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The Need for Advance Care Planning as a Pivotal Means for Respecting the Patient's Will in Poland: Learning Points from Swiss and Australian Models

Abstract: Self-determination is pivotal for a patient's autonomy. Decisions at the end of life should reflect the human right to decide on the last days of life according to personal beliefs, philosophy, preferences, and values. Advance Care Planning (ACP) aims to ensure that patients receive medical care consistent with their values, goals, and priorities during progressive life-threatening chronic illness. We present decades-long experience of the implementation of ACP in different legal systems, in Switzerland and Australia, and the current legal situation of *pro futuro* statements in Polish law. Irrespective of jurisdiction and despite the apparent benefits of ACP, its implementation may face numerous impediments, i.e. poor public health messaging, a lack of skilled, trained personnel to deliver and sustain ACP initiatives, misunderstanding of the practical application of an advance care directive in real terms, and misperception of ACP as a form of crypto-euthanasia. Addressing these impediments would be a prerequisite for its successful national implementation. Furthermore, successful implementation needs public dialogue, collaboration between legislators and healthcare professionals, and engagement with the public, patients, and caregivers to foster a greater understanding of the true meaning of self-determination.

Keywords: Advance Care Planning, end of life, palliative care

Introduction

The key concept of palliative care (PC) and end of life (EOL) is respect for autonomy. Each person has a right to make decisions regarding their life according to their beliefs, philosophy, preferences, and values. Although it is an unquestionable principle, it may encounter numerous impediments and problems in practice. First is how far the patient's will should be respected, especially when it refers to ethically dubious, too expensive, or ineffective methods. Second is the patient's capacity to consent to treatment. Should the patient's wish, once stated, be respected at any time? Who has a right to consent when a patient is unconscious and the clinical situation has changed?

PC focuses on goal-concordant, person-centred care provided by multidisciplinary teams formed by physicians, nurses, social workers, music and occupational therapists, chaplains, and ethicists, specialized in a holistic approach including high-quality skills in symptom-relieving treatment, including sedation where necessary, communication, and complex-care management. Advance Care Planning may be a means to foster this high-quality palliative person-centred care. Ideally, a patient should always be engaged in the decision-making process. However, unfortunately, this ideal cannot be met in patients who are unable to communicate. In such cases, clinical decisions may not reflect patients' preferences.

Advance Care Planning (ACP) has been defined as 'a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care'. It aims to ensure patients receive medical care consistent with their values, goals, and preferences during progressive life-threatening chronic illness.[1] Patients articulate their preferences in advance of their incapacity to make decisions by addressing common EOL clinical scenarios and referring to the procedures that may or may not be provided. How-

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[1] R.L. Sudore, H.D. Lum, J.J. You et al., Defining Advance Care Planning for Adults: A Consensus Definition from a Multidisciplinary Delphi Panel, 'Journal of Pain and Symptom Management' 2017, vol. 53, pp. 821–832.e1.

ever, such scenarios may appear too vague or generic, and may fail to reflect a specific patient's situation in the future. It seems reasonable, then, to assign and prepare a healthcare proxy decision-maker who could make medical decisions when a patient is incapable of doing so and who is included in the ACP process. Usually, the healthcare proxy is a next of kin or other trusted person who knows the patient's history and preferences.

Although ACP is a structured process, it does not come down to a simple question of ticking a box. It is a multi-step approach that includes discussion, personal reflection, and, finally, completion of ACP documents. There is strong evidence that ACP has positive effects on patients, relatives, health professionals, and the healthcare system.[2] An advance directive and substitute (proxy or surrogate) decision-maker has become increasingly accepted and endorsed by state or federal legislation, including in Australia and Switzerland. Poland belongs to countries where neither ACP nor proxies are legally constituted. In this position paper, we aim to present ethical, medical, and legal arguments that support implementing ACP as pivotal for respecting patient autonomy. We also underscore the learning points and pitfalls from the countries where ACP is well established, i.e. Australia and Switzerland. Finally, we try to identify the prerequisites for implementing ACP successfully.

1. Advance Care Planning as shared decision-making for goal-concordant care: Ethical foundations

1.1. Advance Care Planning: What it is and what it isn't

ACP has its roots in a deep respect for the human rights, dignity, and values of a person particularly when they are vulnerable, and is one of the main tools to foster a patient-centred healthcare system. It takes into account the important bioethical principles of respect for autonomy, beneficence, non-maleficence, and justice, on which all countries, as well as international professional organizations such as the WHO, the World Medical Association, and the International Council of Nurses, have agreed.[3]

The definition of ACP proposed by the international Delphi consensus process on ACP[4] differs little from the original apt definition of the Canadian bioethicists Singer, Robertson, and Roy, published in the 1990s:

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[2] S. Diegelmann, S. Bidmon, R. Terlutter, Promoting Advance Care Planning via Mediated Health Resources: A Systematic Mixed Studies Review, 'Patient Education and Counseling' 2022, vol. 105, pp. 15–29.

[3] B.J. Hammes, M.R. Warner, M.O. Leavitt, Having Your Own Say: Getting the Right Care When It Matters Most, United States, CHT Press 2012.

[4] S. Diegelmann, S. Bidmon, R. Terlutter, Promoting Advance Care Planning…, *op. cit.*; R.L. Sudore, H.D. Lum, J.J. You et al., Defining Advance Care Planning…, *op cit.*, p. 821; J.A.C. Rietjens,

Advance care planning is a process whereby a patient, in consultation with healthcare providers, family members, and important others, makes decisions about his or her future healthcare. Grounded in the ethical principle of autonomy and the legal doctrine of consent, ACP helps to ensure that the norm of consent is respected should the patient become incapable of participating in treatment decisions.[5]

The definition provides clarity on what ACP is and what it is not. ACP is:

- not a single event but a process
- not about an individual signing a form but a dialogue of patients with their healthcare providers and loved ones (family, important others as defined by patients, which may include close friends, religious leaders, or other persons important to the patient)
- not reliant on a ‘Western individualistic concept of autonomy’ but an international concept of relational autonomy, when the kind of influence human relations may have on individual decisions is defined by the person in need of (future) treatment and care
- not about refraining from life-sustaining treatments but rather fostering informed consent to future goals of care and treatment
- not about a negative, defensive right to non-interference but a positive right to receive care based on valid informed consent via a shared decision-making process supported by all caregivers
- not about end-of-life care (only) but about care in situations in which the patient is incapable of decision-making themselves.

