

Health advance directives, policy and clinical practice: a perspective on the synergy of an effective advance care planning framework

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Abstract

The delivery of quality care at the end of life should be seamless across all health care settings and independent from variables such as institutional largeness, charismatic leadership, funding sources and blind luck . . . People have come to fear the prospect of a technologically protracted death or abandonment with untreated emotional and physical stress. (Field and Castle cited in Fins et al., p. 1–2).¹

Australians are entitled to plan in advance the medical treatments they would allow in the event of incapacity using advance directives (ADs). A critical role of ADs is protecting people from unwanted inappropriate cardiopulmonary resuscitation (CPR) at the end stage of life. Generally, ADs are enacted in the context of medical evaluation. However, first responders to a potential cardiac arrest are often non-medical, and in the absence of medical instruction, default CPR applies. That is, unless there is a clear AD CPR refusal on hand and policy supports compliance. Such policy occurs in jurisdictions where statute ADs qualifying or actioning scope is prescriptive enough for organisations to expect all health professionals to appropriately observe them. ADs under common law or similar in nature statute ADs are open to broader clinical translation because the operational criteria are set by the patient. According policy examples require initial medical evaluation to determine their application. Advance care planning (ACP) programs can help bring AD legislation to effect (J. Cashmore, speech at the launch of the Respecting Patient Choices Program at The Queen Elizabeth Hospital, Adelaide, SA, 2004). However, the efficacy of AD CPR refusal depends on the synergy of prevailing AD legislation and ensuing policy. When delivery fails, then democratic AD law is bypassed by paradigms such as the Physician Orders for Life-Sustaining Treatment (POLST) community form, as flagged in Australian Resuscitation Council guidelines.²

Amidst Australian AD review and statute reform this paper offers a perspective on the attributes of a working AD model, drawing on the Respecting Patient Choices Program (RCP) experience at The Queen Elizabeth Hospital (TQEH) under SA law. The SA *Consent to Medical Treatment and Palliative Care Act 1995* and its 'Anticipatory Direction' has been foundational to policy enabling non-medical first responders to honour ADs when the patient is at the end stage of life with no real prospect of recovery.³ The 'Anticipatory Direction' provision stands also to direct appointed surrogate decision-makers. It attunes with health discipline ethics codes; does not require a pre-existing medical condition and can be completed independently in the community. Conceivably, the model offers a national AD option, able to deliver AD CPR refusals, as an adjunct to existing common law and statute provisions.

This paper only represents the views of the author and it does not constitute legal advice.

What is known about the topic? Differences in advance directive (AD) frameworks across Australian states and territories and between legislated and common law can be confusing.⁴ Therefore, health professionals need policy clarifying their expected response. Although it is assumed that ADs, including CPR refusals at the end of life will be respected, unless statute legislation is conducive to policy authorising that non-medical first responders to an emergency can observe clear AD CPR refusals, the provision may be ineffectual. Inappropriate, unwanted CPR can render a person indefinitely in a condition they may have previously deemed intolerable. Such intervention also causes distress to staff and families and ties up resources in high demand settings.

What does this paper add? That effectual AD law needs to not only enshrine the rights of individuals but that the provision also needs to be deliverable. To be deliverable, statute AD formulation or operational criteria need to be appropriately scoped so that organisations, through policy, are prepared to legally support nurses and ambulance officers in making a medically unsupervised decision to observe clear CPR refusals. This is a critical provision, given ADs in common law (or similar statute) can apply broadly and, in policy examples, require medical authorisation to enact in order to ensure the person's operational terms are clinically indicated. Moreover, compliance from health professionals (by act or omission) with *in-situ* ADs in an unavoidable emergency cannot be assumed unless the scope harmonises with ethics codes. This paper identifies a working

model of AD delivery in SA under the *Consent to Medical Treatment and Palliative Care Act 1995* through the Respecting Patient Choices Program.

What are the implications for practitioners? A clear, robust AD framework is vital for the appropriate care and peace of mind of those approaching their end of life. A nationally recognised AD option is suggested to avail people, particularly the elderly, of their legal right to grant or refuse consent to CPR at the end of life. ADs should not exclude those without medical conditions from making advance refusals, but in order to ensure appropriate delivery in an emergency response, they need to be scoped so as that they will not be prematurely enacted yet clinically and ethically safe for all health professionals to operationalise. Failure to achieve this may give rise to systems bypassing legislation, such as the American (Physician Orders for Life-Sustaining Treatment) POLST example. It is suggested that the current SA Anticipatory Direction under the *Consent to Medical treatment and Palliative Care Act 1995* provides a model of legislation producing a framework able to deliver such AD expectations, evidenced by supportive acute and community organisational policies.

Definitions. *Advance care planning* (ACP) is a process whereby a person (ideally 'in consultation with health care providers, family members and important others'⁵), decides on and 'makes known choices regarding possible future medical treatment and palliative care, in the event that they lose the ability to speak for themselves' (Office of the Public Advocate, South Australia, see www.opa.sa.gov.au).

Advance directives (ADs) in this paper refers to legal documents or informal documents under common law containing individuals' instructions consent to or refusing future medical treatment in certain circumstances when criteria in the law are met. A legal advance directive may also appoint a surrogate decision-maker.

Although there is variation in scope and operation between statutes, Australians are legally entitled to plan in advance through advance directives (ADs) about how their care will be managed in the event of future incapacity.⁶ Therefore, it is an expectation that wishes regarding medical intervention including cardiopulmonary resuscitation (CPR) through ADs by way of written directions or an appointed surrogate decision-maker(s), or less rigidly expressed under common law,⁷ will be respected. However, in order to bring this legal provision to effect, health professionals need policy clarifying their expected response to ADs, and the health sector needs to be supportively geared throughout. Moreover, statute legislation must be conducive to policy authorising first responders, who are often nurses or ambulance officers, to be able to safely observe such refusals.

