**The Case for ACP/ACD**

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Medical care has increasingly become a patient-centered business. It is common practice for physicians and healthcare professionals to keep the patient in the loop of any treatment they are receiving. The entire course of the care provided is described in detail to the patient or their relatives. Express and written consent over drastic steps is also essential. Moving forward in the same direction, doctors are now asked to carry out ACP or advanced care planning. This means that the doctor undertakes a detailed discussion with the patient who decides the type of care they would like to receive in the future. A legal document called ACD or advance care directive is signed as a result. (Tinetti, 2012) However, an ethical dilemma lies at the root of this exercise. Since the issue is controversial and both sides on this debate have a defendable moral stance, it is a paradox for ethical decision making. In this paper, I would be arguing for ACP/ACD and would make a case for the morality and positive practical implications of this practice. Especially in the case of Victoria, I would describe in detail why Victoria formalizing a law on ACP/ACD is a welcome initiative. I would also offer suggestions on the best way to practically implement ACP/ACD.

Advance care planning is the procedure whereby doctors and their patients engage in a lengthy legal discussion over the specific kind of care the patient would like to receive when they are incapable of deciding so in the future. (Anjali Mullick, 2013) Most patients, when they advance to old age and are in need of constant care, are likely to experience a steady deterioration in their physical and cognitive abilities. Patients with degenerative disorders are even more vulnerable in this regard. As a result of the patient no longer being able to properly decide the course of their medical treatment, it is likely that they will either continue to receive costly unwanted treatment or be deprived of the treatment plan of their choice. In order to cater to the debilitating financial and emotional cost of a treatment that is not wanted, the medical industry has started focusing on ACP/ACD for end of life (EOL) care. (Sarah Yeun-Sim Jeong, 2010)

The ethical discussion around ACP/ACD however involves two very morally acceptable sides of an argument. On one end is the ethical requirement of upholding patient autonomy. However, there is experienced medical decision-making on the other side. Patients can choose to decline treatments that have the potential to become the difference between their own life and death. For the doctor to forego a medical emergency, especially in the case of surgery, would also be ethically questionable. It is, therefore, a dilemma. (Jennifer Yu, 2015)

In the earliest years of the implementation of advance care planning, this procedure was only understood and discussed in the context of formulating ACDs. However, as time has passed, the discussion around ACP has evolved to understand ACP as an ongoing process which includes lengthy discussions around palliative care, end of life care, surrogate decision making, life support and ACDs. (Carmen H.M. Houben, 2014) Early implementation of ACP also received relatively unanimous support. However later on, debates and controversies have fired up more frequently making the ethical considerations around ACP more complicated and well-discussed. (Tinetti, 2012) Issues about the qualification of doctors and nurses to make legal discussions regarding care in the future and the emotional and cultural repercussions attached are also being reviewed. (Connie M. Ulrich, 2010) Although progressive legislation still protects ACP/ACD, general discussion around it has expanded.

Victorian law around advanced care planning has existed in its raw form since 1988 in the form of a Medical Treatment Act. This act allowed the creation and implementation of a legal document termed as the ROTC or the Refusal of Treatment Certificate. It gave the patients the right to refuse treatments. However, the new law, called the Medical Treatment Planning and Decisions Act 2016, will expand on these rights by replacing a ROTC with an ACD. (Counsel, 2016) In force since March 12, 2018, this law upholds the rights of patients to refuse treatment in the previous law. The new law makes it compulsory to only begin implementation of ACD once the person loses the capacity to make a decision.

My argument for the ethical standing of carrying out ACD solely depends on the idea of patient autonomy. The fact that doctors might have medical experience trumping the decision made by the patient is still not enough ethical justification for providing the doctors with the power to make decisions on behalf of the patient. Modern medicine has increased the chances of people surviving with chronic illnesses. Most of these people are at the mercy of their healthcare providers and are liable to receiving unnecessary or unwanted interventions. (Ian A Scott, 2013) The only ethical course of action here that outweighs its alternatives is respecting patient autonomy over their bodies.

Once it has been established that proceeding with ACP is indeed the more ethical course of action, it is important to outline the various steps that can improve the current practices around ACP. The first and foremost requirement in this case is extensive awareness programs so a greater number of people are aware of their right to choose their own end of life care. Increasing health literacy should be the priority. (Nouri, 2019) Other than this, improving the quality of the discussions during ACP, some degree of emotional and legal counseling for the patient and correct timing for the conversation are some aspects that would help improvements.

Hence, ACP/ACD is a historically controversial concept of providing patients with the autonomy to choose the care they would prefer when they lose the capacity to decide. An ethical dilemma exists but tips in the favor of ACP and the new Victorian law is a positive reinforcement for this idea. The hurdle to pass now is to increase the percentage of patients that opt for ACP.

# References

Anjali Mullick, J. M. (2013). An Introduction to Advance Care Planning in Practice. *British Medical Journal*, 28-32.

Carmen H.M. Houben, M. A. (2014). Efficacy of Advance Care Planning: A Systematic Review and Meta-analysis. *Journal of the American Medical Directors Association* , 477-489.

Connie M. Ulrich, C. T. (2010). Everyday ethics: ethical issues and stress in nursing practice. *Journal of Advanced Nursing*, 2510-2519.

Counsel, C. P. (2016, November 9). *Medical Treatment Planning and Decisions Act 2016.* Retrieved from End of Life Law in Australia: http://www.legislation.vic.gov.au/Domino/Web\_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B4D3EBB66E52E98CCA25807A0014F70D/%24FILE/16-069aa%20authorised.pdf

Ian A Scott, G. K. (2013). Difficult but necessary conversations — the case for advance care planning. *The Medical Journal of Australia*, 662-666.

Jennifer Yu, D. B. (2015). Looking beyond the crystal ball: An ethical dilemma in advance directive implementation in multidisciplinary patient care. *Surgery*, 1389-1394.

Nouri, S. B. (2019). Health Literacy Matters More Than Experience for Advance Care Planning Knowledge Among Older Adults. *Journal of the American Geriatrics Society*.

Sarah Yeun-Sim Jeong, I. H. (2010). The essentials of Advance Care Planning for end-of-life care for older people. *Journal of Clinical Nursing*, 389-397.

Tinetti, M. E. (2012). The Retreat From Advanced Care Planning. *The Journal of the American Medical Association*, 915-916.