1.2. Advance Care Planning: International experiences with its implementation

Based on this understanding, ACP has been further developed as an evidence-based, empirically validated complex intervention on all levels of a national healthcare system to foster goal-concordant care in persons acutely, temporarily, or constantly not able to participate in decision-making. It is currently implemented in culturally adapted ways in numerous and various countries in the Americas, Asia, Europe, Africa, Australia, and the Pacific.[6]

R.L. Sudore, M. Connolly et al., Definition and Recommendations for Advance Care Planning: An International Consensus Supported by the European Association for Palliative Care, ‘Lancet Oncology’ 2017, vol. 18, pp. e543–e551.

[5] P.A. Singer, G. Robertson, D.J. Roy, Bioethics for Clinicians: 6. Advance Care Planning, ‘CMAJ: Canadian Medical Association Journal’ 1996, vol. 155, p. 1689.

[6] See, e.g., S.Y. Cheng, C.P. Lin, H.Y.L. Chan, et al., Advance Care Planning in Asian Culture, ‘Japanese Journal of Clinical Oncology’ 2020, vol. 50, pp. 976–989, www.acp-i.org (19.07.2023).

Although there are national and regional differences, as is true for all complex interventions, some legal prerequisites and fundamental core elements known to be essential to foster patient-centred care in situations of incapability in decision-making, including emergencies, intensive and end-of-life care, as well as care for the elderly in nursing homes or at home, are widely accepted.[7] These elements include:

1. The legal recognition of the respect for autonomy in situations where persons are incapable of decision-making
2. A legal right of persons to define a surrogate decision-maker and to write legally binding advance directives
3. A whole-system approach, including:
    a) grass root-level initiatives ('caring communities') and national conversation days and weeks to talk about 'what matters most', 'what is important', and 'what should never happen' with regard to a flourishing life, a serious illness, and when it comes to the end of life
    b) a high-quality PC service available in all areas of the healthcare system
    c) high-level generic and specific inter-professional ACP communication skills training for eliciting the goals of care and promoting shared decision-making
    d) excellent written documentation and tools (advance directives, including regionally (or, better, nationally) validated, legally recognized, and respected emergency orders, signed by patients, surrogates, and physicians) that should best be stored in electronically available patient records to be easily found in any healthcare institution and setting where a patient is treated
    e) refunding of ACP processes by health insurance
    f) skilled regional and national coordination of ACP implementation.

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[7] See, e.g., C.H.M. Houben, M.A. Spruit, M.T.J. Groenen, et al., Efficacy of Advance Care Planning: A Systematic Review and Meta-Analysis, 'Journal of the American Medical Directors Association' 2014, vol. 15, pp. 477–489; A. Brinkman-Stoppelenburg, J.A.C. Rietjens, A. van der Heide, The Effects of Advance Care Planning on End-of-Life Care: A Systematic Review, 'Palliative Medicine' 2014, vol. 28, pp. 1000–1025; J. Gilissen, L. Pivodic, T. Smets, et al., Preconditions for Successful Advance Care Planning in Nursing Homes: A Systematic Review, 'International Journal of Nursing Studies' 2017, vol. 66, pp. 47–59; C.A. Austin, D. Mohottige, R.L. Sudore, et al., Tools to Promote Shared Decision Making in Serious Illness: A Systematic Review, 'JAMA Internal Medicine' 2015, vol. 175, pp. 1213–1221; M. Butler, E. Ratner, E. McCreedy, et al., Decision Aids for Advance Care Planning: An Overview of the State of the Science, 'Annals of Internal Medicine' 2014, vol. 161, pp. 408–418.

1.3. What happens if Advance Care Planning is taken seriously?

There is ample evidence that most of us – including physicians – want to die a peaceful death. For some, this may be ‘while sleeping, quick and sudden’, and for others, ‘conscious until the end, after a last goodbye’. For most, death at home or in a place chosen by the severely ill person is preferable. Complex symptoms like pain, anxiety, hunger, or thirst should be well managed, and existential and spiritual needs addressed with the person surrounded by loved ones who are not themselves severely traumatized by the treatment and death, believing care to be concordant with the person’s values until the end. This is how Pope Benedict and Pope John Paul II died; this is how physicians most probably die – but not ‘the rest of us’.[8] ‘Normal patients’, especially in industrialized countries without ACP and with no strong PC service in place [9], often die:

- in institutions (hospitals, nursing homes)
- increasingly in intensive care units
- without their needs and wishes concerning the goals of care being recognized
- often without adequate symptom control
- with no order ‘not to resuscitate’
- admitted only days or hours before a foreseeable death.

A ‘physician death’, with adequate symptom control and care outside of institutions, is, however, only possible if decisions have already been made (e.g. not to call the ambulance, not to resuscitate, no transfer to hospital), discussed, and shared among the family and treating physicians, with a symptom-management emergency plan including appropriate medication in place. The current evidence reveals that when high-quality ACP is offered to elderly and severely ill patients by facilitators (who can be physicians, nurses, chaplains, lawyers, or social workers) who are knowledgeable about medical care services and have training in ACP, including specific communication skills, individual treatment is in fact considered as being more concordant with patients’ goals of care, families are less traumatized, and persons receive higher quality PC.[10]

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[8] Cancer World Archive, How Doctors Die: It’s Not like the Rest of Us, But It Should Be, https://archive.cancerworld.net/featured/how-doctors-die/ (07.01.2023).

[9] For national differences, see The Economist Intelligence Unit, The Quality of Death: Ranking End-of-Life Care across the World, 2015. https://impact.economist.com/perspectives/sites/default/files/2015 EIU Quality of Death Index Oct 29 FINAL.pdf (11.08.2023)

[10] K.M. Detering, A.D. Hancock, M.C. Reade, et al., The Impact of Advance Care Planning on End of Life Care in Elderly Patients: Randomised Controlled Trial, ‘British Medical Journal’ 2010, vol. 340, p. 847; T. Krones, A. Budilivschi, I. Karzig, et al., Advance Care Planning for the Severely Ill in the Hospital: A Randomized Trial, ‘BMJ Supportive and Palliative Care’ 2019, vol. 12, pp. E411–E423.

