

SUBMISSION

on the Discussion Paper:

“Medical Treatment for the Dying”

for the West Australian Department of Health

Southern Cross Bioethics Institute

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Advance Directives Ethical Analysis

We submit to the WA Department of Health a basic ethical analysis of advance directives along with our response to the questions raised in the discussion paper. Our submission is focused only on the issue of advance directives.

1. The justification given for the existence of advance directives is flawed. According to the discussion paper: support for advance directives relies on the fact that patients may feel uncertainty about their future medical treatment, and the common law position that the right to self-determination extends also to decisions made in anticipation of mental incapacity. The conclusion is that patients ought to be able to make binding decisions in anticipation of their loss of competence.
2. The right to self-determination comes from the recognition that self-determination is good for people, so long as it doesn't conflict with other goods or the rights of others. But it is only the exercise of self-determination that is good, not the products of that exercise. Various products of self-determination may be good in themselves: a home, a family, friends, a job; but our respect for these things is not included in the right to self-determination. The right to self-determination recognises that it is good for people to determine the course of their own lives rather than be coerced. But it does not pretend that it is good for people to do things that harm themselves or harm others.
3. Incompetent people have lost the ability to exercise self-determination. Though we may know and respect their wishes, our respect does not contribute to the good of these people. No incompetent person will necessarily benefit or suffer if we do or do not respect their expressed wishes.
4. What about the person's subjective knowledge? Doesn't the person know what is in their own best interest? This could theoretically be so, but is contradicted by the common law references cited in the discussion paper. The paper cites that any person may refuse treatment "however unreasonably",¹ even though doctors "do not consider it to be in his best interests to do so",² and "had to be respected by doctors regardless of the outcome".³ The possibility of superior subjective knowledge is also undermined by the fact that advance directives are created in ignorance of future conditions.
5. What about the deceased will? If we respect the wishes of the deceased, shouldn't we also respect the wishes of the living (living will)? Our respect for the wishes of the deceased person does not serve their good, nor are they harmed when their will is contested. The deceased person is similar to the incompetent person because neither possesses the right to self-determination. But the deceased person has no rights or goods at all, while the incompetent person still retains

¹Discussion Paper "Medical Treatment for the Dying". pp3

² Ibid

³ Ibid

some goods and rights such as the good of life. Respect for the wishes of the incompetent person could conflict with their remaining good.

6. Self-determination is constrained by other goods and rights. We do not have a right to homicidal or suicidal self-determination, because the good of self-determination is negated by the destruction of the good of life: another's (homicide) or one's own (suicide). The same must apply to advance directives, hence advance directives should not be allowed to conflict with the best interest of the patient, or with good medical practice.
7. Patient uncertainty should not be resolved through absolute patient autonomy. Uncertainty should be resolved through explanation of best interest and good medical practice. The patient's own self-determination ought naturally to seek their best interest. The medical principles of best interest, good medical practice, futility, and burdensomeness provide objective standards on a case-by-case basis. Patient self-determination may be legally free to disregard best interest, but it is morally obliged to serve the patient's good.
8. Presuming the sanctity of human life, people are morally obliged to consent to life-sustaining measures that are neither futile nor excessively burdensome. Self-determination may only dispute such measures where the patient disagrees reasonably with the doctor over the degree of burdensomeness. In this instance alone, the patient's subjective insight can inform the doctor. Other factors such as suicidal intention or fear of incompetence do not in themselves justify acting against the good of life.
9. To make advance directives legally binding in spite of their lack of moral authority, is to imply that health professionals cannot or will not make treatment decisions in the best interest of the patient; or that the best interest of the patient cannot be objectively known. However, we have already shown in paragraph 4 that discussion paper states that the wishes of the patient need not be reasonable or even deliver a good outcome. The necessary conclusion is that advance directives are intended to overcome a lack of trust in the beneficence or competency of health professionals.
10. Given that advance directives are a purely legal contrivance without moral basis, that their sole apparent function is to overcome patient fear and uncertainty, and that they nevertheless may cause unnecessary harm to the patient, or contain implicitly suicidal directions; we suggest that any form of advance directive legislation allow health professionals to disregard directions that conflict with patient best interest and good medical practice. Patient certainty ought to be achieved through faith in the beneficence and reasonable practice of the medical profession.

