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Review

Legal Aspects of Withdrawal of Therapy

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SUMMARY

The ability of intensive care to replace or support vital organ function has resulted in some patients surviving for long periods of time without improvement or a terminal event. In patients with no realistic chance of survival, decisions to withdraw or withhold life-sustaining therapies are commonly made.

Withdrawal of life support at the patient's request is lawful at common law and, in some states of Australia, by legal statute. In the intensive care setting though, it is more common for therapy to be withdrawn because the therapy is of no perceived benefit or not in the patient's best interests. However, in Australia there is little case law and very little legislation to direct the decision of whether to withdraw life-sustaining therapy on the grounds of futility or the patient's best interests.

The legislation that does exist in Australia, as well as law from other jurisdictions, largely places responsibility for the decision to withdraw therapy on the doctor in charge of the patient's care. However much weight is frequently placed on the wishes of the family.

Disagreements between family and clinicians over decisions to withdraw therapy are unusual and generally resolve over time. However if disagreement persists, it may be advisable to apply to the courts for a declaratory judgement, given the tenuous legal basis of withdrawal of life-sustaining therapy in Australia and the uncertainty over the courts' view of the role of the patient's family in the decision-making process.

Key Words: WITHDRAWAL OF THERAPY: revision of treatment, passive euthanasia, ethics, not for resuscitation, critical care, intensive care

With the increasing ability of intensive care to replace or support vital organ function, clinicians are often confronted with critically ill patients on invasive life support who have no realistic chance of recovery. For these patients further intervention will only serve to prolong the dying process with no definable benefit to the patient. In such cases decisions to withdraw or withhold life-sustaining measures are commonly made.

The process by which the decision to withdraw therapy is made varies widely between institutions and intensive care clinicians. No accepted guidelines exist in Australia for a standard practice in relation to withdrawal of therapy.

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The relatively informal approach to withdrawal of therapy that has been taken by doctors in Australia has been reasonably successful, in that it has resulted in very little legal challenge. As suggested by Sir Gustav Nossal: "The paucity of landmark cases on the "right to die" issue seems to reflect that the untidy, polyvalent, inchoate and unwritten methods of a diversified, free and humane society are working reasonably well"[1]. However the risk of this approach to such a sensitive issue is that it may lead to litigation at the behest of a relative who is disaffected or later reconsiders the role of the treating doctor in the withdrawal process[2].

This paper addresses the current practice of withdrawal of life-sustaining therapy. It considers the existing common and statutory law applying to these issues and specifically addresses the role of the patient and the patient's family in the withdrawal process.

THE PROBLEM

Intensive care is a relatively new specialty in medicine. It has evolved from the recognition that patients

with acute life-threatening illnesses or injuries receive better care if they are grouped in specific areas of the hospital. The rapid technological developments in the latter half of the twentieth century have enabled increasingly invasive vital organ support and have resulted in the successful treatment of patients who previously would have been unsalvageable.

The ability of intensive care to replace or support vital organ function has enabled dying patients to be supported for long periods of time without improvement or a terminal event. Thus death has become more of a process than an event[3]. As a result, in patients with no realistic chance of survival, withdrawal of life-sustaining measures may be necessary to allow the dying patient a peaceful and relatively dignified death. Published data show that 40-90% of intensive care unit deaths are preceded by decisions to withdraw or withhold therapy[4-7].

Decisions to withdraw therapy are generally made by the doctor caring for the patient, although occasionally the patient or patient's family may request withdrawal. The decision is based on considerations of the wishes of the patient, a realistic assessment of the probability of survival, the impact of therapy on the disease process, a subjective assessment of the patient's likely quality of life and the degree of discomfort acceptable to support this quality[8]. This process would be greatly facilitated if doctors were able to predict the patient's outcome. However, despite the vast amounts of time and expense invested in this area, the accuracy of outcome prediction remains inadequate for application in decisions to withdraw therapy.

A number of severity of illness models that provide an estimate of hospital mortality have been developed, including the Acute Physiology and Chronic Health Evaluation (APACHE) III, Mortality Prediction Model (MPM) II, Simplified Acute Physiology Score (SAPS) II and Paediatric Risk of Mortality (PRISM). However these scoring systems are based on population statistics and must be used with great caution when applied to individual patients[9-12]. The data derived from these scoring systems can provide useful but not determinative information for decision-making[13].

