Title:	When is it in an adult patient's best interests to withhold or withdraw life-sustaining treatment? Australian judicial deliberations at the end of life Willmott, White, Smith, Wilkinson

Abstract

- Intractable disputes about withholding and withdrawing life-sustaining treatment from adults who lack capacity are rare but challenging. Judicial resolution may be needed in some of these cases.
- A central concept for judicial (and clinical) decision-making in this area is a patient's "best interests". Yet what this term means is contested.
- There is an emerging Australian Supreme Court jurisprudence that sheds light on when life-sustaining treatment will, or will not, be judged to be in a patient's best interests.
- Treatment that is either futile or overly burdensome is not in a patient's best interests. Although courts will consider patient and family wishes, they have generally deferred to the views of medical practitioners about treatment decisions.

See over

Text

Introduction

What should doctors do if they cannot reach agreement with a family about life-sustaining treatment for an adult who lacks decision-making capacity? Effective conflict resolution strategies generally resolve these disputes and intractable conflict is rare (1-3). But they are stressful when they occur for clinicians, families and patients. Health professionals can experience moral distress from such cases, with significant personal and professional impact (1, 4). In such cases, or where there are concerns about the lawfulness of proposed conduct, medical practitioners or their hospital may need to seek the opinion of a court or tribunal (1, 5, 6). Concerned family members may themselves seek judicial intervention to ensure continued treatment.

How do courts and tribunals respond to end-of-life conflict? Although all Australian States and Territories have adult guardianship tribunals (7), Supreme Courts retain an important role in this field. They have jurisdiction to resolve these disputes and their decisions provide authoritative guidance for guardianship tribunals and clinicians in their deliberations. The test applied by Supreme Courts is whether the proposed treatment is in the patient's "best interests" and this term (or analogous concepts) is also part of the criteria applied by guardianship tribunals (7). Yet, what "best interests" means is contested (8, 9). In this paper, we identify six key themes from the developing body of Australian Supreme Court jurisprudence about life-sustaining treatment decisions for adults who lack capacity (Box 1).

Box 1: Six key themes from Supreme Courts' jurisprudence of "best interests" for decisions about life-sustaining treatment for adults who lack capacity

1. Futile medical treatment is not in a patient's best interests.
2. Treatment that is overly burdensome is not in a patient's best interests. This may be so even if the patient is unconscious or unaware of treatment burdens.
3. Courts have generally not engaged expressly in quality of life assessments but they remain relevant for determining best interests when considering the patient's medical condition and prognosis.
4. A patient's wishes and values (gleaned when the patient was competent) are relevant to, but do not determine, his or her best interests. Family members' views may also be relevant where they are reflecting a patient's wishes, and perhaps also when reflecting their own wishes, but these views do not determine a patient's best interests.
5. The interests of other people and organisations (including the wider health system) are generally not relevant when determining a patient's best interests.
6. Courts have generally deferred to the views of medical practitioners about treatment decisions, even in the face of strong opposition from the patient's family.

Australian Supreme Court case law concerning end-of-life decisions

We are aware of only 16 Australian Supreme Court decisions on whether life-sustaining treatment should be withheld and/or withdrawn from an adult who lacks capacity. Of these 16, the issue of best interests was directly relevant in eight cases. The other eight cases focused on issues such as the validity of an advance directive and interpretation of guardianship legislation.

See over

The eight cases involving a determination of best interests (Box 2) were thematically analysed to determine trends in judicial reasoning. Most cases involved proposed withdrawal of treatment. The law generally treats withholding and withdrawing treatment as equivalent (10). However, it is possible that situations involving withdrawal are more likely to lead to family conflict since decisions to stop treating, as opposed to not offering treatment, are more apparent and may appear to families to be more causally connected to death (11).

Box 2: Supreme Court cases on best interests and life-sustaining treatment for adults who lack capacity

***Application of Justice Health; re a Patient* (2011) 80 NSWLR 354 (*Justice Health*)**

The NSW Supreme Court declared that life-sustaining treatment for a prisoner who had end-stage lung cancer, lacked capacity and was expected to live for only a matter of days or weeks was futile and need not be given.