It has been demonstrated through advance care planning (ACP) program models⁸⁻¹⁰ that when patients and families are involved in ACP and the health care sector adopts a system-wide approach, then treatment can be streamlined to patients' wishes, providing comfort and satisfaction to all parties.^{11,12} It is important to note that ACP is not about 'helping people to die earlier'.¹³ Indeed, ACP can help alleviate euthanasia driving fears¹⁴ of a medically prolonged death or 'being kept alive as a vegetable', and creates opportunity¹⁵ to provide holistic care. The Australian Government's 2006 Guidelines for a Palliative Approach in Residential Aged Care state that 'there is compelling evidence to support the use of ACP... ACP... helps residents communicate their wishes and enhances their sense of control'; thus it improves satisfaction for both residents and their families and also avoids unwanted transfers or facilitates smooth transition between home and acute care.¹⁶ The 2008 *National Health and Hospitals Reform Commission – Interim Report* states 'We find that the evidence in support of action on ACP, and more specifically the Respecting Patient Choices (RPC) model, is strong and cannot be ignored'.¹⁷ In their final 2009 report, the Commission recommended that \$6 million over 4 years go to supporting ACP in residential care facilities across Australia, with

projected savings through acute occupied bed-days avoided, calculated using Austin Health respecting patient choices community extension data.¹⁸

The Austin Health Respecting Patient Choices Program (RPCP) community extension demonstrated the majority of residents involved in ACP preferred to remain in place for care at the end of life. Those residents without an AD were more likely to die in acute care than those with; and those with legal or informal ADs that died in acute care had shorter length of stays.¹⁹ Each AD represented ~9.2 hospital occupied bed-days avoided at the end of life (J. Field, TQEH, unpubl. data). It could be said that ACP helps facilitate both the ethical and appropriate use of resources through self-selection and not rationing. However, it cannot be assumed that the need or preference to transfer to acute care overturns ADs. Hence, ADs need to be able to facilitate safe passage of individuals across levels of care and effectuate treatment that reflects their preferences – since transfers to acute services, to obtain best available care, may need to take priority over preferred place of care,²⁰ for example, to obtain adequate palliation.²¹

Pertinently, ACP is now integral to the Australian Council of Health Care Standards EQUIP²² hospital accreditation program and forms part of clinicians' professional and advocacy role.²³ In particular:

- Standard 1.1 Consumers/patients are provided with high quality care throughout the care delivery process;
- Criterion 1.1.2 Care is planned and delivered in partnership with the consumer/patient and when relevant the carer, to achieve the best possible outcomes;
- Criterion 1.1.7 Systems exist to ensure that the care of dying and deceased patients is managed with dignity and comfort. Including policy and procedures for the management of patient end-of-life care consistent with state/territory legislation, common law and policy.

Organisational health care policy describes how employees are to behave in order to provide evidence-based best clinical care

and practice within and to uphold the purpose of the law. If employees follow these guidelines professionally, reasonably and in good faith, they have the legal protection of their employer (J. Lemmey, pers. comm.).

A patient's resuscitation status, and a medical 'Not for CPR' instruction, is usually re-established on each admission – whereas valid²⁴ ADs stand (remain in place) post loss of capacity. Whether clear ADs will protect people who do not want CPR attempted depends on the policy stance on who may enact ADs. This is because first responders to arrests are often ambulance officers,^{25,A} nurses²⁵ or junior doctors who are not usually authorised²⁶ to decide on resuscitation issues and will initiate CPR until a senior doctor is available to adjudicate. In hospital this can occur in an emergency presentation, or at after-hours admissions to the ward/unit or at an unanticipated cardiac arrest when CPR status may not have been documented.

Equipping staff through a model such as the RPCP encourages 'patient centered' care and helps avoid distressing,²⁷ inappropriate CPR incidents (Austin Health, consultant training: Respecting patient choices, 2004). The consequences of such incidents can be an undignified death; the subsequent withdrawal of artificial life support; or the patient being left in a state they had previously deemed intolerable. However, the efficacy of ADs in protecting individuals from unwanted CPR from first responders, in the absence of corresponding medical instructions, depends on the synergy of prevailing AD legislation, ensuing policy and clinical delivery framework.

Intent of paper

To this end, amidst Australian AD review^{28–30} and statute reform³¹ a perspective is offered on why South Australian (SA) AD legislation has contributed towards fulfilling AD expectations especially with respect to the protection of people when consent to CPR has been refused.

This paper draws on The Queen Elizabeth Hospital (TQEH) and community RPCP implementation experiences and ensuing policy development primarily under the *Consent to Medical Treatment and Palliative Care Act 1995* (Consent Act),³ in conjunction with the *Guardianship and Administration Act 1993* (Guardianship Act).^{32,B} Focus is given to the legal 'living will' style ADs, known as the 'Anticipatory Direction' in SA, since this provision directs both health professionals and surrogate decision-makers. Although ADs often represent consent to the use, or discontinuance, of life-sustaining interventions provisional to the likelihood of (patient defined) meaningful recovery,^{33,34} and therefore rely on medical appraisal to implement; this paper focusses on the efficacy of ADs in the

instance of clear refusals of consent to CPR, when an immediate response is required to render any such directive effectual. Some comparisons are made to other Australian jurisdictions and comment is made on the 2009 SA Advance Directive Review report and the POLST paradigm in America. This paper only represents the views of the author and it does not constitute legal advice.

Discussion

Legal ADs tend to be binding other than when legislation provides an excuse. However, enacting a common law AD hinges on enquiry as to whether the individual's operational terms apply to the case³⁵; that they understood the consequences of their decisions at the time of making them and decided freely.³⁶ Wilmott *et al.* explain that, 'An adult can choose to comply with the formal requirements of the relevant legislative regime, so that his or her instructions will be regulated by statute' or, 'give an AD which, if valid at common law will govern future treatment'.⁶

It is worth noting what may ensue if a clear robust AD framework is not in place that can protect patients from unwanted inappropriate CPR at the end stage of life. The Australian Resuscitation Council guidelines³⁷ flag their international body's recommendation that the Physician Orders for Life-Sustaining Treatment (POLST) or similar be utilised wherever possible. The POLST form was developed in America to bypass ineffectual AD legislation by translating ADs to physician's orders extending to out of hospital.³⁸ Legal protection was gained for emergency workers to follow the POLST in the community after its successful trial in Oregon in 1996.³⁹ In 1997 the POLST was adopted by the Wisconsin Respecting Choices Program because legal ADs could not be implemented by non-physicians.⁴⁰ And the only statute means of avoiding CPR in the community was to qualify, with a terminal or life-limiting medical condition, for a Do Not Resuscitate (DNR) bracelet, which was viewed as restrictive in scope and an infringement of privacy to have to wear.⁴¹ The POLST, along with a system-wide advance care planning approach has shown to be effective in protecting people from inappropriate unwanted CPR in the community.⁴²

However, the POLST paradigm could be perceived as subjecting autonomy to medical oversight.⁴³ For instance, an elderly competent person's decision to refuse consent to CPR through an AD, may be based on their religious beliefs and preparedness for death in old age and clinical outcomes may be of little or no bearing. This was affirmed in 2009 by a New South Wales Supreme Court where judgment was made that it is not necessary for a person's decision to be medically informed for

^A Ambulance Officers may be authorised to withdraw from resuscitation efforts in certain circumstances. For example, Metropolitan Ambulance Service Rural Ambulance Victoria, 'Withholding or Ceasing Pre-hospital Resuscitation', Version 3 – 010903, CPG A: 0501.