If ACP is implemented across the whole spectrum of care, this leads not only to more goal-concordant care and less traumatized relatives but to decreasing healthcare costs.[11] This process starts with healthy individuals defining a surrogate decision-maker, utilizing freely available decision aids, such as advance directive apps or programs, and 'first step facilitators' (trained lay facilitators within the community) talking to the family about 'what matters most' and 'do's and don'ts', with care adapted and revised by their healthcare providers as health deteriorates. These results are clearly important from an ethical point of view, as cost-effective, patient-centred care is important when the previously mentioned bioethical principles – autonomy, non-maleficence, beneficence and justice, and public health ethical perspectives – are taken into account.

Unfortunately, sometimes ACP can be misunderstood as 'rationing', 'letting people die', or even as resembling 'death panels', but, on the contrary, ACP supports patients to come to valid choices based on deep-rooted beliefs with regard to their personal goals of care. There are very old, severely ill patients undergoing ACP who still choose intensive care intervention until there is no medical possibility for life-prolonging treatment (sometimes called 'medical futility'). However, good examples of intensive palliative care instead of intensive care provided in an ICU do exist, from New Zealand to Brazil and from South Africa to Norway.

2. Advance Care Planning: Experiences from Switzerland

A rapid review of the literature shows that Switzerland has had significant investment in the development, understanding, and application of ACP. A range of projects across the lifespan, including perinatal, disease-specific, and older person care in a range of clinical settings, attests to the professional and public interest in the topic, supported by legislative changes at the federal level, which have helped to establish the principle of ACP as a strategic element of optimal healthcare delivery.[12] This said,

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[11] B.J. Hammes, M.R. Warner, M.O. Leavitt, Having Your Own Say…, *op. cit*.; B. Zhang, A.A. Wright, H.A. Huskamp, et al., Health Care Costs in the Last Week of Life: Associations with End-of-Life Conversations, 'Archives of Internal Medicine' 2009, vol. 169, pp. 480–488; C. Klingler, J. In Der Schmitten, G. Marckmann, Does Facilitated Advance Care Planning Reduce the Costs of Care near the End of Life? Systematic Review and Ethical Considerations, 'Palliative Medicine' 2016, vol. 30, pp. 423–433.

[12] L. Garten, K. von der Hude, T. Strahleck, et al., Extending the Concept of Advance Care Planning to the Perinatal Period, 'Klinische Pädiatrie' 2020, vol. 232, no. 5, pp. 249–256; E. Sukockienė, R. Iancu Ferfoglia, M. Boegli, et al., Early Advance Care Planning in Amyotrophic Lateral Sclerosis Patients: Results of a Systematic Intervention by a Palliative Care Team in a Multidisciplinary Management Programme – a 4-Year Cohort Study, 'Swiss Medical Weekly' 2021, vol. 151, p. w20484; K. Hecht, T. Krones, T. Otto, et al., Advance Care Planning in schweizerischen Alters- und Pflegeheimen: Ergebnisse einer Fokusgruppenstudie, 'Praxis' 2018, vol. 107, no. 20, pp. 1085–1092; F. Hotzy, K. Cattapan, A. Orosz, et al., Psychiatric Advance Directives in Switzer-

the Swiss context of ACP presents particular challenges for a multicultural and multilinguistic country, which impact on the potential to implement national initiatives at a political level.

An important element that underpins understanding of how ACP works in Switzerland is the context of political governance. Whereas most countries regulate policies at a national level, Switzerland's cantonal system permits many decisions, including those related to health and well-being, to be mediated at the local level. This means that most national policies must be ratified at the municipal level, and hence there can be wide variability in how national strategies are applied and interpreted. As an example, although specific legislation related to ACP was formally ratified in the Swiss Civil Code in 2013, Geneva had already implemented legislation on ACP as early as 1996.[13] Therefore, the development and implementation of ACP in Switzerland are variable by region and policy.

Legislation in 2013 specifically clarified the legally binding character of advance directives.[14] In particular, it made it mandatory for medical practitioners to act in accordance with the wishes expressed in a patient's advance directive. The legislation was derived from Switzerland's ratification of the Council of Europe's Oviedo Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine.[15] This legislation seemed to be a starting point for ACP discussion across the country, and many Swiss studies looking at the uptake of, facilitators of, and barriers to ACP relate to that point in time. A second important development that has supported the discourse on ACP has been the establishment of national strategies on dementia and PC.[16] Both strategies emphasize the importance and value of ACP as an early intervention for care planning, particularly for older, frail populations. Despite the regional differences cited earlier,

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land: Knowledge and Attitudes in Patients Compared to Professionals and Usage in Clinical Practice, 'International Journal of Law and Psychiatry' 2020, vol. 68, p. 101514; C. Meier, S. Vilpert, G.D. Borasio, et al., Perceptions and Knowledge Regarding Medical Situations at the End of Life among Older Adults in Switzerland, 'Journal of Palliative Medicine' 2023, vol. 26, no. 1, pp. 35–46.

[13] Recueil official systématique de la législation genevoise, Loi Genevoise, K1.30, art. S.3.1996; Conseil Fédérale, Message concernant la modification du code civil Suisse, 'Feuille fédérale' 2006.

[14] S. Haesen, D. Shaw, Directing Citizens to Create Advance Directives, 'Swiss Medical Weekly' 2018, vol. 148, p. w14628.

[15] *Ibidem*; Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, European Treaty Series No. 164, https://rm.coe.int/168007cf98 (19.07.2023).

[16] Federal Office of Public Health, National Platform Dementia, http://www.nationaldementiastrategy.ch; Federal Office of Public Health, Palliative Care Strategy, https://www.bag.admin.ch/bag/en/home/strategie-und-politik/nationale-gesundheitsstrategien/strategie-palliative-care.html (19.07.2023).

these particular strategies seem to be better implemented nationally and so help to raise the profile of ACP.

