# Withholding and withdrawing life-sustaining measures

*Legal considerations for adult patients*

## Consent to withhold/withdraw life-sustaining measures

- Queensland guardianship legislation provides a consenting framework for adults with impaired capacity, through the use of Advance Health Directives (AHD) and substitute decision-makers (SDMs). EXCEPT IN EMERGENCY SITUATIONS, consent is required to withhold and/or withdraw life-sustaining medical treatment (including those measures considered to be "futile").
- Under the law, patients with capacity provide their own consent (and may refuse life-sustaining treatment, even if this results in their death or would cause it to happen sooner).
- The guardianship law provides for a COLLABORATIVE APPROACH to obtaining consent and includes a legal requirement to DOCUMENT the decision-making pathway.
- Good medical practice and clinical judgement will determine the best approach to the consenting process, with the objective of obtaining CONSENT TO THE OVERALL TREATMENT PLAN.
- Consent is NOT A CONTRACT. There is no "legal" offer and acceptance, but rather a CONVERSATION to ensure information is provided and broad understanding is obtained. This is to avoid criminal and civil action (ASSAULT).
- CONVERSATION = (discussion of) CONDITION + PROGNOSIS + OVERALL TREATMENT PLAN.
- COMMUNICATION IS KEY: The overall treatment plan should be discussed in the context of what can and can't be done (within reasonable limits of what is achievable) for the patient in a sensitive, yet honest way. This conversation may include discussion, in broad terms, of AVAILABLE treatment options, palliative care and other support measures. The conversation should occur as early as practicable to avoid decisions being made in a crisis.
- COMMUNICATION IS TWO-WAY: Silence or ambivalence from patients or SDMs is not consent. Ensure overall treatment plan is UNDERSTOOD.
- SDMs MUST adhere to the General Principles and the Health Care Principle, and act in best interests of adult (if not => the facility's dispute resolution process activates and => Public Guardian or court as a last resort).
- If the patient lacks capacity, consent is not required to provide comfort cares (minor/ uncontroversial health care). In these cases, the doctor must reasonably consider this is to promote the patient's health and wellbeing.


## Futile medical treatment

- Concept difficult, controversial and term is best avoided in end-of-life discussions with patients and SDMs. Guardianship law definition linked to "good medical practice" (medical and ethical standards). AHPRA (Medical Board of Australia) provides a *code of conduct for doctors* on good medical practice, with specific guidance on end-of-life care.
- Doctors are only required to OFFER what is clinically appropriate and available to the patient, but doctors must still have the consenting conversation (see above).
- Doctors are only required to PROVIDE what is clinically appropriate and available to the patient in accordance with good medical practice.
- Doctors do NOT have to provide, nor accede to demands by patients and their families for clinically inappropriate medical treatment (i.e. futile treatment). THINK dispute resolution.
- Where no AHD, a consent to the withholding or withdrawal of life-sustaining measures (LSM) by a SDM cannot operate unless the doctor reasonably considers PROVIDING the measures would be INCONSISTENT with good medical practice, that is PROVIDING LSMs would be potentially futile.
- Doctors can override directions in AHDs in **very limited** circumstances (e.g. different circumstances

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apply to directions in AHD; also, a direction to withhold or withdraw LSMs cannot operate in an AHD **unless** - the patient is in a coma, or is terminally ill with less than 1 year to live, or has no prospect of regaining capacity for health matters, **and** the treating doctor believes that PROVIDING the measures would be INCONSISTENT with the standards of good medical practice, in other words providing LSMs would be futile).

- An objection by the patient to withhold and/or withdraw LSMs is awkwardly dealt with in the guardianship legislation, but is considered rare in reality. An OBJECTION to a clinical decision to withhold and/or withdraw LSMs = DEMAND for futile treatment (see Acute Resuscitation Plan [ARP] Quick Guide). QH policy position is that objections must be expressed directly to the treating doctor (NOT through a family member).
- The position in legislation is that if the objection is expressed to the doctor, consent will be needed to withhold and/or withdraw treatment.

## Clinical management, coordination and responsibility

- Medical technology and the medicalisation of dying has increased demands on the health care system, particularly in ICUs. Queensland Health has to respond by ensuring its approach is both practical and capable of balancing competing interests. Shifting the focus to a more realistic expectation of dying and providing patients with appropriate treatment can reduce unnecessary and unwanted invasive measures and transfers to ICUs.
- Starting point is ALWAYS clinical. When completing an ARP, DOCTORS: What is good medical practice in THIS situation? What can realistically be offered? What can YOU provide this patient to improve their life and health? What would YOU do if the patient arrests? What would YOU want an attending team to do if the patient arrests?
- Remember – Clinical is followed by the legal: Legal does NOT determine the clinical.
- Medical treatment should never be withheld merely on the grounds that it is easier to withhold treatment than to withdraw treatment which has commenced.
- Do not create 'artificial' emergencies to avoid obtaining consent, if there is time to do so.
- If clinical doubts or uncertainties, the decision must favour life. Seek a second opinion from an experienced clinician.

## Clinical leadership

- Clinical leadership is required to ensure only clinically necessary and available treatment is offered and provided to patients. (DOCTORS: Should the patient be referred to palliative care? If not now, when?)
- If patients are being transferred inappropriately to ICU, must resolve with other specialty.
- Conducting advance care planning (ACP) discussions with the patient and/or their decision-makers as early as appropriate can assist with this process. Ideally, ACP discussions should commence long before a patient has a need for an ARP.
- Documentation of all decisions around life-sustaining measures must be clear & thorough (legal requirement).
- Completing the ARP which was designed to be used in acute emergency situations assists to:
  - identify earlier those patients for whom life-sustaining measures (such as CPR) are clinically inappropriate;
  - identify those patients who refuse medical treatment (e.g. do not want "heroic" LSMs);
  - ensure the appropriate decision-making process is documented and followed (clinical, ethical, legal);
  - initiate dispute resolution when needed; and
  - avoid the "11th hour" crisis and commencement of clinically inappropriate treatment.
- Policy and process compliance => protections under law and indemnity from Queensland Health.

## Queensland Health guiding principles for decision-making about life-sustaining measures

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| **Principle 1:** | All decision-making must reflect respect for life and the patient's right to know and choose. |
| **Principle 2:** | All decision-making must meet the standards of good medical practice. |
| **Principle 3:** | All efforts must be made to obtain the appropriate consent through a collaborative approach. |
| **Principle 4:** | There must be transparency in and accountability for all decision-making. |

**Please note:**

This resource is designed primarily for health professionals treating and caring for those at or approaching the end of life. Information about end of life law and palliative care education for clinicians can be found at https://ellc.edu.au/.