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End of life decisions and the law

This article discusses end of life decision making and highlights some important legal issues in relation to the withdrawal of life sustaining treatment.

Case study

On 17 October 2004, Mr Isaac Messiha, 75 years of age, was admitted to the intensive care unit (ICU) following an out of hospital cardiac arrest. It was estimated that 25 minutes had elapsed before the arrival of ambulance officers and the commencement of cardiopulmonary resuscitation (CPR). The patient had a past history of severe lung disease and had suffered a cardiac arrest 3 months earlier. On admission to ICU, the patient was deeply comatose with little response to external stimuli. A neurologist who examined Mr Messiha on 18 October 2004 stated that the patient had suffered severe hypoxic brain damage from which there was 'no realistic possibility of meaningful recovery of cerebral function'. An electroencephalogram performed on 21 October 2004 suggested that there was no cortical activity. A discussion was held with the patient's family about what further course of treatment, if any, should be offered to the patient. The prospect of withdrawing mechanical ventilation and changing the nature of the treatment to 'comfort care' was discussed. The patient's family wanted the current treatment regimen to continue. At the request of the patient's family, on 27 October 2004, another neurologist reviewed the patient. He was of the view that there was no real prospect of significant recovery and that the continued treatment of the patient in ICU could not be justified on purely medical grounds. The patient's family remained of the view that the patient's condition was improving and that, if the current treatment regimen was continued, thus prolonging the patient's life by even a short period of time, his condition might improve.

On 1 November 2004 Mr Messiha's family made an application to the Supreme Court of New South Wales to restrain the ICU staff from altering the patient's current treatment. The Supreme Court had the power to decide Mr Messiha's treatment under the *parens patriae* jurisdiction, which allows courts to oversee the care and treatment of children and incompetent adults. Judgment was handed down on 11 November 2004.[1] The Court found that, apart from extending the patient's life for some relatively brief period, the current treatment was futile, and that the treatment of Mr Messiha was burdensome and intrusive. The Judge stated that the: '... withdrawal of treatment may put his life in jeopardy but only to the extent of bringing forward what I believe to be the inevitable in the short term. I am not satisfied that the withdrawal of his present treatment is not in the patient's best interest and welfare'.

The application by the family was dismissed and the patient's treatment was subsequently withdrawn.

Discussion

When discussing the law and end of life decision making, it is useful to consider the issue in the context of competent and incompetent adult patients. A competent adult patient is someone who has the capacity to make treatment decisions on their own behalf. Capacity is present if the patient can fulfill the following criteria:

- an ability to comprehend and retain information, and
- weigh that information to reach a choice.[2]

Decision making capacity is often lost as a serious illness progresses or death approaches. Therefore timely and appropriate decision making about end of life care is more likely to occur where those close to the patient understand the patient's wishes in advance. General practitioners can play an important role in this process. Advance care planning may involve a number of approaches, including advance health directives or the appointment of a substitute decision maker.[3]

Competent adult patient

A competent adult patient can accept or refuse life sustaining treatment, even where that decision may lead to serious deterioration

in health or death. In a situation in which a patient refuses treatment, it is crucial that the patient is properly informed of the consequences of such refusal. A patient with decision making capacity does not share decision making authority with treating health professionals. Rather the treating team acts in an advisory capacity to the patient enabling him or her to make choices regarding reasonable treatment options.[4] It should be noted, however, that patients cannot demand treatment that a health professional thinks is inappropriate. While the law respects a patient's decision to refuse treatment, is does not give them power to demand treatment. Treatments can be chosen from those offered; if treatment is not offered, the law will generally not require it to be offered against the health professional's judgment.[5]

Incompetent adult patient

A consensus building approach to end of life decision making that considers the patient's best interests as paramount is recommended where the patient lacks capacity to determine his or her own care.[4] A consensus is sought within the treating team, and between the treating team and family about a plan of care that is as consistent with the patient's wishes and values as possible. Where there is reasonable doubt about the medical assessment in the treating team, advice should be sought from other colleagues and any second opinions documented. Substitute decision makers for incompetent adults may include the courts, guardianship tribunals, appointed guardians, enduring attorneys and persons responsible.

Risk management strategies

There are some important legal issues that GPs need to be aware of when considering end of life decisions.

What is the distinction between euthanasia, assisted suicide and lawful treatment decisions?

Euthanasia and assisted suicide both involve deliberate acts or omissions that are undertaken with the intention of ending a person's life. Assisting a suicide is a crime in all Australian jurisdictions and is inconsistent with the duties of a medical practitioner. Lawful care of a terminally ill patient never involves an intention to end a patient's life.[4]

Euthanasia and assisted suicide are different from withholding or withdrawing life sustaining treatment in accordance with good medical practice by a medical practitioner. If life sustaining treatments are not in the patient's best interests, there is no legal duty on the part of the health professional to provide them. When treatment is withheld or withdrawn in these circumstances, and a patient subsequently dies, the law classifies the cause of death as the patient's underlying condition and not the actions of others.

What about the use of analgesia and sedation?

Analgesia and sedation should be provided by whatever route is necessary for relief, in proportion with clinical need, and with the primary goal of relieving pain or other unwanted symptoms. Such administration will not be unlawful provided the intention of the GP is the relief of symptoms, even if the GP is aware that the administration of the drug might also hasten death. This is often referred to as the doctrine of double effect.

Are 'No CPR' orders lawful?

The principles for No Cardiopulmonary Resuscitation ('No CPR') are consistent with those for withdrawing life sustaining treatment. Decisions relating to withholding CPR should be made on an individual basis. A 'No CPR' order may be compatible with providing the patient with maximum therapeutic care, short of CPR. 'No CPR' orders should be clearly documented in the patient's medical records, as with other treatment decisions.

Conflict of interest: none.

References

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