It is important to recognize that the decision to withdraw therapy is, in essence, a subjective one. Differences of opinions and values can exist not only between patients and physicians but also between different physicians[14]. Cook et al surveyed intensive care clinicians' proposed management approach to a number of clinical scenarios[15]. They showed that in choosing the level of care, the same option was chosen by more than 50% of respondents in only one of twelve scenarios and that opposite extremes of care were chosen by over 10% in eight of twelve scenarios. Thus while one physician may feel strongly about instituting or withdrawing life-sustaining therapy in a patient, an equally competent physician may completely disagree.

Disagreements between clinicians and patients or families over withdrawal of therapy are unusual. Generally physicians and the family recognize when a patient's prognosis becomes hopeless and the burden of therapy outweighs any potential benefit to the patient. If disagreement does initially occur it often resolves with time as the patient's lack of progress becomes clear. However disagreements can occur for a variety of reasons, including religious beliefs, unrealistic expectations, failure of communication or fear of litigation. Such disagreements are a source of considerable emotional and moral distress for health care workers and families alike. The options in these cases are to continue the perceived worthless therapy or to act against the wishes of the family. The former is costly, both fiscally and emotionally, and the latter is associated with the risk of legal challenge.

GROUNDS FOR WITHDRAWAL OF THERAPY

If a doctor withdraws or withholds life-sustaining therapy and this results in the death of the patient the doctor may be exposed to criminal liability.

Where there is a duty to treat (as exists between the doctor and patient) an omission to give appropriate treatment may be murder if the intention is to cause the death of the patient[16]. Lord Browne-Wilkinson in Airedale NHS Trust v Bland ("the Airedale case") stated: "In general an omission to prevent death is not a [criminal act] and cannot give rise to a conviction for murder. But where the accused was under a duty to the deceased to do the act which he omitted to do, such an omission can constitute the [criminal act] of homicide, either murder or manslaughter"[17].

Despite the principle that it is not lawful for a doctor to act (or omit to do an act) to bring about the patient's death, there are cases in which some omissions are lawful. These include circumstances where: (i) the patient has refused treatment; (ii) an agent, parent or guardian has refused on the patient's behalf; (iii) when the treatment is futile; and (iv) when the treatment is not in the patient's best interests. It is important to note when considering these circumstances in which withdrawal of life-sustaining therapy may be lawful that only some omissions can be lawful. While some actions are allowed in the

process of withdrawing treatment, these acts are treated as omissions. Acts that kill are never lawful.

The right of a competent patient to refuse therapy, even if that refusal will result in death, is well established in common law and is supported by legal statute in South Australia[18], Victoria[19], the Northern Territory[20], the ACT[21] and Queensland[22]. At common law only the patient has a right to refuse treatment[16]. However South Australia[18], Victoria[19], Tasmania[23], the ACT[21] and Queensland[24] have enacted legislation that enables a person with lawful authority (e.g. a medical power of attorney) to decide on the patient's behalf to withdraw therapy.

Advanced directives or medical powers of attorney give authority for medical treatment in the event that the individual is not competent to provide or refuse consent. However, often the legislation is fraught with interpretive difficulties. A medical power of attorney, for example, is merely an instrument or a means through which a person is able to give effect to the wishes of the patient. However it is of limited value when the patient's wishes are unknown to the agent. Whilst certain protections are built into each legislative scheme for the protection of the patient the limitations often prove cumbersome and limiting. For example, in Victoria an agent is able to complete a refusal of treatment certificate but:[19]

- "A medical practitioner and one other person must be satisfied that the agent has been fully informed of and understands the patient's condition.
- The agent may only refuse medical treatment if the treatment could cause unreasonable distress to the patient or there are reasonable grounds for believing that the patient, if competent and after giving serious consideration to their condition, would decide that the medical treatment is unwarranted."

In the clinical setting difficulties arise as to what amounts to "medical treatment" and which treatment is unwarranted. Other jurisdictions have similar issues. These types of legislation have been infrequently applied and have never been tested through the court system.

