ELDER CARE ISSUES – ADVANCE DIRECTIVES

The provisions of the Health & Disability Commissioner Act 1994 ("HDC Act") and, in particular, the Code of Health & Disability Services Consumers Rights ("HDC Code") now promulgated as regulations, make explicit reference to the ability of an individual to make health care decisions "in advance" by the use of "advance directives".

Clause 7(5) of the HDC Code provides : "*Every consumer may use an advance directive in accordance with the common law*". Clause 4 of the HDC Code provides that an advance directive means:

"*A written or oral directive –*

(a) By which a consumer makes a choice about a possible future health care procedure; and

(b) That is intended to be effective only when he or she is not competent."

Typically, an advance directive mandates against the use of extraordinary measures under conditions of mental disability. What is sought is not so much the right to die, but freedom from treatment which prolongs life on terms that are not acceptable to the person concerned. In other words, the advance directive sets out the donor's own parameters as to what is acceptable or unacceptable. This is in contrast to the enduring power of attorney for personal care and welfare, which essentially allows the donor to appoint an agent to make treatment decisions for the donor once they become incompetent.

It is likely that in New Zealand an advance directive that states a patient's advance wishes to have a treatment withdrawn or withheld in specified circumstances, would be considered highly persuasive rather than binding, should a situation provided for in the document arise. In other words, **if** the question comes to be decided in Court, and, it fulfils the necessary requirements of evidence (principally that it is clearly established and applicable in the circumstances), then it is likely to be the deciding factor.

Accordingly, advance directives can be documented such that older clients can set out those circumstances or situations when they would want treatment withheld or withdrawn. This would allow doctors to rely on the expression of intent without the problem of going to Court for approval. These documents can provide an understanding of an individual's personal life values – how they feel about, for example, recovery but with a tube surgically implanted and leading into the stomach for feeding over the long term ("gastronomy tube"), or recovery, but with partial paralysis, or recovery, but with memory loss or no possible chance of recovery, but breathing functions intact. These value statements can assist a medical team in deciding what treatment to give or withdraw in order to best respect a patient's wishes and underlying values. With satisfactory documents, clear directions can be given, that not only achieve the goals of the person themselves, but give assistance to those in whose care the older person is placed.

One of the biggest disadvantages of advance directives is that the directive is not able to provide guidance for every possible circumstance. The advance directive largely focuses on the desire for treatment to be terminated, and also intends to apply only if the patient is dying. The result is that it may not assist a patient in a persistent vegetative state who is not dying and who may live a normal life span. In addition, as a donor cannot possibly take into account in making the directive how their values may change with time, or how medical technology may develop, it is important for the advance directive to be constantly re-evaluated. However, it is more likely that the donor who documents their wishes in an advance directive when competent is able to ensure that their values as to the quality of their future life and acceptable treatment practices is honoured. In effect, the advance directive gives the donor a measure of autonomy if they ever find themselves in a situation set out in the directive, notwithstanding their medical condition.

The Health & Disability Commissioner has expressed a view that where a terminally ill consumer is no longer able to give consent, but has previously expressed a wish not to be resuscitated in the event of cardiac arrest, it will be reasonable in the circumstances not to perform the resuscitation procedure and the provider will not be obliged to do so. Where the views of an unconscious patient cannot be ascertained, providers are obliged to seek the views of "suitable advisors" and to take

those views into account in deciding whether to withhold resuscitation. These views would include an advance directive signed by the terminally ill person when competent. (HDC letter, 10 October 1998) cited in **Health Care Law** [1999] New Zealand Law Review.

To date, in New Zealand, the validity of advance directives have not been specifically tested. However, it is likely that United Kingdom jurisprudence would provide a reasonable indication of how such documents may be treated by the New Zealand Courts. In ***Airedale NHS Trust v Bland*** (1993) 3 WLR 316 the House of Lords gave clear support to the principle of respecting advance directives as did the Court in an earlier case involving a Jehovah Witness refusal of blood products ***Re T (Adult: Refusal of Treatment)*** (1992) 3 WLR 782. In ***Re T*** at 787 Lord Donaldson said:

"*An anticipatory choice … **if** clearly established **and** applicable in the circumstances … would bind the practitioner.*"

Based on the legal position as it stands in the United Kingdom, the current advice to doctors from the British Medical Association is:

"*Where incompetent or unconscious patients have made a formal and specific statement applicable to the circumstances, doctors should regard it as potentially legally binding.*"

Subsequent to the ***Bland*** case, the New Zealand Medical Council endorsed, a report written by the Otago Bio Ethics Centre recommending that where a patients wishes are known and documented in an advance directive, then this is persuasive evidence that a decision to withdraw a particular treatment is acceptable and in accord with the patients wishes and "good medical practice" in such situations. In ***Re L (Auckland Area Health Board v Attorney General [1993] INZLR 235***) Thomas J said that the phrase could not be precisely defined, but that the decision to "omit to treat" should encompass the following, if it is to accord with good medical practice:

- It must encompass prevailing medical standards/practices which command general approval in the medical profession;
- It must accord with the doctors best judgment as to what is in the best interests of his or her patient;
- It must be supported by the agreement of all necessary specialists;
- It must be approved by the medical professions recognised ethical body;
- The patients family, welfare guardian and/or personal care and welfare attorney, must be fully informed and concur with the decision.