Response to 'Issues and Options for Reform'

Should common law advance health directives continue to be legally binding or should the statutory scheme apply to all advance health directives?

If the statutory scheme is able to limit the undue authority of common law advance directives, then we recommend that common law advance health directives cease to be legally binding.

Should a person be able to give a direction in an advance health directive to withdraw or withhold life-sustaining measures? If so, should the definition of life-sustaining measures included artificial nutrition and artificial hydration?

A person should not be able to give a direction to withdraw or withhold life-sustaining measures unless such a direction is consistent with good medical practice, patient best interest, and the usual measures of futility and burdensomeness of treatment. In simple terms, an advance directive should not be able to refuse life-sustaining treatment that is good for the patient.

It is important to distinguish between artificial nutrition and hydration and other life-sustaining measures. Artificial nutrition and hydration is quite distinct from life-sustaining measures such as assisted ventilation, though the two are often incorrectly compared. The insertion of a percutaneous endoscopic gastroenterostomy (PEG) merely overcomes the patient's inability to swallow – bypassing the usual path of nutrition and hydration. This is comparable to the use of a tracheotomy to bypass the usual path of respiration. In both cases a simple medical procedure allows the provision of a basic substance essential to human life. By contrast, assisted ventilation stimulates the function of the human organ itself. This would be analogous to a machine that stimulates the peristalsis of the digestive system. Assisted ventilation is a process of continuous medical treatment, while only the insertion of the PEG constitutes medical treatment.

There are also important differences in the relative cost and burdensomeness of the two techniques. Ventilation is an invasive procedure requiring regular manual suction on the trachea from 16-20 times a day; it represses any spontaneous breathing that might occur, and costs 24 times the average weekly wage to perform. By contrast, the treatment aspect of artificial nutrition and hydration is complete once the tube is inserted; the insertion of a PEG is one-third the cost of normal feeding, and the nutrition and hydration itself is cheaper than a hospital meal.⁴

Even if legislators decide to allow advance directives to withdraw or withhold life-sustaining measures in opposition to good medical practice and the best interest of the patient, the distinction must be maintained between highly costly, invasive and burdensome medical treatments such as assisted ventilation, and the extremely cheap, non-invasive and non-burdensome provision of basic nutrition and hydration.

⁴ Personal correspondence, Dr Nick Tonti-Filippini. May 24th 2005.

Should a person be able to give a direction in an advance health directive to refuse the provision of palliative care?

There is no justification for denying an incompetent patient the benefit of palliative care, even when their advance health directive refuses such treatment. Relieving the suffering of a dying patient is in the patient's best interest, constitutes good medical practice, and is neither futile nor burdensome.

Should an advance health directive cover any situation in the future where a person may be incapable of making his or her decisions regarding health care or, alternatively, should the legislation restrict the operation of an advance health directive?

If legislation prevents advance directives from conflicting with good medical practice and the best interest of the patient, then it doesn't matter what timeframe is covered by the advance directive. However, if the legislation allows contravention of best interest and good medical practice then legislation ought to limit the application of advance directives to the very end of life. Advance directives should not be applied when patients are only temporarily incompetent, or if the refused treatment could restore patient competence. Advance directives should not come into effect simply when the patient loses competence but is otherwise healthy.

Requirements for a Legally Valid Advance Health Directive

An advance directive should be subject to the same informed consent criteria as contemporaneous decision-making, especially if it is to be given similar or equivalent powers. The patient should also be tested for possible suicidal tendencies.

Should a health professional be required to have regard to good medical practice before giving effect to a direction in an advance health directive?

It is of utmost importance that health professionals be allowed to disregard directives that contradict good medical practice and the best interest of the patient. Bearing in mind that the patient will not benefit or suffer directly by the mere fact that their wishes are followed or rejected, it is essential that these wishes not be allowed to undermine the objective best interest of the patient. There is no justification for disregarding good medical practice or ethical standards in the treatment of an incompetent patient. Why should health professionals be obliged to neglect the best interest of their patient, and the acknowledged standards of their profession, for the sake of a legal document that does not serve the interests of the patient?

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