^B In 2007 TQEH received an 'Outstanding Achievement' award for the mandatory EQuIP Criterion 1.1.2 Care Planning. The assessor wrote, 'Management of the deteriorating patient is extremely impressive. The program called RPC is supported by all disciplines within the hospital setting as well as community-based services'.⁹⁷ In the August 2009 accreditation, at the 'summation of findings' delivery to staff, surveyors made special mention of outstanding TQEH initiatives including the RPCP.⁹⁸ Subsequently in October 2009, the Central Northern Adelaide Health Service (in which the TQEH sits) announced that the RPCP would be rolled out across the region in 2010. This complies with South Australia's Health Care Plan 2007–2016 commitment to providing advance care planning as part of care to the elderly (p. 14, see www.health.sa.gov.au/Default.aspx?tabid=247, accessed 3 March 2010). The SA Health Palliative Care Services Plan 2009–2016 states 'In SA, TQEH has championed the uptake of ADs through the RPCP. Since 2004 the RPC team at has built up considerable capacity and experience in this area, and has demonstrated strong uptake of ADs across western Adelaide' (p. 51, see www.health.sa.gov.au/Portals/0/palliative-care-plan-2009-2016.pdf, accessed 3 March 2010).

their AD to be valid, if the decision is based on religious, social, moral or other grounds.⁴⁴ The POLST movement promotes that people complete ADs and then as they get closer to the end of their life (less than 12 months expectancy⁴⁵) they have them translated into an out-of-hospital medical order. In effect, this creates another level of paper work and simultaneously annuls the need for legal ADs, since it is the medical order which non-medical first responders will follow.⁴⁶ Out-of-hospital medical orders are issued according to the doctor or nurse practitioner's judgement⁴⁷ and the American Bar Association Commission on Law and Ageing advises consumers that if their doctor has objections to their AD and will not sign an out-of-hospital DNR or issue a bracelet, then they should find another doctor.⁴⁸ Therefore, this paradigm may not necessarily achieve an individual's objectives or, conversely, the vulnerable may gain inappropriate DNR orders, which health professionals will be obligated to follow (given the benchmark excuses normally provided by AD legislation have been overridden). This model circumnavigates AD regulation formulated through democratic processes which stand to preserve personal liberty and protect community interests.⁴⁹

Nonetheless, imposing medical sign off on legal ADs can improve the likelihood of non-medical health professionals abiding by an AD. For example, the Victorian Refusal of Medical Treatment Certificate,⁵⁰ which requires a pre-existing medical condition, is the only AD recognised in the Metropolitan Ambulance Service, Victoria, policy.⁵¹ Policy in hospitals such as Austin Health Melbourne, where the RPCP was developed, also support compliance with this certificate. However, a qualifying condition to complete an AD does not cater for some individuals, such as the well young who may not wish for life-prolonging measures to continue should they end up in a moribund state or, the frail elderly who may want to be treated for episodic illness without being subjected to CPR if they have a cardiac arrest. This issue is addressed under Queensland AD law, where a doctor must sign off on an AD but there is no pre-existing medical condition requirement for making an advance refusal of life-sustaining treatment. Instead, AD operational scope terms apply which, generally put, cover terminal, with less than 12 months life expectancy, incurable or irreversible conditions. However, the Queensland *Powers of Attorney Act* 1998⁵² has a 'good medical practice' AD override (Chapter 3 Part 3 s 36 (2)(b)), which could eclipse common law rights and also puts a question mark over the non-medical health professional's position to enact an AD (R. Laidlaw, pers. comm.). In the Northern Territory, the 'Notice Of Direction' Pursuant To *Natural Death Act* is addressed to the treating doctor who determines firstly whether the person is terminally ill.⁵³

Contrastingly, Tasmania and New South Wales do not have formal AD 'living will' provision⁵⁴ and future wishes are conveyed through appointed Guardians or common law documents such as RPCP Statement Of Choices,⁵⁵ or Let Me Decide⁵⁶ (Good Palliative Care Plan [SAJ]⁵⁷). Assuming an AD made under common law was formulated validly,³⁶ since the operational criteria are set by the adult individual,⁵⁸ implementation generally involves medical appraisal to determine whether the

clinical circumstances meet the conditions the individual intended the directive to apply under. Reducing the risk of the AD being prematurely enacted, when enquiry is warranted, due to situational or treatment option changes shedding doubt on whether the person would still want the decisions. The same applies for legislation which primarily reinforces, rather than complements common law provision,⁵⁹ for example, Australian Capital Territory⁶⁰ legislation (the recently enacted WA legislation⁶¹ is similar). Examples of both NSW⁶² and ACT policy^{63,64} stipulate that the responsibility for determining whether an AD applies lies with the medical officer. It follows that these ADs are not certain to protect people with CPR refusals from non-medical first responders. Furthermore, if there is provision for instructions by patients to their Medical Agent or Enduring Guardian in the appointing forms, these are intended to operate through the surrogate decision-maker. If the surrogate is unavailable (although the instructions stand to guide health professionals) in the interim, the patient may be at risk of unwanted intervention.

An example of advance care planning framework synergy

In SA, through the implementation of the Respecting Patient Choices Program in October 2004, TQEH developed organisational AD policy under the Consent Act, in conjunction with the *Guardianship and Administration Act* 1993 (Guardianship Act). The Consent Act operational scope for its standalone 'Living Will' style document, the 'Anticipatory Direction', is the 'terminal phase of a terminal illness' or 'persistent vegetative state'.^{65,C} In the Act, 'terminal illness' is defined as 'an illness or condition that (is) likely to result in death'; the 'terminal phase' is defined as 'the phase of the illness reached when there is no real prospect of recovery or remission of symptoms (on either a permanent or temporary basis)' (p. 3). TQEH AD policy clarifies that all health professionals are to observe clear legal ADs when the operational criteria apply, even if there is no opportunity to obtain a corresponding medical instruction⁶⁶; also, that ADs under common law should be respected unless there is good reason otherwise. In June 2008, the Central Northern Adelaide Health Service adopted a region-wide ACP policy based on TQEH's version.⁶⁷ The SA Ambulance Service 'Clinical Communication' is similarly supportive.⁶⁸

The Medical Power of Attorney document (also under the Consent Act), does not have such an operational scope, although the Act goes further than providing guiding principles for the Medical Agent. Medical Agents can not refuse treatment that will return the person to capacity unless they are in this terminal phase of a terminal illness.⁶⁹ Nor can the agent refuse palliative care or the natural provision of food or fluids. According to the Office of The Public Advocate's Fact Sheet 9,⁷⁰ decisions made by Enduring Guardians (appointed in an Enduring Power of Guardianship form under the Guardianship Act) relating to the use of life-prolonging treatments also apply at this phase. If the surrogate is unavailable to adjudicate it could be rationalised that any instructions should guide health professionals as at common law, within the constraints and guidelines to decision-makers in the respective Acts.