To support these discussions, the Swiss Academies of Arts and Sciences and the Office of Public Health have developed a multi-professional, multi-agency working group to steer the implementation of ACP and address priorities. A model for the advancement of ACP in Switzerland was made available for public consultation (which concluded in the summer of 2022) and is currently under expert review and evaluation. It is proposed that future thematic working groups will focus on specific elements to improve access and consolidate quality standards.[17]

Despite these positive developments, challenges remain in the establishment of ACP in the country. Switzerland has three linguistic regions (German, French, and Italian) and, within that, a series of dialects (notably in the German-speaking region), a situation that can, in and of itself, inhibit the transfer of information. Literature highlights the disparity across the regions in terms of knowledge and action (i.e. understanding versus the actual preparation of an advance directive). Generally, understanding of ACP and advance directives is high – nearly 80% of adults over 55 report having heard about ACP, with the lowest awareness in the French-speaking region.[18] Indeed, studies consistently report a lower understanding of ACP and uptake of advance directives in the Francophone areas. Estimates suggest that although up to 70% of the population have thought about an advance directive, only 20% of the population have actually written one. The reasons for this may be cultural, linked to religious views, or, indeed, due to uninformed healthcare professionals reluctant or without the skills to address ACP with their patients. An observation by Bosisio et al. suggests that a range of issues have prevented the establishment of ACP despite legislative support – a focus on perfecting a written document rather than a process of decision-making, misunderstanding about the authenticity and validity of the document and its application in complex clinical situations.[19]

Switzerland has universal and regulated healthcare, but basic private health insurance is compulsory for all Swiss residents. Insurance is available to everyone, regardless of their age or medical condition. Government subsidies are available to help those on low incomes pay for their insurance. The high quality of the healthcare

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[17] Planification anticipée concernant la santé, Propositions pour la mise en œuvre, mai2021/OFSP/ASSM, https://www.samw.ch/en/Ethics/Topics-A-to-Z/Advance-care-planning.html; Informations complémentaires sur le modèle de mise en œuvre de la planification anticipée concernant la santé, mai2022/OFSP/ASSM, https://www.samw.ch/en/Ethics/Topics-A-to-Z/Advance-care-planning.html (19.07.2023).

[18] S. Vilpert, C. Borrat-Besson, J. Maurer, et al., Awareness, Approval and Completion of Advance Directives in Older Adults in Switzerland, 'Swiss Medical Weekly' 2018, vol. 148, p. w14642.

[19] F. Bosisio, R. Jox, L. Jones, et al., Planning Ahead with Dementia: What Roles Can Advance Care Planning Play? A Review of Opportunities and Challenges, 'Swiss Medical Weekly' 2018, vol. 148, p. w14706; S. Haesen, D. Shaw, Directing Citizens…, *op. cit.*

system should, in theory, support implementation policies. However, Switzerland is also a country of immigration, albeit largely economic. This means that gaps exist in healthcare provision, access to information, and the understanding of some residents regarding rights and responsibilities, including how to communicate wishes and desires.

Some local projects, in partnership with national agencies such as ACP Swiss, foster dialogue between professionals and the public regarding ACP.[20] Project PROSA (*Projet de soins anticipés*) in the Canton de Vaud provides training and information for the public, patients, and professionals on how to plan and manage ACP and has shown positive results in terms of preparing advance directives based on Swiss legislation and legal parameters.[21] In addition, as mentioned earlier, work on ACP for specific conditions is also underway, for example, in the case of amyotrophic lateral sclerosis (ALS) but also in wider healthcare situations.[22] For the future, an article by Haesen and Shaw highlights a range of challenges that need to be addressed if ACP is to be implemented successfully.[23] These include:

- ensuring the knowledge base and communication skills of healthcare professionals so that they can advise, guide, and support people to understand the benefits, and enact ACP and advance directives when desired
- understanding the factors which facilitate or mitigate against the choice of ACP and finding solutions to address these (for example, public health measures to promote community dialogue, 'death café' meetings, etc.)
- challenging misconceptions that ACP and advance directives are only about the refusal of treatment rather than positive and personal choices about wishes and desires.

There is momentum within political and healthcare circles to develop dialogue and practice around ACP. The unique political governance of Switzerland has an impact on the implementation and roll-out of ACP, but the principles of choice, self-determination, and respect for choice are embedded in the Swiss psyche and bode well for future engagement and dialogue on this topic.

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[20] See https://acp-swiss.ch (20.07.2023).

[21] See https://www.projetdesoinsanticipe.ch/info (20.07.2023).

[22] E. Sukockienė, R. Iancu Ferfoglia, M. Boegli, et al., Early Advance Care Planning…, *op. cit.*; T. Krones, A. Budilivschi, I. Karzig, et al., Advance Care Planning…, *op. cit.*; R.J. Jox, F. Bosisio, E. Rubli Truchard, Demenz aus palliativmedizinischer Perspektive: Warum ein krankheitsspezifisches Advance Care Planning wichtig ist, 'Therapeutische Umschau' 2018, vol. 75, no. 2, pp. 105–111.

[23] S. Haesen, D. Shaw, Directing Citizens…, *op. cit.*

3. Advance Care Planning: Experiences from Australia

In Australia, since the early 1990s there has been legislative interest in the law and practice relating to death and dying. The Consent to Medical Treatment and Palliative Care Act was passed in South Australia in 1995.[24] It has been pivotal to the legal and ethical framework that underpins the modern practice of PC with 'the public policy imperative to relieve pain and suffering and avoid prolongation of the dying process',[25] and to provide a mechanism for people to appoint an adult person to be their medical decision-maker or 'give a voice' if or when they are unable to exercise this themselves, and to detail limitations to future care that does not align with their values and wishes. It clearly moves the decision-making power from a paternalistic medical model to a collaborative one, with a strong respect for the autonomy of the patient even if they have lost the ability to participate in decisions themselves. It does not give a right to demand treatments. The documents and appointments are not discretionary upon medical practitioners but have legal status and the potential for sanctions. In South Australia in 2013, further refinements and clarifications to the law were made in the Advance Care Directives Act 2013.[26] This act enables a person to make decisions and give directions in relation to their future healthcare, residential and accommodation arrangements, and personal affairs; to provide for the appointment of substitute decision-makers to make such decisions on behalf of the person; to ensure that healthcare is delivered to the person in a manner consistent with their wishes and instructions; to facilitate the resolution of disputes relating to advance care directives; and to provide protections for health practitioners and other persons giving effect to an advance care directive.[27]

There was considerable misunderstanding and anxiety in the 1990s, and the parliamentary process to enact this legislation was not straightforward. The intent was to facilitate the documentation of a person's values and limitations regarding future care, but there was concern that the intention was to enact euthanasia by stealth. More than 25 years of clinical practice following the introduction of this legislation demonstrates this was not the intention nor the result.

A properly executed advance care directive gives certainty to medical staff when limiting or withdrawing burdensome or ineffective treatments. It gives certainty

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[24] South Australia, Consent to Medical Treatment and Palliative Care Act 1995 (Version 29.3.2015), https://www.legislation.sa.gov.au/__legislation/lz/c/a/consent%20to%20medical%20treatment%20and%20palliative%20care%20act%201995/current/1995.26.auth.pdf (16.01.2023).

