Advance Directives

Revised 2007

Background

An advance directive is defined in the Code of Health and Disability Consumers' Rights as "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".

Advance directives about medical treatment are a facet of patient choice. The recording of such decisions provides a mechanism for individuals with capacity to say what they would like to happen in the future if their mental capacity becomes impaired. Advance directives only come into consideration once patients lose their mental capacity, are unconscious or otherwise unable to communicate. In that situation, doctors must act in the incapacitated patient's best interests. Evidence of an informed advance decision, whether oral or written, should be taken into account when deciding what is in the individual patient's best interests.

Patients cannot demand or refuse anything in advance that they cannot demand or refuse when conscious and competent. Therefore, patients cannot refuse in advance compulsory treatment provided under the mental health legislation or demand euthanasia or assisted dying. Also although advance requests or authorisation of specific treatment can be helpful, they lack legal weight if clinicians assess that treatment to be inappropriate.

While the NZMA recognises the advantages of advance statements in terms of encouraging openness, dialogue and forward planning, it also draws attention to potential disadvantages. Health professionals and the public should be aware that treatment decisions are complex and practice is constantly evolving. If advance directives are made a long time before capacity is lost, treatment options may have significantly changed. Over time, patients' views can also change about what constitutes a tolerable existence. Advance directives cannot encompass unforeseen possibilities and options. Therefore, while upholding patients' rights to decide in advance, the NZMA also emphasises that patients need to think carefully about the risks associated with committing themselves in advance.

NZMA has produced information about advance directives in line with the Code and we have sample forms that can be used by patients.

Position Statement

The NZMA:

1. Upholds the (competent) patient's right to make health care decisions, including withholding and/or withdrawing life-sustaining measures 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.

2. 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. Respects cultural, ethnic and religious diversity and encourages health care professionals to be sensitive to cultural, ethnic and religious perceptions of how health care decisions are to be made and by whom.

4. Endorses advance directives 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. Advance directives can be part of a health care discussion with patients of all ages within the primary health care environment or hospital setting.

5. 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, 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.

6. Notes that when engaged in developing an advance directive, 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).

7. Recommends that subject to resource constraints, advance directives are reviewed as the patient's health, and possibly preferences, change. Patients should be encouraged to explore all advance directives options, including the appointment of an enduring power of attorney.

8. Anticipates that advance directives would be particularly useful in the following clinical settings:

    (a) The patient is in the final 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.

9. Notes that it is the responsibility of the patient or advocate to make the contents of an advance directive known. Patients should be encouraged to give a copy of their documents to their doctor, 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 directive, 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.

10. Recognises that advance directives may play an important role in the health care process and can enhance patient self-determination, however, the direct application of an advance directive under certain circumstances may pose the following serious ethical and clinical challenges to the health care team:

(a) The circumstances that existed at the time the advance directive was made may have changed. It may then be impossible to determine the extent to which the advance directive may still apply. Health care decisions arising from an advance directive 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 advance directive was made;

(b) Patients may use ambiguous terms in advance directives such as "heroic measures" or "extraordinary treatment" that make interpretation and application of the advance directive 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 advance directive, a patient cannot predict and account for every relevant future health care scenario; therefore, a patient's advance directive may not be directly applicable to the actual circumstance at the time of losing decision-making capacity.

As such, the NZMA is concerned that legally valid advance directives 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 advance directive which is not consistent with good medical practice.

11. Respects the rights of doctors to hold differing views regarding advance directives. Doctors should be under no obligation to follow an advance directive to which they hold a conscientious objection or see the action as unethical. 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 advance directive, and, where possible, the doctor should remove themselves from the treatment team and if possible, recommend another practitioner.

12. Calls for the development of clear, nationally consistent guidance for:

    (a) the preparation, notification, and storage of advance directives, including consistent pro-formas; and

    (b) the establishment of procedures for identifying an appropriate decision-maker when there is no advance directive or enduring power of attorney 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).