^CPersistent Vegetative State (PVS): Note, the National Health and Medical Research Council change in criteria and term to Post-coma Unresponsiveness (VS), www.nhmrc.gov.au/publications/synopses/hpr23syn.htm (accessed 28 September 2009).

SA legislation does not impose a qualifying health condition or medical sign-off to draw up a legal AD. This provision makes the RPCP trained facilitators role of assisting with the ACP process relatively straightforward. It also reduces the need for doctors to have to deal with the time-consuming documentation, which as yet does not attract a Medicare item number.⁷¹ An authorised witness is required to testify that the person appeared to understand the nature and effect of a direction or power and was not coerced.^{72,73} Authorised witnesses under the Consent Act include members of the clergy and registered pharmacists, both of whom tend to be on hand in health services if a justice of the peace is unavailable. Furthermore, because AD copies need not be certified, the process is expedient, and allows for timely distribution to and between health services.

The Consent Act allows for emergency treatment if to the best of the medical practitioner's knowledge the person has not refused consent (s13 (1) (c)). This section provides support to respect ADs other than those in the legal format. This is pertinent given that to administer treatment, despite a known refusal of consent, means the protections from criminal and civil liability⁷⁴ may no longer apply (J. Murray, pers. comm.), and in common law this situation could constitute assault and battery,⁷⁵ risking 'wrongful life' suits.⁷⁶ Yet, the Consent Act's AD prescriptive operational scope also makes available reasonable excuses for clinicians to resort to standard care, pending more advice in an emergency when there is real uncertainty about the legal AD application to the clinical presentation.⁷⁷ This is of particular importance given that withholding treatment in accordance with an AD that is not legally valid risks substantial harm to the patient and may constitute breach of the duty of care and negligence,⁷⁸ risking 'wrongful death' suits. The balance needs to be carefully weighed up as, clearly, the risks are not the same; in the former scenario an individual will be able to die again but in the latter, death is final.⁷⁶

In a cardiac arrest situation there may be no time to refer a case or decision, should an AD act or omission request breach medical or nursing ethics codes or spark individual, conscientious objection. However, the end-stage operational scope has not seemed to have put health professionals at odds with their personal⁷⁹ or professional ethics codes.^{80,81} Indeed, health professionals express satisfaction and relief when care can be provided in accordance with patients' wishes⁸² and good clinical practice. Furthermore, this criterion offsets the risk of inadvertently facilitating needless death through ADs based on misinformation or suicidal ideology. For example, a person may refuse consent to (cardiac) defibrillation: this may be reasonable, especially if the person has experienced the procedure in the past and they have reached an end stage where a palliative focus is preferred. On the other hand, the person may have based the refusal on the assumption that the process would be painful, not realising that defibrillation can correct a monitored potentially fatal arrhythmia, and that they would not be conscious for the procedure. In the latter case, the Consent Act would provide an excuse for overriding the AD, providing the person was not end-stage, making it possible to confirm the intent of their AD. The Consent Act does not authorise euthanasia or assisted suicide (s18) and an AD cannot be used as a means to this end – even if 'voluntary euthanasia' were legal, by designation it is a contemporary arrangement with a willing doctor, not a

future directive. It should be noted that philosophically the RPCP does not support euthanasia.¹⁴

Concern has been expressed that strict interpretation of the statute operational terms could mean those without a diagnosed illness may have their AD CPR refusals overturned. Arguably, most health professionals can recognise the end stage of life when there is no real prospect of recovery, and inexperienced staff are rostered with experienced staff who can make a judgement. In this context, to restrict through policy who may abide by the AD, would thwart the purpose of the law – pertinent, given that, although CPR can achieve a return of circulation in ~23% (SA Ambulance Service, unpubl. data) of SA Ambulance retrievals, cardiac arrest survival rates to hospital discharge for those over 70 years (according to some American studies) are less than 1% if the arrest occurs in the community and 3.8% if in hospital, potentially with new deficits.^{83,84} An in-hospital study showed that 37.1% of patients who had a witnessed cardiac arrest were resuscitated, with 14.7% surviving to discharge, and 20.6% of patients who had an unwitnessed cardiac arrest were resuscitated but none survived to discharge.⁸⁵

Compliance with AD CPR refusals has been facilitated through strong policy underpinned by the knowledge that ADs also hold evidentiary weight in common law of the patient's wishes. The end-stage operational terms and supportive policy enables ACP facilitators to offer genuine assurance when helping people with ACP that 'treatment limitation' directives will not be acted on prematurely and that 'CPR refusals' will be honoured appropriately. The 'Anticipatory Direction' seems to have set a safe implementation benchmark for non-medical first responders to apply to both statute and non-statute AD CPR refusals, outside of which default intervention applies pending medical guidance.

I was impressed with how the ACP system worked . . . it felt much better than performing an inappropriate obligatory resuscitation. The patient died peacefully, just after arrival, and I had opportunity to counsel her daughter. (TQEH Emergency Department Staff Specialist, March 2007)

In SA there has been a review of ADs initiated in the SA Department of Health⁸⁶ and the AD Review Committee reports were recently released.⁸⁷ The Committee proposes finance, lifestyle and health directives combine under one Act and health ADs be aligned with other statute trends (1st report, letter of transmittal). The first report recommends that operational terms for health ADs be set by the individual: that AD decisions need not be informed (although this is advised); that they can apply for any period of incapacity (temporary or permanent); and whether ADs are statute or otherwise, that they are binding when the individual's terms are met (1st Report, Rec 11, 12, 16 and 17). The Report adopts broad common law principles for formulating health ADs but seems to risk the principles of enquiry normally associated with such ADs to ensure their application is clinically indicated, by stipulating that all 'professionals' must comply. Generally, discipline boards and organisational policies regulate the practice scope of different health professionals so as they are not acting beyond their clinical competency.⁸⁸ In the balance, it is reasonable to assume that health professionals in an emergency response situation can make a judgment as to whether the patient is at the end stage of life and make a medically unsupervised decision

to accordingly honour a clear legal AD CPR refusal or default to resuscitation pending medical advice. However, to legislate that all ‘professionals’ be bound to follow ADs during any period of incapacity and for any given clinical circumstance is irreconcilable. The Report recommends indemnity for ‘professionals’ who follow valid ADs and sanctions upon those who fail to comply (1st Report, Rec 24).