[25] See M.A. Ashby, Natural Causes? Palliative Care and Death Causation in Public Policy and the Law, Doctor of Medicine thesis, University of Adelaide 2001, https://digital.library.adelaide.edu.au/dspace/handle/2440/38237 (16.01.2023).

[26] South Australia, Advance Care Directives Act 2013 (Version 14.12.2017), https://www.legislation.sa.gov.au/__legislation/lz/c/a/advance%20care%20directives%20act%202013/current/2013.10.auth.pdf (16.01.2023).

[27] *Ibidem.*

about who should be consulted about decisions, particularly at the end of life. It clearly places personal autonomy in decision-making as the dominant philosophy. The intention was also to encourage discussions within society and families about values, wishes, and limitations to care, and ultimately about death and dying. Recent research suggests that greater benefit would result from framing advance care directives in terms of end-of-life values but also framing them within the individual's health trajectory. This would require significant medical input as well as clarity about properly executed documentation.[28]

The uptake of advance care directives has not been without difficulty. The original intention was that the documentation could be completed without the aid of lawyers, and extensive information packs were developed. Criticisms of these and of the process include a need for a willingness to discuss the possibility of death and to have significant health and general literacy.[29] There is also a need to have an understanding of the extent, likely outcomes, and success of medical interventions in any given clinical scenario.

There are still relatively low levels of completion.[30] There is uncertainty about where the document should be stored and difficulties with retrieval; it relies on family members advocating for the document's existence. A document also cannot anticipate every future possible scenario. The appointment of a health-literate, responsible person as a 'substitute decision-maker' who understands the patient's wishes and desires is of pivotal importance. There is evidence of misunderstanding not only within society but by healthcare providers, relating to the purpose and legislative status. There is a need for continuing facilitation of the process. Early implementation involved dedicated staff to assist in the education of clinical staff and, for the public, to facilitate access to documents and to aid completion. Continuing support for the process with education would ensure a better understanding and uptake. The desire is to respect an individual's choices and to allow the refusal of health interventions that may be perceived as burdensome; it is to respect patient choice, not to facilitate an active end of life.

Advance care directives, if legislated, enshrine the right for individuals to be able to engage in decisions about their care, to refuse treatments that they perceive as burdensome, and to appoint someone to speak for them in the event of a loss of capacity.

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[28] G.B. Crawford, K. Hodgetts, T. Burgess, et al., Documenting Plans for Care: Advance Care Directives and the 7-Step Pathway in the Acute Care Context, 'BMC Palliative Care' 2021, vol. 20, no. 1, pp. 1–9.

[29] B.F. Murphy, What Has Happened to Clinical Leadership in Futile Care Discussions? 'Medical Journal of Australia' 2008, vol. 188, no. 7, pp. 418–419, https://doi.org/10.5694/j.1326–5377.2008.tb01690.x.

[30] K. Buck, L. Nolte, M. Sellars, et al., Advance Care Directive Prevalence among Older Australians and Associations with Person-Level Predictors and Quality Indicators, 'Health Expectations' 2021, vol. 24, no. 4, pp. 1312–1325.

There are benefits for the individual and the health system, and indeed for all of society.

4. The effectiveness of a patient's pro futuro statements as a basis for the legality of medical acts according to Polish law

A healthcare professional may be faced with a dilemma as to which value to give primacy to: the health and life of the patient or their right to self-determination. Such a collision occurs when a patient requires a medical intervention to which he or she does not consent. Doubts in this regard are compounded when the patient is in a state in which they cannot make or express a decision (e.g. they are unconscious) and has previously made a declaration as to the direction of medical action, in particular that they oppose certain interventions. The medical professional then has to decide whether such a declaration is effective and can form the basis for abandoning rescue attempts. This dilemma not only has a theoretical dimension but also important practical implications. On the one hand, performing a medical procedure without the patient's consent may justify the legal liability of the medical professional (civil,[31] professional,[32] and even criminal),[33] while, on the other hand, failure to take the necessary medical actions may also result in liability. In particular, if the medical professional has the status of a guarantor, they may be liable for a crime against the life or health of the patient committed by omission (e.g. under Article 160 of the Penal Code, for exposure to imminent danger of loss of life or grievous bodily harm). A medical practitioner should therefore have the appropriate legal instruments to resolve this dilemma and thus have a clear direction for their actions. Such a regulation would also guarantee the legal security of both the patient and the medical professional. However, Polish legislation currently lacks such a norm. Solutions in this area can therefore be sought by resorting to various formulations arising from either general or medico-legal regulations.

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[31] In particular, the basis for asserting claims may be Article 4(1) of the Act of 6 November 2008 on Patients' Rights and the Ombudsman for Patients (Journal of Laws 2022, item 1876, as amended), which entitles a patient to claim monetary compensation for a culpable violation of a right, and thus also the right to decide whether to undergo a medical procedure, which arises, among other things, from Articles 15–19 of this Act.

[32] Performing a procedure without the patient's consent can be qualified as so-called professional misconduct, for which medical professionals are liable to a corporate court (see, for example, Article 53 *et seq*. of the Law of 2 December 2009 on Medical Chambers, Journal of Laws 2021, item 1342, as amended).

[33] According to Article 192.1 of the Penal Code, performing a medical procedure without the patient's consent is a misdemeanour punishable by a fine, restriction of freedom, or imprisonment for up to two years.

Prima facie, there is a temptation to reach for the institution of a state of superior necessity,[34] the application of which would justify the violation of one of the consolidated positives having a lesser social value. In the present case, the life and health of the patient and his/her freedom to decide whether to undergo a medical procedure remain in contention. In terms of the axiological system adopted in Poland, natural life and health are more valuable than freedom. This thesis is confirmed by the dimension of punishment provided for crimes against life, health, and freedom. In the latter case, the sanctions are more lenient, and moreover, the crime of performing a medical procedure without the patient's consent is prosecuted by motion. However, the literature rejects the possibility of performing a procedure against the patient's will and justifying such actions with the invoked formulation. Sawicki spoke against its application as early as the 1960s, arguing that the invocation of a state of superior necessity would make 'the patient's right to an autonomous decision illusory and fictitious in practice'.[35] Similar views are also propounded today. Indeed, it is argued that invoking this institution would in fact lead to coercive treatment. This is because, in any case, a medical professional could consider that there is a need to save at least the patient's health, which is objectively a higher value than freedom, and thus carry out the procedure even against the patient's objection. Such a course of action, on the other hand, would be incompatible with the assumptions underlying the patient's right to self-determination, which have found expression even at the constitutional level and have been included in many medico-legal norms dedicated to the autonomy of the patient.[36]

Moreover, such a solution would be unacceptable for the sake of protecting the legal security of physicians. This is because, recognizing that a medical professional in such circumstances could make decisions, s/he would be held responsible for them. Assuming, on the other hand, that the relationship between the patient and his/her medical professional is based on the principles of partnership, the burden of this responsibility is distributed. After all, it is the task of the medical professional to explain the patient's medical situation in detail, but the latter makes the choice to undergo treatment and its specific method.[37] Jurisprudence indicates that the patient

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[34] Such a solution is provided for in both civil law (Article 424 of the Civil Code) and criminal law (Article 26 of the Criminal Code).