***Slaveski v Austin Health* [2010] VSC 493 (*Slaveski*)**

The Victorian Supreme Court held that continuing artificial ventilation for a 71-year-old man, who had suffered a catastrophic stroke and remained in a coma, was burdensome and not in the man's best interests. The medical team did not need to provide treatment despite family requests.

***Australian Capital Territory v JT* (2009) 4 ACTLR 68 (*JT*)**

The ACT Supreme Court held that artificial nutrition and hydration was not futile for a 69-year-old man who suffered from a psychiatric illness manifesting in religious obsessions which led to extreme fasting. The Court declined to make the declaration sought by the government that it would be lawful to stop this treatment.

***Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197 (*Melo*)**

The NT Supreme Court held that treatment for a 29-year-old man, who had sustained catastrophic injuries in a motor vehicle accident, including high-level fractures of the cervical cord and brain damage, was futile. It did not require continued treatment despite family requests.

***In the Matter of Herrington; Re King* [2007] VSC 151 (*Herrington*)**

The Victorian Supreme Court declined to order that active treatment (including the administration of fluids) be continued for a woman who suffered hypoxic brain damage and had been in a vegetative state for six months. It held that the medical team should progress with palliative care despite family request for more active treatment.

***Queensland v Astill* (unreported, Supreme Court of Queensland, Muir J, 18 January 2006) (*Astill*)**

The Queensland Supreme Court ordered blood transfusions be given to a woman who was injured in a motor vehicle accident despite her possessing a "no blood" card. This card did not comply with formalities of Queensland legislation and so did not operate. Treatment was ordered to promote the patient's welfare.

***Messiha v South East Health* [2004] NSWSC 1061 (*Messiha*)**

See over

The NSW Supreme Court held that active treatment for a 75-year-old man, who suffered severe brain damage after he collapsed at home and his brain was deprived of oxygen for 25 minutes, was futile, burdensome and intrusive and should not be continued. The Court did not accept the family's view that treatment was in the patient's best interests.

***Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 (*Northridge*)**

The NSW Supreme Court reinstated active treatment for a man who suffered brain damage following a drug overdose and was in a "chronic vegetative state". The Court held that withdrawing treatment was premature, contrary to the hospital's own guidance, and not in the patient's best interests.

Theme 1: Futile treatment is not in a patient's best interests

The concept of "futility" is contested (12, 13) and we do not add to that debate here, but instead highlight the link made in judgements between futility and best interests. In three of the eight decisions (*Melo*, *Herrington* and *Messiha*), the court *explicitly* stated that where treatment is futile, it would not be in the patient's best interests to commence or continue with it. In two of these cases (*Melo* and *Herrington*), the court did not explain why the treatment was futile. Instead, the medical practitioners' assessments of futility were relied upon to inform the best interests assessment. In the third case (*Messiha)*, it was held that treatment would be futile because continuation of life-sustaining measures gave no real prospect of recovery.

Two other cases also shed light on the role of futility in these deliberations. The Court in *Justice Health* stated that active treatment was futile because it would "achieve no more than a short prolongation of life without quality" and therefore did not need to be provided. By contrast, in *JT*, the Court found that treatment was <u>not</u> futile (the patient was not dying) and so it would not authorise non-treatment.

The courts have expressed the view that futile treatment will not be in a patient's best interests (14). But what justifies labelling treatment as futile? Courts have generally relied heavily upon medical determinations of futility. So despite ongoing debate regarding this concept, medical opinion is important to judicial determinations.

Theme 2: Overly burdensome treatment is not in a patient's best interests

In the end-of-life setting, decisions may be made to commence or continue invasive forms of treatment such as assisted ventilation or to progress to palliative treatment. The courts have held that life-sustaining treatment that creates excessive burdens for a patient, relative to possible benefits, is not in the patient's best interests (*Slaveski*). This includes considering potential pain or indignity the patient may suffer through receiving treatment (*Herrington*). Treatment may still be burdensome even where the patient is unconscious and unaware of these burdens (*Messiha*).