The recommendations seek to extend common law. However, by removing the current protective AD operational scope, an uninformed AD treatment refusal (when the decision is made for health reasons alone) is given the same weight as competent informed refusal of consent.⁸⁹ In the second example of the patient with an AD cardiac defibrillation refusal, should the person have lapsed into unconsciousness, under the recommended law, ‘professionals’ could be bound to preside over a needless death. The AD Review Committee could have avoided this problem by retaining the reliable Consent Act provisions, namely, that ADs be legally binding when the person is in the ‘terminal phase of a terminal illness’ (s7 (1)), or when ‘medical treatment would not result in the person regaining capacity to make their own medical treatment decisions’ (s8 (7)) and that AD refusals at other times be advisory.^D

The AD Review Committee endeavour to overcome the potential issue of conscientious objection to AD requests. Should ADs breach personal or medical or nursing ethics codes, health professionals would be required to refer such cases to another health professional who will comply (1st Report, Rec 32). This effectively makes the objecting health professional party to the process any way and subjugates professional ethics to the demands of individuals, or potentially leaves them in the place of Antigone, having to choose between the ruler Creon’s law and a higher universal law – which in Antigone’s case was that of ‘God and heaven’.⁹⁰

Public submissions to the SA AD Review have been listed in the Report (1st Report, pp. 97–98) but not posted⁹¹ (although they are available on request). TQEH’s RPC view on why current SA AD law provides an effective framework for AD delivery can be seen on the National Health and Hospitals Reform Commission’s web site in the joint Australian RPC submission.⁹² The August 2009 *MedicSA* article, ‘Choosing the future: advance directives’⁹³ conveys that the Australian Medical Association (SA) submission to the AD review supports a practical and easier AD system but recommends there be legal protection for doctors who fail to follow ADs on sound clinical grounds: ‘Circumstances are not always black and white’ and, ‘health care workers must be able to intervene where a potentially reversible and unforeseen event has occurred’ (p. 12).

Conclusion

A supportive AD legislative, policy and delivery framework is important and vital for the appropriate care and peace of mind of those approaching the end stage of life. AD legislation that bears little difference from common law provision can offer no distinguishing choice in practical outcome for the individual when it comes to protection from unwanted CPR. Examples of

policy for implementing such ADs, which have operational terms set by the individual and not prescribed by statute, understandably require medical adjudication because they can apply in broader circumstances. This leaves individuals with such ADs still at risk of CPR from non-medical first responders. Furthermore, in unavoidable emergency situations health professionals, by act or omission, could not be bound to follow AD terms they were previously blind to, which could conflict with ethical codes. Practically speaking, the likelihood of AD CPR refusals being consistently delivered throughout the health care sector lessens as legislated AD operational scope broadens.

Acts enabling Agents or Guardians to be appointed have guiding principles for the surrogate decision-makers. However, if the surrogate is unavailable to convey when any instructions in the appointing form should apply, logically, instructions stand to direct health professionals also as in common law. Jurisdictions with legal AD refusals, subject to a pre-existing medical condition, achieve compliance but leave the well (particularly if they have no one to appoint as a surrogate) with only AD provision under common law. Queensland has no qualifying condition needed to make an advance refusal and applies an operational scope but the law is weakened by provision for medical veto.

In comparison, the SA Consent Act Anticipatory Direction can be availed of and completed independently in the community. Although the document’s operational scope is relatively narrow, the antecedent legislation has shown to produce organisational policy endorsing that non-medical health professionals can, even in the event of there being no opportunity to gain a corresponding medical instruction, follow a clear legal AD when the patient is at the end stage of life with no real prospect of recovery.³ Therefore, the advantage of a clear legal AD CPR refusal in this format, when it travels with the patient, is that it can be followed by all health professionals. Underpinned by the current SA law, organisations are prepared to support health professionals in making a medically unsupervised⁹⁴ decision to observe a clear legal AD CPR refusal. This illustrates that for the delivery of legal AD CPR refusal to be assured across the health care continuum, all parties likely to be involved must be able to recognise and concur with its operational terms.

Recommendation

The Commonwealth Parliament House of Representatives Standing Committee on Legal and Constitutional Affairs calls for a national approach to ACP.²⁹ It stands to reason that facilitating the ongoing uptake of ACP in Australia would benefit from a standardised national AD able to avail people,⁹⁵ particularly the elderly, of their legal right to grant or refuse CPR at the end of life, throughout the Australian health care sector. Giving people the option of entering into a legal AD with known statute terms offers both the comfort of knowing instructions will not be acted on prematurely and the assurance that their wishes will be honoured. These are important ethical issues both for ACP facilitators and people formulating the plans. Ideally, the AD would be the least restrictive on personal liberty and barriers to complete, while ethically and clinically safe for non-

^DAcknowledgement of Former Public Trustee Judith Worrall’s contribution to this concept (2007).

medical health professionals to activate. From a patient-centred perspective this would ensure the highest compliance possible.¹⁵ I would suggest a provision akin to the current SA *Consent to Medical Treatment and Palliative Care Act 1995* 'Anticipatory Direction' may suffice, given it has shown to meet these conditions, evidenced by supportive policy. Anything less may render AD CPR refusals retrospective withdrawal guides post emergency intervention, perpetuate incidents of unwanted inappropriate CPR and trigger a POLST paradigm.⁹⁶

Competing interests

The author declares she has no competing interests.