[35] J. Sawicki, Przymus leczenia, eksperyment, udzielanie pomocy i przeszczep w świetle prawa, Warsaw 1966, p. 84.

[36] Cf. A. Zoll, Stan wyższej konieczności jako okoliczność wyłączająca przestępczość czynu w praktyce lekarskiej, 'Prawo i Medycyna' 2005, vol. 2, p. 10. See also T. Dukiet-Nagórska, Stan wyższej konieczności w działalności lekarskiej, 'Prawo i Medycyna' 2005, vol. 2, p. 28.

[37] This position is presented in the jurisprudence. To exemplify, one can cite the Judgment of the Court of Appeal in Gliwice of 25 April 2018, IV SA/Gl 1203/17, Lex No. 2497044, in which the Court instructed that 'it is up to the doctor to choose the method of action (treatment or examination), and the patient has the right to accept or refuse to accept one or another therapy. After all,

then assumes the risk of such treatment so it does not burden the medical professional.[38] The invocation of a state of superior necessity could also lead to the instrumental treatment of a person's life and health, justified by the need to protect the public interest. Such an attitude, however, would disrupt the partnership relationship between the patient and the medical professional, undermine the patient's trust in their medic, and even lead to dangerous consequences straight out of the Third Reich. The application of the institution of a state of *force majeure* is also opposed by certain dogmatic assumptions. First of all, this formulation is applicable when two positives in conflict belong to different entities. In the situation in question, however, their possessor is the same person – the patient. Thus, if s/he does not wish to maintain a given positive, this cannot be done coercively, as it is reasoned that 'criminal law does not accept the principle of making people happy against their will'.[39]

From this brief overview, it is clear that the patient's will has primacy in the analysed situation. Indeed, the right to self-determination in Polish legislation is treated affirmatively. It is derived, among other things, from Article 31(1) of the Polish Constitution, which guarantees the legal protection of human freedom, as well as from Article 41(1), according to which everyone is guaranteed personal integrity and freedom. Patient autonomy is further described in a number of medico-legal norms, and in particular, this right is guaranteed in Articles 15–19 of the Act on Patients' Rights and the Ombudsman for Patients. These provisions, in turn, from the side of duty, correspond to regulations in the professional acts that normalize various medical professions. They impose the obligation to gain consent and also define the conditions for its legal effectiveness.[40] Violation of this right, as already mentioned, can be the basis for the multifaceted liability of a medical professional, even criminal liability under Article 192 of the Criminal Code. The medico-legal regulations also precisely indicate cases of compulsory treatment and the possibility of performing the procedure with so-called implicit consent. In the latter case, the decision-maker is the doctor, and at the heart of this formulation is the assumption that the patient, guided by the instinct of self-preservation, would approve of any action necessary to save his/her life and health.

These norms were introduced in the spirit of the principle of proportionality, proclaimed in Article 31(3) of the Polish Constitution, and form an exception to the

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it is the subject's health and life that are at stake in any treatment. It is also always the patient who bears the consequences of the choice made' [author's emphasis].

[38] See the Judgment of the Court of Appeal in Szczecin of 11 May 2017, I ACa 560/15, Lex No. 2376937, and the Judgment of the Court of Appeal in Katowice of 18 January 2017, V ACa 146/16, Lex No. 2233014.

[39] E. Zielińska, Odpowiedzialność zawodowa lekarza i jej stosunek do odpowiedzialności karnej, Warsaw 2001, pp. 378–379, and the letter given there.

[40] See, e.g., Articles 31–35 of the Act of 5 December 1996 on the Professions of Physician and Dentist, Journal of Laws 2022, item 1731, as amended.

principle of respect for the autonomy of the patient. In turn, according to the rule of *exceptiones non sunt extendendae*, such exceptions must not be interpreted broadly, and furthermore, these regulations do not directly refer to the possibility of making *pro futuro* declarations and do not regulate the effectiveness of such declarations. Thus a question arises about the possibility of invoking such a declaration and taking or not taking certain medical actions in accordance with the patient's will expressed in such a declaration. In Polish medico-legal practice, this issue is considered mainly in respect to objections made by Jehovah's Witnesses with regard to procedures combined with the administration of blood. This is also the context in which the issue was considered by the Supreme Court. However, it is of a more universal nature, since *pro futuro* declarations, especially the so-called *pro futuro* objection, can be made on the basis of various motivations, not necessarily religious. Note that such a statement does not have to be justified by the declarant, and the medical professional is not entitled to demand an indication of the motives for such a decision. Nevertheless, as mentioned, the issue of declarations made by Jehovah's Witnesses lay at the heart of the statements of the judicature, which subsequently became a point of discussion in the doctrine. Indeed, in an order dated 27 October 2005, the Supreme Court ruled that 'a patient's statement expressed in the event of unconsciousness, specifying a will regarding the doctor's treatment of the patient in treatment situations that may arise, is binding on the doctor – if made explicitly and unambiguously'.[41] In its reasoning, the Supreme Court pointed out that

> the principle of respect for the patient's autonomy dictates that the patient's will must be respected, regardless of motives (concessionary, ideological, health, etc.), so it should be assumed that a patient's lack of consent to a certain procedure (type of procedure) is binding on the doctor and removes criminal or civil liability, while in the case of performing the procedure, it delegitimizes it.

However, the Supreme Court added that 'the patient's objection should be taken into account in particular when it was externalized in a clear and unambiguous manner, with awareness of the choice made and the preferences adopted, especially when the temporal connection between the statement and the procedure is sufficiently close'. The statement can therefore be seen as decreeing the effectiveness of *pro futuro* statements.