Theme 3: Quality of life considerations are relevant

"Quality of life" considerations have not been explicitly acknowledged by the Supreme Court as relevant to patients' best interests, apart from a brief mention in one case: *Justice Health* (cardiopulmonary resuscitation "would achieve no more than a short prolongation of life without quality"). Nevertheless, in the remaining seven cases we contend that quality of life has been relevant when assessing best interests. This has at least occurred implicitly through an examination of a person's prognosis as part of a best interests assessment.

See over

To illustrate, in the four cases where treatment was withheld or withdrawn, the patients had profound brain injury with no prospect, or very little prospect, of neurological recovery (*Slaveski*, *Melo*, *Herrington* and *Messiha*). By contrast, the three remaining cases where life-sustaining treatment was commenced or continued, all involved patients in better neurological states (*Northridge*, *JT* and *Astill*). Although not couched in terms of quality of life, the capacity to engage meaningfully with the world seems to be relevant. It appears that, at least indirectly, judges consider how the proposed treatment will affect quality of life.

Theme 4: Views and wishes of the patient are relevant [but not determinative] (and perhaps those of family too)

When assessing a patient's best interests, the courts have given some consideration to the views and wishes of the patient and family members. This was given at least some attention in three cases, although such views were not influential on the courts' final conclusions.

In *Astill*, a woman's "no blood" advance directive failed because it did not comply with formalities required by Queensland legislation. The Court still considered her views but concluded there was no evidence to suggest that they remained current when the case was heard. Further blood transfusions were authorised despite the previous directive. In *Herrington*, the Supreme Court considered the views expressed by the patient (which were communicated to the Court by the patient's partner), stating that she would have wanted continued treatment. Ultimately, however, treatment was universally regarded by the medical evidence as futile and so was not provided. In *JT*, the Court acknowledged the patient's views as a relevant factor, but they were disregarded because they were "the product of delusional and irrational thought".

The cases also demonstrate several ways that the views and wishes of family members can be considered in the best interests assessment. First, family can provide information relating to the patient's values or wishes about proposed treatment and this occurred in *Herrington* and *Astill*. Second, family members may have their own views about the patient's best interests. In *Astill*, the judge observed that he had taken into account views expressed by all family members when determining the patient's welfare. The other seven cases did not formally acknowledge the views of family members as being directly relevant to the best interests assessment, however, some made reference to family views and/or preferences (*Slaveski*, *Melo*, *Herrington*, *Messiha* and *Northridge*). Finally, family members have expressed views to the court about the patient's level of responsiveness and awareness of their surroundings. Thus, in some cases, the family has challenged the medical prognosis to suggest that the patient has responded or engaged in a way that indicates an improved state. In all such cases, the court preferred the views of the medical team, concluding that continued treatment was not in the patient's best interests (*Melo*, *Herrington* and *Messiha*).

Theme 5: The interests of others are not relevant

The court has not regarded the interests of others (aside from the potential relevance of the views of the family members outlined above) as being relevant to the best interests assessment. For example, in *Northridge*, the Court observed that "the exercise of the *parens patriae* jurisdiction should not be for the benefit of others … including a health care system that is intent on saving on costs". Similarly, in *JT*, the potential distress to health professionals from providing forced treatment did not influence the assessment of what was in the *patient's* best interests.

Theme 6: Judicial deference to medical profession

See over

The Supreme Court has usually deferred to medical opinion when assessing best interests. In many instances, the courts did not question the conclusion reached by medical practitioners that treatment was futile. It should be emphasised, however, that the final assessment does rest with the court (a point emphasised in *Messiha*). And in *Northridge*, medical decision-making was found not to be clinically justified, and the NSW Supreme Court was critical of the medical opinion provided. But this case aside, there is clear judicial deference to medical opinion in assessing best interests.