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References

- 1 Fins J, Peres J, Schumacher J, Meier C. On the road from theory to practice: progressing toward seamless palliative care near the end-of-life. Washington: Last Acts, National Program Office, 2003.
- 2 Australian Resuscitation Council. Guideline 11.10. Legal and ethical issues relating to resuscitation. 2006. p. 3. Available at <http://www.resus.org.au/> [verified 11 September 2009].
- 3 *Consent to Medical Treatment and Palliative Care Act 1995*. p. 3. Available at <http://www.dh.sa.gov.au/consent/> [verified 17 January 2009].
- 4 National Health and Hospitals Reform Commission. A healthier future for all Australians – interim report 2008. Available at [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/\\$File/NHHRC.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf) [verified 13 March 2009].
- 5 Singer PA, Robertson G, Roy DJ. Advance care planning. Bioethics for clinicians series 6. *CMAJ* 1996; 155(12): 1689–92.
- 6 Wilmott L, White B, Howard M. Refusing advance refusals: advance directives and life sustaining medical treatment. *Melbourne University Law Review* 2006; 30(1): 211–43. Available at <http://eprints.qut.edu.au/7094/> [verified 15 December 2009].
- 7 Stewart C. Advance directives the right to die and the common law: recent problems with blood transfusions. *Melbourne University Law Review* 1996; 23: 161–83.
- 8 Austin Health. Respecting patient choices: final evaluation of community implementation of the respecting patient choices program. 2006.
- 9 La Trobe University, Australian Institute for Primary Care. Respecting Patients' Choices Program evaluation. Data report. Melbourne: Queen Elizabeth Hospital, 2006.
- 10 Hammes BJ, Rooney BL. Death and end-of-life planning in one midwestern community. *Arch Intern Med* 1998; 158: 383–90. doi:10.1001/archinte.158.4.383
- 11 Gunderson Lutheran Medical Foundation. Respecting choices. Available at <http://www.respectingchoices.org/history.asp> [verified 16 January 2009].
- 12 Street A, Ottmann G. State of the science review of advance care planning models. Melbourne: La Trobe University, 2006. Available at http://www.caresearch.com.au/Caresearch/Portals/0/Documents/WhatisPalliativeCare/NationalProgram/RespectingPtChoices/State_of_the_Science_Review.pdf [verified October 2008].
- 13 National Health and Hospitals Reform Commission. A healthier future for all Australians – interim report 2008. p. 187, 192. Available at [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/\\$File/NHHRC.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf) [verified 13 March 2009].
- 14 Austin Health. RPC News; Autumn 2005. Available at <http://www.respectingpatientchoices.org.au/rpc-newsletters/> [verified 2 March 2010].
- 15 Hammes BJ, Briggs LA. Initiating, facilitating, and honoring conversations about future medical care. In: Doka KJ, Jennings B, Corr CA, eds. Ethical dilemmas at the end of life. Washington, DC: Hospice Foundation of America, 2005: 125–38. Available at <http://www.respectingchoices.org/documents/EthicalDilemmas.pdf> [verified 17 January 2009].
- 16 Australian Government, Department of Health and Aging. 2004 Guidelines for a Palliative Approach in Residential Aged Care. Guidelines 2–10. Available at <http://www.nhmrc.gov.au/publications/synopses/ac12to14syn.htm> [verified 4 October 2009].
- 17 National Health and Hospitals Reform Commission. A healthier future for all Australians – interim report 2008: 81, 191, 187–8, 191–3. Available at <http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008> [verified 3 March 2010].
- 18 The National Health and Hospitals Reform Commission. A healthier future for all Australians – final report June 2009. Recommendation 57: 219, 266. Available at [http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/1AFDEAF1FB76A1D8CA25760000B5BE2/\\$File/Final_Report_of_the%20nhhrc_June_2009.pdf](http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/1AFDEAF1FB76A1D8CA25760000B5BE2/$File/Final_Report_of_the%20nhhrc_June_2009.pdf) [verified 3 March 2010].
- 19 Blackford J, Stickland E, Morris B. Advance care planning in residential aged care facilities. *Contemporary Nurse* 2008; 27(1): 141–51.
- 20 Tolle SW, Tilden VP. Changing end-of-life planning: the oregon experience. *J Palliat Med* 2002; 5(2): 311–7. doi:10.1089/109662102753641322
- 21 Tilden V, Tolle S, Drach L, Perrin N. Out-of-hospital death: advance care planning, decedent symptoms, and care giver burden. *J Am Geriatr Soc* 2004; 52(4): 532–9. doi:10.1111/j.1532-5415.2004.52158.x
- 22 The Australian Council on Health Care Standards. Evaluation and quality improvement program. Criteria 1.1.2, 1.1.7. 2006.
- 23 Shanley C, Wall S. Patient autonomy and communication through advance care planning: a challenge for nurses. *Aust J Adv Nurs* 2004; 21(3): 3–5.
- 24 Biegler P, Stewart C, Savulescu J, Skene L. Determining the validity of advance directives. *Med J Aust* 2000; 172: 545–8.
- 25 Elliott J, Olver I. Choosing between life and death: patient and family perceptions of the decision not to resuscitate the terminally ill cancer patient. *Bioethics* 2008; 22(3): 179–89. doi:10.1111/j.1467-8519.2007.00620.x
- 26 Johnstone M. Bioethic: a nursing perspective. 4th edn. Sydney: Elsevier, 2004: 320.
- 27 Johnstone M, Da Costa C, Turale S. Registered nurses' experiences of ethical issues in nursing practice. Final report to the Nurses Board of Victoria. Melbourne. RMIT University 2002; 31, 37.
- 28 The Australia Health Ministers' Advisory Council. Available at http://www.respectingpatientchoices.org.au/images/stories/pdfs/news/spring_newsletter_2008.pdf [verified 16 January 2009].
- 29 Commonwealth of Australia. House of Representatives Standing Committee on Legal and Constitutional Affairs report. Older people and the law. 2007.
- 30 National Health and Hospitals Reform Commission. Available at <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/018-wilsiletal> [verified 16 January 2009].
- 31 South Australia Advance Directive Review Committee. Available at <http://www.health.sa.gov.au/advancedirectives/> [verified 16 January 2009].