Alternative decision makers include the Guardianship Board or Tribunal of each state or territory and the Supreme Court exercising its parens patriae jurisdiction. Parens patriae allows the court to decide on proposed medical treatment for a child or a person who is mentally incapacitated, on that person's behalf[25].

In the intensive care setting withdrawal at the request of the patient or a person with lawful authority to decide on behalf of the patient is uncommon. Generally therapy is withdrawn because of considerations of futility or the patient's best interests.

WITHDRAWAL OF "FUTILE" TREATMENT

A number of judicial decisions in countries other than Australia have found it lawful for therapy to be withdrawn on the basis that the therapy was futile or the patient had no hope of recovery.

The Airedale case was a landmark case[17]. Anthony Bland was 17 years of age when he was injured in the Hillsborough soccer disaster and suffered chest injuries and severe hypoxic brain damage. He remained in a persistent vegetative state for over three years. With the agreement of his doctors and family, the Airedale NHS Trust (which was responsible for his care) applied to the court for his nasogastric feeding and other treatment to be ceased to allow him to die. The case was appealed to the House of Lords where Lord Goff found that the legal basis for withdrawing the treatment in such a case was the futility of continuing treatment when the patient has no prospect of benefiting from the treatment: "I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life, when such treatment has no therapeutic purpose of any kind, where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition."

In 1976 the New Jersey Supreme Court considered the case of Karen Anne Quinlan who was in a persistent vegetative state[26]. The court noted that developments in medical technology had "obfuscated the use of the traditional definition of death" and found that, if her family and guardian agreed and her physicians concluded that there was no reasonable possibility of recovery, the mechanical ventilator could be removed without civil or criminal liability.

In Auckland Area Health Board v Attorney General (Re L) the New Zealand High Court considered the case of a man, L, with severe Guillain-Barré syndrome[27]. L's wife and doctors and the Auckland Area Health Board applied for a declaration that ceasing mechanical ventilation would be a lawful act. Justice Thomas considered that the act of discontinuing the life support system would not of itself inflict "bodily injury" within the meaning of the Crimes Act so that the Act would not operate to make the doctors criminally responsible. Justice Thomas considered the value of continuing L's treatment if it had no therapeutic or medical benefit, and suggested that the life support system was used to "defer death rather than sustain life". The court found that "... doctors have a lawful excuse to discontinue ventilation when there is no medical justification for continuing that form of medical assistance."

In Northridge v Central Sydney Area Health Service ("the Northridge case") the New South Wales Supreme Court considered the case of a 37-year-old man who suffered hypoxic brain injury following a cardiac arrest secondary to a drug overdose[28]. The attending doctors assessed his prognosis as poor and, since he was "not going to make a recovery", further antibiotics and other treatments were considered to be futile. He was transferred from the intensive care unit and active treatment measures were withdrawn. The patient's sister objected to his management and applied to the New South Wales Supreme Court to intervene. The Court exercised its parens patriae jurisdiction to resolve the dispute. In doing so it held that it had the jurisdiction to protect the right of an unconscious patient to receive ordinary, reasonable and appropriate (as opposed to burdensome, futile or not in the best interests) medical treatment, sustenance and support. Justice O'Keefe found that problems existed with the patient's neurological assessment and prognostication, and that "the level of communication [between the doctors and patient's family] ... was less than adequate." He ordered that the patient "be provided with necessary and appropriate medical treatment directed towards the preserving of his life."

There are no Australian cases that support the withdrawal of therapy on the basis of futility.

WITHDRAWAL OF TREATMENT THAT IS NOT IN THE PATIENT'S BEST INTERESTS

There is some common law support for the withdrawal of therapy if the treatment imposes a burden on the patient that is not justified by the patient's prognosis or the treatment is not in the patient's best interests[16]. Clearly issues of best interests overlap with futility since it is not in the patient's best interests to be given futile treatment.

Lord Goff in the Airedale case stated that a doctor cannot "... be under an absolute obligation to prolong [the patient's] life by any means available to him, regardless of the quality of the patient's life [and] the doctor's decision whether to take any such step must ... be made in the best interests of the patient"[17].