The views expressed by the Supreme Court have generally met with approval in the doctrine.[42] However, the issue is more complicated, which was also pointed out by those discussing the decision who, in principle, accepted its thesis. In particular, the wording used by the Supreme Court, namely that the statement must be 'clear' and

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[41] Order of the Supreme Court of 27 October 2005, III CK 155/05, OSNC 2006/7–8/137.

[42] See, e.g., J. Kulesza, Glosa do postanowienia Sądu Najwyższego z dnia 27 października 2005 r., 'Palestra' 2007, vols. 3–4, pp. 316–324; R. Tyminski, Glosa do postanowienia z dnia 27 października 2005 r. (III CK 155/05), 'Przegląd Sądowy' 2008, vol. 3, pp. 116–121.

'unmistakable', was pointed out as being evaluative. It was argued that judgments in this regard would be subjective and may be erroneous due to a need for urgent medical intervention, which would preclude a careful examination of the patient's will.[43] In addition, it was noted that there may be a discrepancy between the patient's decision expressed at the time of the declaration and at the time s/he requires the medical actions covered by such a declaration. Indeed, in the face of a threat to life or health, s/he could change his/her position. In a situation where the patient would still be able to make a decision and articulate it, it was therefore recommended that the medical professional make the final determination of the patient's will. If, on the other hand, s/he is unconscious or remains in other states that preclude the formulation and expression of a decision,

> it should be assumed that a doctor whose vocation is to save human life has the right and duty to make decisions to do so. […] The patient's right to self-determination should not be absolutized. Doubts in this regard should always be resolved in favour of saving life and health, exposing oneself even to the charge of disregarding the patient's will.[44]

On the background of the case under review, the doctrine has analysed in detail the very construction of *pro futuro* statements in terms of their admissibility, especially under civil law. Among other things, it was considered what the jurisprudential nature of this statement is; if it is part of a legal act, it would be a unilateral legal act. These, in turn, are permissible only if the regulations expressly allow them (the so-called *numerus clausus* principle). Given that *pro futuro* statements are not normalized, they would be inadmissible in light of this principle. In addition, their effectiveness was questioned in terms of the conditions of the legal relevancy of such declarations. This is because, recognizing that opposition to treatment is symmetrical in terms of its prerequisites with consent to medical intervention, its fundamental condition is its particularity and a combined awareness on the part of the declarant. Specificity means that the declarant refers in his/her statement to a specific medical intervention, a particular treatment. On the contrary, general declarations, authorizing an unspecified set of treatments, are not legally effective.[45] Specificity, however, is conditioned by the possession of relevant medical information showing the current state of the patient's health and his/her prospects in this regard. Thus, medico-legal regulations state as a basic right of the patient the right to obtain medical information (Article 9 of the of the Act of 6 November 2008 on Patients' Rights and the Ombudsman for Patients (Journal of Laws 2022, item 1876, as amended), which is matched

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[43] *Ibidem*, p. 118.

[44] A.T. Olszewski, I. Stańczyk, Glosa do postanowienia z dnia 27 października 2005 r. (III CK 155/05), 'Przegląd Sądowy' 2008, vols. 11–12, p. 221.

[45] Such a view is also expressed in the judicature. Cf. for example, the Judgment of the Court of Appeal in Krakow of 8 July 2016, I ACa 360/16, OSP 2019/7–8/67.

by the information obligation incumbent on medical professionals (e.g. Article 31 of the PHA). Medical information is provided adequately for the current health situation and allows the patient to compensate for deficits in medical knowledge in this respect, which in turn allows him/her to make a reasonable decision.[46] These prerequisites are not *eo ipso* fulfilled in the case of *pro futuro* declarations, which are made in the abstract, in isolation from the current need to obtain a health service. In turn, it is difficult to require that the declarant anticipate all possible situational options and refer to them in his/her statement. Moreover, as already mentioned, at the moment when medical intervention would be required, additional circumstances, such as a change in the state of medical knowledge, could occur, which could affect the patient's final decision; at the time of the declaration, the declarant did not have such knowledge, so his/her declaration would not have been sufficiently detailed and informed.[47]

To avoid this dilemma, the doctrine proposes that consent and objection should not be treated symmetrically. While the requirement to inform consent is a guarantee for patient autonomy, it would be absurd to introduce such a requirement for objection. After all, an objection need not be rationalized in any way. Moreover, additional requirements for objections could constitute restrictions on autonomy, 'since the addressee of the objection would thus gain an instrument for challenging the objection and a pretext for disregarding it'. The need for sufficient information before expressing an objection is 'a demand that is not feasible for purely technical reasons'. This is because *pro futuro* objections are based on anticipation, which cannot be precise.[48] Recognizing the admissibility of such statements, the form of such statements is also debatable. Since medico-legal regulations generally do not require any specific form for consent, such conditions cannot be placed on objections either. Thus they could be expressed freely, even orally. It is only important that the statement be made in a form that clearly indicates the will of the declarant. However, if it is made in writing, it should be signed in the certifier's own hand.[49]

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[46] This issue was pointed out by the Supreme Court in its Judgment of 24 September 2020, IV CSK 49/19, Lex No. 3057399. It explained that 'the attribution of the patient's right to information is intended to make it possible to compensate, to a certain extent, for the *deficit in the patient's medical knowledge*, and thus create the opportunity for a person to truly participate in the diagnostic and treatment process concerning his body. The provision of accessible information, as referred to in Article 31(1) in principio of the U.s.l. and Article 9(2) in principio of the U.s.p.l., thus becomes *a means of empowering the patient in his relations with the doctor*' (author's emphasis).

[47] See B. Janiszewska, Dobro pacjenta czy wola pacjenta – dylemat prawa i medycyny (uwagi o odmowie zgody na leczenie oraz o dopuszczalności oświadczeń pro futuro), 'Prawo i Medycyna' 2007, vol. 2, pp. 46–48.

[48] M. Boratyńska, Niektóre aspekty świadomej zgody pacjenta na leczenie na tle orzecznictwa Sądu Najwyższego. Część pierwsza. Sprzeciw pro futuro, 'Prawo i Medycyna' 2007, vol. 2, pp. 31–32.

[49] R. Tyminski, Glosa…, *op. cit.*, pp. 119–120.