- 32 Government of South Australia. *Guardianship and Administration Act* 1993. Available at http://www.austlii.edu.au/au/legis/sa/consol_act/gaaa1993304/ [verified 2 March 2010].
- 33 The Queen Elizabeth Hospital. Submission to the Advance Directive Review. Adelaide: TQEH, 2007: 11 (unposted).
- 34 The Queen Elizabeth Hospital. Advance Directives (RPC) Procedure, Clinical Practice Manual. Adelaide: TQEH, 2007: s. 4.5.
- 35 Central Northern Adelaide Health Service. Advance Care Planning, Individual Regional Policy. Adelaide: 2008. Available at http://dev.health.sa.gov.au/cnchs_dev/LinkClick.aspx?link=Repository%2fPP%2fPOL%2fPol-AdvanceCarePlanning.pdf&tabid=119&mid=2283 [verified 17 December 2009].
- 36 Office of the Public Advocate. Fact Sheet 22. Available at http://www.opa.sa.gov.au/cgi-bin/wf.pl?pid=&mode=cd&file=/html/documents/10_Fact_Sheets [verified October 2008].
- 37 Australian Resuscitation Council. Guideline 11.10. Legal and ethical issues relating to resuscitation. 2006, p. 3. Available at <http://www.resus.org.au/> [verified 11 September 2009].
- 38 Last acts. Focus: Oregon's POLST Program. Implementing end-of-life treatment preferences across clinical settings. 1999; Issue 3. Available at <http://www.lastacts.org/files/publications/polst0599.html> [verified April 2004].
- 39 Tolle SW, Tilden VP. Changing end-of-life planning: the Oregon experience. *J Palliat Med* 2002; 5(2): 311–7. doi:10.1089/109662102753641322
- 40 PACE and The La Crosse Medical Centers' Advance Directive Task Force. Recording do not resuscitate and other life-sustaining orders in the out-of-hospital setting. Guidance for health providers. Advance Directive Task Force, 2002. Available at http://www.ohsu.edu/polst/docs/wisc_polst.pdf [verified 21 October 2007].
- 41 Hammes B. POLST program description for Wisconsin. POLST.ORG 2007 information for health care professionals in Wisconsin. Program description. 2005. Available at <http://www.ohsu.edu/polst/state/wi.shtml> [verified 22 October 2007].
- 42 Tilden V, Tolle S, Drach L, Perrin N. Out-of-hospital death: advance care planning, decedent symptoms, and care giver burden. *J Am Geriatr Soc* 2004; 52(4): 532–9. doi:10.1111/j.1532-5415.2004.52158.x
- 43 Mills JS. Of the limits to the authority of society over the individual on liberty. Chapter IV; 1869. Available at <http://www.bartleby.com/130/4.html> [verified 22 January 2009].
- 44 Hunter and New England Area Health Service v A [2009] NSWSC 761. Available at <http://www.lawlink.nsw.gov.au/scjudgetments/2009nswsc.nsf/6ccf7431c546464bca2570e6001a45d2/48dd2b1db7c8987dca257608000a28da?OpenDocument> [verified 3 October 2009].
- 45 Physician Orders for Life-Sustaining Treatment (POLST). Frequently asked questions for health care professionals. Available at <http://www.ohsu.edu/polst/programs/OregonFAQHCP.htm#Q1> [verified 3 October 2009].
- 46 Physician Orders for Life-Sustaining Treatment (POLST). Frequently asked questions for patients and families. Available at <http://www.ohsu.edu/polst/patients-families/faqs.htm#8> [verified 3 October 2009].
- 47 Wickham B. Alert: POLST of Oregon (doctors orders to limit treatment) moves to NC and other states. Life Issues.net: Clear thinking about crucial issues. 2006. Available at http://www.lifeissues.net/writers/wic/wic_03doctorsordered.html [verified 2 March 2010].
- 48 American Bar Association Commission on Law and Aging. Consumer's tool kit for health care advance planning. What to do after signing your health care advance directive. Tool 8 point 3. Available at <http://www.abanet.org/aging/toolkit/tool8.pdf> [verified 22 January 2009].
- 49 Devlin P. Morals and the criminal law. In: The enforcement of morals. Oxford: Oxford University Press, 1965: 16.
- 50 *Medial Treatment Act (Victoria)* 1988. Refusal of treatment certificate: competent person. Available at http://www.austlii.edu.au/au/legis/vic/consol_act/mta1988168/sch1.html [verified 2 March 2010].
- 51 Metropolitan Ambulance Service, Rural Ambulance Victoria. Withholding or ceasing pre-hospital resuscitation. Version 3–010903, CPG A: 0501.
- 52 (a) *Queensland Powers of Attorney Act* 1998. Available at <http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PowersofAttA98.pdf> [verified 2 March 2010].
(b) *Queensland Powers of Attorney Act* 1998. Form 4 (Section 3). Available at <http://www.justice.qld.gov.au/files/Guardianship/advancehealthdir.pdf> [verified 23 January 2009].
- 53 *Natural Death Act (Northern Territory)* 1988. Natural Death Regulations. Available at [http://notes.nt.gov.au/dcm/legislat/legislat.nsf/0/87d0f084f019de376925635b0020c9f9/\\$file/repn019r1.pdf](http://notes.nt.gov.au/dcm/legislat/legislat.nsf/0/87d0f084f019de376925635b0020c9f9/$file/repn019r1.pdf) [verified 2 March 2010].
- 54 Palliative Care Knowledge Network. Resources for advance care planning. Available at <http://www.caresearch.com.au/caresearch/ClinicalPractice/PatientConsiderations/AdvanceCarePlanning/ResourcesforAdvanceCarePlanning/tabid/473/Default.aspx> [verified 2 March 2010].
- 55 Fremantle Hospital. Advance care plan statement of choices [WA version developed by Fremantle Hospital]. Austin Health, 2006. Available at http://70.87.111.98/~rpccom/images/stories/pdfs/advance_CarePlans/WA_Statement_of_Choices.pdf [verified 23 January 2009].
- 56 Central Coast Division of General Practice. Let me decide. Health and Personal Care Directive. New South Wales version. Available at <http://www.planningwhatiwant.com.au/Documents/c%20let%20me%20decide.pdf> [verified 23 January 2009].
- 57 Palliative Care Council of South Australia Inc. Good palliative care plan. Available at <http://www.pallcare.asn.au/sale.php> [verified 23 January 2009].
- 58 NSW Department of Health. Using advance care directives New South Wales. 2004: p. 9, s6, Q2. Available at <http://www.health.nsw.gov.au/pubs/2004/adcairectives.html> [verified October 2008].
- 59 Australian Resuscitation Council. Guideline 11.1. Legal and ethical issues relating to resuscitation. ARC, 2006: 3. Available at <http://www.resus.org.au/> [verified 11 September 2009].
- 60 *Australian Capital Territory Medical Treatment (Health directions) Act* 2006, Part 3, s11(2) & (3). Available at <http://www.legislation.act.gov.au/a/2006-51/default.asp> [verified 22 January 2009].
- 61 Western Australia, The Acts Amendment (Consent to Medical Treatment) Act 2008. Available at [http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDDocument:7384P/\\$FILE/ActsAmConsenttoMedTrtmtAct2008_00-00-01.pdf?OpenElement](http://www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDDocument:7384P/$FILE/ActsAmConsenttoMedTrtmtAct2008_00-00-01.pdf?OpenElement) [verified 3 March 2010].
- 62 NSW Health. Consent to medical treatment. Patient information, 2004. Policy Directive (S 23). Available at http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf [verified 4 March 2010].
- 63 Health ACT. Reference to 'withholding cardiopulmonary resuscitation – clinical services policy'. Canberra Hospital, 2000: 4. Consent to treatment policy. Section 9.1: Not for cardiopulmonary resuscitation orders. Available at <http://health.act.gov.au/c/health?a=dlpol&policy=1156898985> [verified 2 June 2008].
- 64 Calvary Health Care Act consent policy 2004, Section 10. Available at <http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1102985419&sid=ACTHealth> [verified 17 January 2009].
- 65 *Consent to Medical Treatment and Palliative Care Act* 1995, Part 2 Division 2, s7. Available at <http://www.dh.sa.gov.au/consent/> [verified 17 January 2009].
- 66 The Queen Elizabeth Hospital. Advance directives (RPC) policy and procedures, clinical practice manual. Adelaide. http://qehintranet/tqeh/policies_procedures/clinical_manuals/clinical_practice_manual.jsp [verified 17 December 2009].
- 67 Central Northern Adelaide Health Service. Advance care planning. Individual regional policy. 2008. Available at <http://10.22.161.59/cnchs/Portals/0/Pol-AdvanceCarePlanning.pdf> [verified 23 January 2009].