Lord Browne-Wilkinson, also in the Airedale case, further expanded on this concept of the patient's best interests by stating, "If there comes a stage where the responsible doctor comes to the reasonable conclusion ... that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system"[17].

Justice Thomas in Auckland Area Health Board v Attorney General (Re L) considered that good medical practice should "... begin with a bona fide decision on the part of the attending doctors as to what, in their judgment, is in the best interests of the patient"[27].

In the recent English case of Re A the court considered permitting surgical separation of conjoined twins with the result that one twin would die[29]. It was argued in that case that the separation was in the best interests of the twins as one would be able to live a normal life but if not separated both would die within 3-6 months. The court approached the decision on the basis that it first had to decide where the twins' best interests lay and then, if the operation was in their best interests, whether the operation could be lawfully done. (If not, the death of one twin would be an unlawful killing.) The Judge held on appeal that it was right to conclude that the operation would be in one twin's best interests but that the only gain for the other twin from the operation would be to give her the bodily integrity and dignity which is the natural order for all people. The best interests of the twins was to give the chance of life to the child whose actual bodily condition was capable of survival even if that had to be at the cost of the other's life. The case demonstrates that best interest considerations are alive and well in judicial decision making. However there are no Australian cases supporting the withdrawal of treatment on the basis of the patient's best interests.

FUTILITY AND THE PATIENT'S BEST INTERESTS IN AUSTRALIA

It is clear that requests by the competent patient or patient's agent provide grounds for lawful withdrawal of therapy, as discussed above. However, in Australia if the incompetent patient has a terminal illness with no prospect of recovery, there is little case law and very limited legislation to direct doctors in their decision to withdraw life-sustaining therapy.

Legislation governing the provision or non-provision of medical therapy has limited application in these cases:[30]

The Victorian Medical Treatment Act[19] has no application if the patient has not signed a refusal of treatment certificate and has not appointed a medical agent.

The Australian Capital Territory's Medical Treatment Act[21] and the Northern Territory's Natural Death Act[20] are similarly deficient.

The South Australian Consent to Medical Treatment and Palliative Care Act[18] is helpful legislation relating to withdrawal of therapy in Australia, how-

ever, it only applies in South Australia. It states that: "A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness ... is, in the absence of an express direction by the patient or the patient's representative to the contrary, under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state." The Act does not include definitions for "moribund" or "persistent vegetative state". However, Justice O'Keefe in the Northridge case[28] cited the definition for persistent vegetative state established in the United Kingdom which requires that the patient has been in a continued vegetative state for more than 12 months following head injury or more than 6 months following other causes of brain damage[31]. The Act also introduces difficulties when there is disagreement between the "patient or the patient's representative" and the attending doctors, as will be discussed later.

The Queensland Guardianship and Administration Act states that "... a life-sustaining measure may be withheld or withdrawn for an adult without consent if the adult's health provider reasonably considers that the adult has impaired capacity [to decide for him/herself] and ... the continuation would be inconsistent with good medical practice"[22]. Good medical practice is defined as "... having regard to recognised medical standards, practices and procedures of the medical profession in Australia and ... recognised ethical standards."

In New South Wales no similar legislation exists. Guidelines were published by the New South Wales Department of Health in 1993 to regulate the withdrawal of life support[32]. These guidelines suggest that, in the absence of an advanced directive, the attending doctor can make the decision to withdraw therapy if the decision is in the best interests of the patient and after consultation with the family.

In Tasmania the Department of Community and Health Services in 1996 published "Dying with Dignity: Guidelines on the Care and Management of People who are Dying"[33]. If the patient is incompetent and no court order exists, the guidelines suggest that only requests to withdraw therapy "which is futile or too burdensome compared to its benefits should be acted upon". They further state: "Within these circumstances, treatment is not being withdrawn with the intention of bringing about the death of the patient, but because the treatment itself is futile or burdensome."

It can be seen from the discussion above that the existing legislation and guidelines provide limited and variable support for withdrawal of therapy. It should be noted that guidelines do not have the force of law and do not in themselves provide any recognized legal defence[30].