Conclusion

The end-of-life jurisprudence of Australian Supreme Courts is still developing, but there is enough case law to provide useful guidance about assessing best interests. This guidance is significant both for future Supreme Court decisions and those made by guardianship tribunals. And although only a minority of cases require judicial intervention, legal considerations remain relevant for the larger group of difficult decisions that occur each day since medical decisions are made in the "shadow of the law" (15). Our analysis highlights the themes that emerge from judicial decisions. Although every situation has unique circumstances, these factors may be useful for medical practitioners contemplating withdrawing or withholding treatment from incompetent adult patients.

A best interests assessment not to treat can be justified at law if there is a clear basis for deciding treatment is futile (despite this term's subjectivity) (theme 1), or if the patient is extremely unlikely to recover consciousness (theme 3). Treatments that are particularly invasive or burdensome relative to their benefits will also not be in a patient's best interests (theme 2). Decisions should take account of patient views, where known (theme 4), and those of family members. Finally, where a medical view concludes treatment should not be provided, this is likely to be supported by the court, but it should be corroborated, for example, with a second opinion (theme 6).

See over

References

1. NSW Health. Conflict Resolution in End of Life Settings (CRELS): Final CRELS Project Working Group Report 2010. Sydney: NSW Health. http://www0.health.nsw.gov.au/pubs/2010/pdf/conflict_resolution.pdf(accessed May 2014).
2. Bloche MG. Managing conflict at the end of life. *N Engl J Med* 2005; 352(23): 2371-2373.
3. Luce JM. A history of resolving conflicts over end-of-life care in intensive care units in the United States. *Crit Care Med* 2010; 38(8): 1623-1629.
4. Davidson JE, Powers K, Hedayat KM. et al. Clinical practice guidelines for support of the family in the patient-centred intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. *Crit Care Med* 2007; 35(2): 605-622.
5. Hillman K, Chen J. Conflict resolution in end of life treatment decisions: An evidence check review brokered by the Sax Institute for the NSW Department of Health. Sydney: NSW Department of Health 2008. http://www.health.nsw.gov.au/research/Documents/14-conflict-resolution-end-of-life.pdf (accessed May 2014).
6. Faunce TA, Stewart C. The Messiha and Schiavo cases: third-party ethical and legal interventions in futile care disputes. *Med J Aust* 2005; 183(5): 261-263.
7. Willmott L, White B, Then S-N. Adults who lack capacity: Substitute decision-making. In: White B, McDonald F, Willmott L, editors. Health Law in Australia. Sydney: Thomson, 2010.
8. Martin W, Freyenhagen F, Hall E, et al. An unblinkered view of best interests. *BMJ* 2012; 345:e8007.
9. Dunn MC, Clare ICH, Holland AJ, et al. Constructing and Reconstructing "Best Interests": An Interpretative Examination of Substitute Decision-making under the Mental Capacity Act 2005. *Journal of Social Welfare and Family Law* 2007; 29(2): 117-133.
10. Wilkinson D, Savulescu J. A Costly Separation Between Withdrawing and Withholding Treatment in Intensive Care. *Bioethics* 2012. doi: 10.1111/j.1467-8519.2012.01981.x. [Epub ahead of print].
11. Way J, Back AL, Curtis JR. Withdrawing life support and resolution of conflict with families. *BMJ* 2002; 325(7376): 1342–1345.
12. Helft PR, Siegler M, Lantos J. The rise and fall of the futility movement. *N Engl J Med* 2000; 343(4): 293–296.
13. Wilkinson DJ, Savulescu J. Knowing when to stop: futility in the ICU. *Curr Opin Anaesthesiol* 2011; 24(2): 160-165.
14. Willmott L, White B, Downie J. Withholding and withdrawal of "futile" life-sustaining treatment: unilateral medical decision-making in Australia and New Zealand. *J Law Med* 2013; 20(4): 907-924.
15. Pope TM, Waldman EA. Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure. *Ohio State Journal on Dispute Resolution* 2007; 23(1): 143.