every relevant future health care scenario; therefore, a patient's AD may not be directly applicable to the actual circumstance at the time of losing decision-making capacity.

4.2 As such, the AMA is concerned that legally enforceable ADs may lead the doctor into a situation that he or she believes does not reflect good clinical care. Therefore, doctors should be under no absolute legal obligation to follow an AD which is not consistent with Good Medical Practice.

4.3 The AMA respects the rights of doctors to hold differing views regarding ADs. Doctors should be under no obligation to follow an AD to which they hold a conscientious objection. In such a circumstance, the doctor should explain to the medical team involved, and any appointed surrogate decision maker, why they are not willing to follow the AD, and, where possible, the doctor may remove themselves from the treatment team.

5. AMA lobbying

5.1 Given that there are currently jurisdictional differences in the law pertaining to advance care documents between each State and Territory, the AMA calls for **all** States and Territories to enact consistent legislation that establishes ADs as legally enforceable.

5.2 The AMA calls for greater consistency across all State and Territory legislation. All legislation should provide clear, consistent directions on:

(a) determining the validity of an AD;
(b) providing for an Enduring Power of Attorney (EPA) (or similar surrogate decision-maker); and
(c) providing for the recognition of a valid AD from another State or Territory;
(d) under what clinical circumstances an AD comes into effect;
(e) the establishment of appropriate protection for health professionals who:
    i. comply with a valid AD;
    ii. do not comply with an AD that they consider is not valid;
    iii. do not comply with a valid AD where the existence of the AD or the revocation of the AD was unknown;
    iv. do not comply with a valid AD where the health professional determines the direction in the AD is not consistent with Good Medical Practice or where the circumstances have changed so that the terms in the direction are inappropriate;
    v. through conscientious objection, refer the patient's care to another health professional.

5.3 Further, the AMA calls for the development of clear, nationally consistent guidance for:

(a) the preparation, notification, and storage of ADs, including consistent pro-formas; and
(b) the establishment of procedures for identifying an appropriate decision-maker when there is no AD or EPA and the patient's medical circumstances are relevant (e.g. patient is in terminal phase of terminal illness; permanent vegetative state; or illness or injury where unlikely to regain decision-making capacity; etc).

5.4 The AMA encourages doctors to familiarise themselves with the relevant law and practice in their jurisdiction.