DOES THE FAMILY NEED TO AGREE?

In the Airedale case, Lord Goff quoted with approval the guidelines on Treatment of Patients in Persistent Vegetative State of the Medical Ethics Committee of the British Medical Association. These state that "generally the wishes of the patient's immediate family will be given great weight" but that "the relatives' views cannot be determinative of the treatment"[17]. Lord Goff concurred that otherwise "the relatives would be able to dictate to the doctors what is in the best interests of the patient, which cannot be right". However, he later stated that if the next of kin disagreed with the medical recommendation to withdrawal of treatment, the matter should be referred to the court for adjudication.

In Auckland Area Health Board v Attorney General (Re L) Justice Thomas made the concurrence of the next of kin one of the criteria required to make withdrawal legal[27]. In the United States the court in the Karen Anne Quinlan case required the concurrence of her guardian (her father) and her family in the decision to withdraw therapy[26].

A contrasting case occurred in Canada, where Manitoba's Court of Appeal supported the do-not-resuscitate order administered by the doctors of a 1-year-old child in a persistent vegetative state, contrary to the wishes of the child's parents[34]. The child had suffered severe head injuries as a result of parental child abuse, resulting in the persistent vegetative state. Justice Twaddle stated: "It is in no one's interests to artificially maintain the life of a ... patient who is in an irreversible vegetative state. That is unless those responsible for the patient being in that state have an interest in prolonging life to avoid responsibility for the death." Although this case appears to support the doctors' ability to overrule the parents, there were clearly other important considerations that influenced the judge's ruling. In Re G the English Family Court also found it lawful to withdraw artificial feeding despite the mother's objection[35]. Sir Stephen Brown stated: "I have no doubt that, although the mother's views must be taken into account they cannot prevent the course being taken which is considered to be in the best interests of the patient."

The New South Wales Supreme Court considered this issue in Marchlewski v Hunter Area Health

Service[36]. Maria Marchlewski's delivery was complicated by shoulder dystocia resulting in severe hypoxic brain injury. Despite medical advice that Maria's prognosis was so poor that continuation of life support was not in her best interests, her parents requested that treatment be continued. Her parents specifically directed the attending neonatologists not to remove life support without their consent. Maria was weaned from mechanical ventilation over 2 weeks. Twenty days after delivery the three neonatologists involved with her care decided that she was not a candidate for re-ventilation and recorded in the case notes that she should not be intubated in the event of a major cardiorespiratory event. This decision was made without consultation with or the consent of Maria's parents and was against their expressed wishes. Eleven days later she suffered a respiratory arrest. She was given continuous positive airway pressure but not reintubated and she died.

Of great note in this case, the defendant (the Hunter Area Health Service for the doctor and hospital) admitted breach of its duty of care on behalf of the doctor and non-delegable duty of care on behalf of the hospital to Maria's parents regarding her obstetric and neonatal care. The legal argument was therefore narrowed to the issue of what damages should be awarded and whether aggravated and exemplary damages were appropriate.

The defendant submitted: "In making decisions as to the treatment to be provided for Maria, the medical practitioners that were charged with her care owed their primary, and indeed only, duty to Maria and whilst consideration could be and was given to the wishes of [her parents] those wishes could not be allowed to dictate the provision of appropriate medical care to Maria." However Justice Dowd found that: "The Hospital had a duty to Maria but also to [her parents]. The failure to obtain either the parents' consent or approach a court for an order that the treatment be terminated constituted a total disregard for [her parents] notwithstanding what would appear to the Hospital to be a meaningless prolonging of human life." He further stated: "The fact that the decision not to re-ventilate Maria was made in her best interests is irrelevant to the question of whether aggravated damages should be awarded... The Hospital wilfully and deliberately disregarded the wishes of the parents ... It meant that the damage which the defendant has admitted was cruelly exacerbated." Given this, Maria's parents were awarded aggravated damages (i.e. damages awarded when the plaintiff has been subjected to an outrageous indignity, regardless of the defendant's intent[37]). Total damages awarded were $691,023.68 for Maria's father and $346,400 for her mother, plus costs.