From the review presented, it is clear that there are doubts in the doctrine about the admissibility of such statements; even if the authors are willing to recognize their effectiveness, the catalogue of conditions for their legal relevancy is debatable. Leaving aside the dogmatic considerations, it is also worth noting the practical and evidentiary aspects. In favour of the admissibility of such declarations, there is the question of the authorship of such a document (especially if it is provided by a third party) and the conditions for making the declaration, namely, whether the declarant did so freely, without any external pressure, whether they remained in a state in which they could express their will, and whether in the face of an imminent threat to life or health they would not change his mind. Doubts about these aspects may induce medical personnel to disregard the patient's statement and thus violate the patient's actual will. The cited position of the Supreme Court, referring to evaluative formulations, seems unsupportable in the context of the criteria for evaluating the conditions for the effectiveness of such declarations. In other words, it cannot provide clear guidance to medical personnel, who sometimes, in connection with the immediate need for medical intervention, must make decisions quickly without considering the legal uncertainties in detail. In this context, the need to regulate the matter in question appears.

It is worth adding that legislative attempts in this regard have already been made. For example, one can cite the Bill on Fundamental Human Rights and Freedoms in the Field of Applications of Biology and Medicine and the Bill on the Establishment of the Polish Bioethics Council.[50] Article 5(3) of the latter stipulates that 'the patient's previously expressed wishes regarding a healthcare service should be taken into account if the patient is unable to express their will at the time the service is performed'. This normalization thus referred to Article 9 of the Convention for the Protection of Human Rights and Dignity of the Human Being Regarding the Applications of Biology and Medicine. However, it was formulated rather vaguely, as it did not specify the prerequisites for the effectiveness of such a statement. In addition, in the context of respect for the patient's right to self-determination, it could have been questioned due to the optionality of the phrase 'shall be taken into account'. Thus, such a phrase suggested that the patient's position did not have to be respected and that the final decision would be made by the medical professional.

More explicit and specific were the solutions provided for in the Bill on the Protection of the Human Genome and Embryo and the Polish Bioethics Council and amendments to other laws brought to the Sejm on 25 August 2009.[51] As a result of this, it was planned to introduce new articles, 16a and 16b, into the Law on Patients' Rights and the Ombudsman for Patients, stipulating the formulation of a so-called 'living will'. Under these provisions, the it would be addressed to patients in immi-

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[50] This bill was submitted to the Sejm on 28 August 2009, Sejm print no. 3468.

[51] Parliamentary print no. 3467.

nent danger to life or health as a result of a severe terminal illness, who could make an appropriate declaration regarding the medical procedure for sustaining their life. The objection would have to be made voluntarily and knowingly in writing. The authorized subject would be a person of legal age previously informed of the severe terminal illness from which s/he suffers. The statement would be recorded in the patient's medical records. In addition, there were plans to launch a so-called Central Biomedical Registry, maintained in an onlinesystem, which would include entries about the objection made. Thanks to this, a medical professional would have easy access to this data and thus would be able to determine the patient's actual will. The objection could be withdrawn at any time, while its deletion would take place five years after the death of the person who made it. Despite the imperfections of this draft (e.g. limiting the possibility of making a declaration only in the case of a serious, incurable disease and thus omitting emergency situations even if caused by accident), this solution was a step in the right direction. Unfortunately, however, these legislative attempts failed, and ultimately the bill was not enacted. Thus the doctrine still calls for the introduction of an appropriate legal regulation that would, on the one hand, prejudge the admissibility of such declarations and, on the other, define the conditions for their legal relevancy. Such proposals have been made in the doctrine, with specific solutions.[52]

Thus, in the current state of the law, three situations should be considered: first, the patient's declarations made immediately prior to the planned procedure or anticipating the health situation, taking into account the patient's current state of health, especially severe terminal illness. In favour of respecting the patient's right to self-determination, it should be considered that such declarations are binding on the medical professional, even if the consequence of acting in accordance with the patient's wishes will be the omission of actions necessary to save their life. However, the medical professional should ascertain the patient's final decisions, warn them of the consequences of such a position, and seek to formalize it, for example in writing, which will reduce evidentiary doubts; if the patient maintains their will after being properly informed of the consequences of not undergoing a particular medical action (e.g. imminent death), the medical professional should comply. On the other hand, if the patient is in a state in which they cannot make therapeutic decisions and have not previously expressed their position, or alternatively the medical professional does not know their will, s/he should apply the procedures provided for in medico-legal regulations and thus either apply for court authorization to perform the procedure or, in the case of urgent medical intervention, follow the formulation of implied consent (Articles 33 and 34(7) and (8) of the Act on the Professions of Physician and Dentist). On the other hand, in a situation where a patient in a state precluding decision-mak-

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[52] See R. Karcz, Ochrona pacjenta przed niechcianą transfuzją w praktyce sądowej, 'Prawo i Medycyna' 2007, vol. 4, pp. 36–49.

ing and expression of will has previously made a *pro futuro* statement, the assessment will depend on the factual circumstances. However, if there are irremovable doubts as to the effectiveness of such a statement, it would seem that primacy should be given to saving the patient's life or health. This may, though, lead to a violation of the patient's actual will and thus to a violation of their right to self-determination. Therefore it is necessary to call for the introduction of appropriate legal regulation, unambiguously resolving the ways of proceeding in such situations. This is because, on the one hand, it will ensure that the patient's rights are respected, and, on the other, it will set a legally secure course of medical action. This is because the medical professional will know how to behave in such a situation in order to avoid potential liability for failing to provide treatment or performing a procedure without the patient's consent. A model for such a regulation can be the solutions proposed in the draft amendment to the Law on Patient's Rights and the Ombudsman for Patients discussed earlier, as well as those adopted in other legislation systems, as presented above.

Conclusions

It is clear from the comparative data given here that there are marked similarities in the experience of the development and implementation of Advance Care Planning, irrespective of jurisdiction. A common trend is that despite a legislative basis and good knowledge about the benefits of ACP, its uptake can be slow, which can be accredited to poor public health messaging, lack of skilled, trained personnel to deliver and sustain ACP initiatives, and misunderstanding of the practical application of an advance care plan or directive in real terms. Addressing each of these would be a prerequisite for successful national implementation.

Clear messages about the role of palliative and end-of-life care as a societal approach to caring well for all citizens need to be reinforced. Within this, it is critical that the positive benefits of ACP are endorsed and the negative aspects highlighted in this document are dispelled, in particular the misperception of ACP as a form of crypto-euthanasia. The overall benefit of well-prepared supported ACP to society is evident in those jurisdictions where it is well established. Successful implementation is based on dialogue, collaboration between legislators and healthcare professionals, and engagement with the public, patients, and caregivers to foster a greater understanding of the true meaning of self-determination.

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