- 68 South Australian Ambulance Service. End of life decisions. Clinical Communication, 2004.
- 69 *Consent to Medical Treatment and Palliative Care Act* 1995, Division 3, s8 (7)(b)(iii). Available at <http://www.dh.sa.gov.au/consent/> [verified 17 January 2009].
- 70 Office of the Public Advocate. Fact Sheet 9. Available at http://www.opa.sa.gov.au/cgi-bin/wf.pl?pid=&mode=cd&file=/html/documents/10_Fact_Sheets [verified October 2008].
- 71 House of Representatives Standing Committee on Legal and Constitutional Affairs. Older people and the law. 2007; Recommendation 23, s 3.167, p. 113.
- 72 *Consent to Medical Treatment and Palliative Care Act* 1995. Medical power of attorney. Prescribed form. Available at <http://www.dh.sa.gov.au/consent/> [verified 17 January 2009].
- 73 *Guardianship and Administration Act* 1993. Schedule – Instrument appointing enduring guardian. Available at http://www.health.wa.gov.au/mhareview/resources/legislation/SA_Guardianship_Administration_Act_1993.pdf
- 74 *Consent to Medical Treatment and Palliative Care Act* 1995, Part 3 Division 1, s16 & Division 2 s17. Available at <http://www.dh.sa.gov.au/consent/> [verified 17 January 2009].
- 75 NSW Department of Health. Using advance care directives. New South Wales, 2004; p. 9, s6, Q2. Available at <http://www.health.nsw.gov.au/pubs/2004/adcairectives.html> [verified October 2008].
- 76 Lynch HF, Mathes M, Sawicki NN. Compliance with advance directives wrongful living and tort incentives. *J Legal Med* 2008; 29: 133–78. Available at <http://papers.ssrn.com/abstract=1148384> [verified 2 March 2010].
- 77 Central Northern Adelaide Health Service. Advance care planning. Individual regional policy. 2008. Available at <http://10.22.161.59/cnchs/Portals/0/Pol-AdvanceCarePlanning.pdf> [verified 23 January 2009].
- 78 Biegler P, Stewart C, Savulescu J, Skene L. Determining the validity of advance directives. *Med J Aust* 2000; 172: 545–8.
- 79 Catholic Health Australia. A guide for health professionals implementing a future health care plan. 2001. Available at www.cha.org.au/site.php?id=230 [verified 16 December 2009].
- 80 Australian Medical Association Inc. The role of the medical practitioner in advance care planning. 2006 position statement. Available at <http://www.ama.com.au/node/2428> [verified 17 January 2009].
- 81 Australian Nursing and Midwifery Council. Codes of professional conduct & ethics for nurses & midwives in Australia (Conduct statement 2), Explanation 3. 2008. Available at <http://www.nursesboard.sa.gov.au/documents/ANMCwebsiteversion.pdf> [verified 17 January 2009].
- 82 Seal M. Patient advocacy and advance care planning in the acute hospital setting. *Aust J Adv Nurs* 2007; 24(4): 29–36.
- 83 Teno JM. The wrongful resuscitation. MedscapeCME. Available at <http://cme.medscape.com/viewarticle/575601?src=mp&spon=25&uac=66745PX> [verified 15 December 2009].
- 84 Taylor DMcD, Cameron P. A. Advance care planning in Australia: overdue for improvement. *Intern Med J* 2002; 32: 475–80. doi:10.1046/j.1445-5994.2002.00268.x
- 85 Brindley P, Markland D, Mayers I, Kutsogiannis D. Predictors of survival following in-hospital adult cardiopulmonary resuscitation. *CMAJ* 2002; 167(4): 343–8.
- 86 Murray J. Rights responsibilities rhetoric – unpacking the policy and practice issues in mental health law, guardianship and trusteeship. In *SA Mental Health Conference*; 2009 October 8: Adelaide; p. 18. Available at <http://www.health.sa.gov.au/mentalhealth/Portals/0/090624-2009MentalHealthConference.pdf> [verified 31 October 2009].
- 87 The SA Advance Directive Review Committee. Planning ahead: your health, your money, your life. First report of the review of South Australia's advance directives. Proposed changes to law and policy. 2009. Available at <http://www.agd.sa.gov.au/news/index.php#advancedirectives> [verified 31 October 2009].
- 88 Australian Nursing and Midwifery Council. Code of professional conduct for nurses in Australia. Conduct Statement 1: Nurses practice in a safe and competent manner. Available at http://www.anmc.org.au/userfiles/file/research_and_policy/codes_project/New%20Code%20of%20Professional%20Conduct%20for%20Nurses%20August%202008.pdf [verified 5 November 2009].
- 89 Skene L, Smallwood R. Informed consent: lessons from Australia. *BMJ* 2002; 324: 39–41. doi:10.1136/bmj.324.7328.39
- 90 Davies M. Natural law and positivism. In: Asking the law question. Sydney: The Law Book Co., 1994: 65–92.
- 91 Brown M, Evans M. A better scheme of advance directives for South Australia. Stage 1 Report – planning ahead. Changes to law and policy [power point presentation]. 2009. Available at http://www.publictrustee.sa.gov.au/uploads/Mental_Health_Conference/EVANS%20&%20MURRAY%20powerpoint.pdf [verified 31 October 2009].
- 92 National Health and Hospitals Reform Commission. First round submissions received. See '018 William Silvester *et al.*' 22 August 2008. Available at <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/submissions-1lp> [verified 3 November 2009].
- 93 Australian Medical Association. *MedicSA* (magazine); August 2009. Available at http://www.amasa.org.au/media/medic_sa.aspx [verified August 2009].
- 94 *Consent to Medical Treatment and Palliative Care Act* 1995, Part 3, Division 2, s17 (2). Available at <http://www.dh.sa.gov.au/consent/> [verified 17 January 2009].
- 95 World Health Organization. Ottawa Charter for Health Promotion, 30 Jun 2006. Available at <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/> [verified 16 December 2009].
- 96 Sabatino CP. Advance directives and advance care planning: legal and policy issues. American Bar Association, Commission on Law and Aging, US Department of Health and Human Services. 2007. Available at <http://aspe.hhs.gov/daltcp/reports/2007/adacplpi.pdf> [verified].
- 97 Seal M, Hunt R. Improving end-of-life care: addressing patient advance directives [power point presentation]. 2008. Available at http://www.changechampions.com.au/resource/Marion_Seal.pdf [verified 17 January 2009].
- 98 Woods J. General Manager's Bulletin. Adelaide: The Queen Elizabeth Hospital; 2 September 2009.

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