The findings of a recent South Australian Coroner's Inquest ("the DellaTorre Inquest") also suggest that the court considers the patient's family has a significant role in the decision to withdraw therapy[38]. The Coroner stated: "It is vitally important that close family members understand the issues being discussed [in the decision to withdraw therapy] and their rights to be involved."

The most recent case to date is the Northridge case, discussed above[28]. In that case it appears that, at least initially, the Court was prepared to reverse the medical decision to withdraw treatment because of the objection of the patient's family.

As discussed earlier there is little statute law in this area, with the South Australian Consent to Medical Treatment and Palliative Care Act the only relevant legislation in Australia[18]. The Act states: "A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness ... is, in the absence of an express direction by the patient or the patient's representative to the contrary, under no duty to use or to continue to use life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state." If the double negatives are removed from this clause it may indicate that, in the presence of an express direction by the patient or patient's representative the medical practitioner is under a duty to continue life-sustaining therapy. The Act defines the "patient's representative" as "a person who is empowered by medical power of attorney or some other lawful authority to make decisions about the medical treatment of another when the other is incapable of making decisions for her/himself". However it does not define "other lawful authority". The Guardianship and Administration Act in South Australia regards an "appropriate authority" in issues of consent for incompetent adults to be a guardian appointed under the Act or "in any other case ... a relative of the person"[39]. Thus the patient's family may be empowered by this legislation to be involved in the decision to withdraw therapy and, presumably, to negate such a decision.

CONCLUSION

The ability of intensive care to replace or support vital organ function has resulted in some patients surviving for long periods of time without therapeutic benefit or a terminal event. As a consequence withdrawal of life-sustaining treatment has become

common in patients considered not to have a realistic chance of survival.

It is clear that withdrawal of life support at the patient's request is lawful at common law and, in some states of Australia, by legal statute. However, in Australia if an incompetent patient has a terminal illness with no prospect of recovery and has not signed an advanced directive or appointed a medical agent, there is limited legal support for the doctor's decision to withdraw life support.

A number of cases from other jurisdictions have determined that it is lawful for the doctor responsible for the patient's care to withdraw therapy that is futile and not in the patient's best interests. However, while those judgements may provide guidance for future cases, the law is not settled in this country. Practitioners in Australia must currently take limited comfort from the implication that there is no reason to believe that the courts would take a different view from those in other jurisdictions. Only South Australia has clear legislation that supports withdrawal of therapy on these grounds. The Health Departments of New South Wales and Tasmania have published guidelines but these guidelines do not provide lawful authority.

The legislation and guidelines that exist in Australia, as well as case law, place responsibility for the decision to withdraw therapy on the doctor in charge of the patient's care. However in all of these sources the wishes of the family are given great importance and in fact the family may have the power to negate a decision to withdraw therapy. In the case of Marchlewski v Hunter Area Health Service the New South Wales Supreme Court found that withdrawal of therapy was inappropriate if the patient's family objected[36]. The fact that the decision to withdraw therapy was made in the patient's best interests was no defence. The DellaTorre Inquest also suggests that the courts in Australia consider the family have a power of veto in decisions to withdraw therapy[38]. The Northridge case provides a clear example where the courts overturned a decision made by a doctor to withdraw active treatment where the family did not agree[28].

Doctors are not obliged to provide treatments that offer no physiologic benefit to the patient but few treatments are ever physiologically futile[40-42]. More problematic are decisions to withdraw therapy that may prolong life, albeit life at a greatly debilitated level. Perhaps the apparent legal empowerment of the family in decisions to withdraw therapy reflects a reluctance to assign critical quality of life decisions to medical practitioners. As suggested by Cranford and Gostin: "The judgement as to whether a short existence with severe disabilities is a life worth living is a personal and value-laden, not merely medical, judgement[43]."

Disagreements between family and clinicians over decisions to withdraw therapy are unusual. In the vast majority of cases, disagreements should be resolved by the doctor and the patient or patient's family over time. However if disagreement persists, it may be prudent to apply to the court to exercise its parens patriae jurisdiction, given the tenuous legal basis of withdrawal of therapy in Australia. Otherwise a decision to withdraw therapy against the wishes of the patient's family may return to haunt the doctor responsible.

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