
BIOETHICS OUTLOOK

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“Dying with Dignity”: the new Guidelines

Bernadette Tobin

On 3rd May 1993 the NSW Department of Health published its long-awaited guidelines on the care of patients who are dying. These interim guidelines “indicate factors which should be taken into account in the management of dying patients”. They are not intended to change the relevant law¹ but merely to clarify it (though in an accompanying letter reference is made to “a need to explore minor amendments to existing legislation, to address issues of criminality and guardianship”).

In clarifying the law, the guidelines also attempt to describe and restate what constitutes good clinical (and thus good ethical) practice in an age in which medical technology has the power not only to sustain life in circumstances in which many people would not want to be kept alive but also to foreshorten lives judged not to be worth preserving. How well do they do this?

The guidelines begin by setting out five **principles**: (1) a respect for human life, (2) patient autonomy, (3) consultation, (4) access

and (5) professionalism. They then outline the elements of a **management plan**: discussion with the patient, the offering of a second opinion, the drawing-up of a treatment (including circumstances in which treatment should be foregone), documentation of discussions and decisions, the implementation of the treatment plan, the provision of palliative care. The guidelines then consider “**related issues**”: cardiopulmonary resuscitation; drugs which “ameliorate symptoms but present a risk of shortening life”; the use of ‘advance directives’. Finally, a **glossary** of key terms is provided: advance directive, advocate, attending medical officer, family member, futile treatment, life-supporting treatment.

How much guidance do they provide?

On one issue at least the guidelines ought to dispel a confusion felt by some practitioners about the practical implications of the law in New South Wales. The source of this confusion is historical. In August 1990 (in answer to an enquiry about the legal ramifications of a hospital protocol to assist doctors and nurses on the subject of withdrawing or withholding life-supporting treatments from seriously-ill patients) the State Crown Solicitor advised the NSW Department of Health that in his opinion “it would be most imprudent for anyone to assume, in the absence of clear statutory authorisation, that the withdrawal of life-saving

Inside

What's wrong with assisted suicide ?	3
Foregoing Life-Supporting Treatment.....	5
Notebook	12

treatment from a patient could not give rise to serious criminal liability on the part of persons concerned with the medical treatment of such patient". Motivated by this advice, the Minister for Health put forward a draft of proposed legislation which would allow a terminally-ill patient to die a 'natural death' rather than being subjected to 'artificial life support'. However, both the content of this specific draft legislation and the very idea of trying to legislate for good clinical practice were generally rejected. Better, many thought, for the Department of Health merely to publish guidelines which clarify the existing law.

To this extent, then, the guidelines are useful. They restate the fact, recognized by the law, that sometimes the appropriate care of a seriously-ill patient may include the withdrawing or withholding of life-supporting treatment. Such a decision should be based on what, in the doctor's professional judgment, is in the patient's best interest. In working that out, the doctor needs to consider whether further life-supporting treatment for a particular patient would be futile or overly-burdensome. This is the main strength of the guidelines: they make it clear that the law recognizes the fact that sometimes the withdrawing or withholding of life-prolonging treatment is appropriate clinical practice.

In addition, the guidelines remind practitioners of the importance of consulting, informing and advising the parties concerned, and of clearly and unambiguously documenting decisions (though they fail to note that sometimes this responsibility must be balanced against the capacity of patients and their representatives to enter into collaborative decision-making).

Weaknesses

However, the guidelines are stronger on the *procedures* which characterize good clinical conduct than they are on articulating the *principles of conduct* which underpin these procedures. For instance, the statement of principles in the guidelines contains only a very weak reference to the value of human life. The statement needs strengthening with the addition of the idea that, while death is

inevitable and is often preceded by a process of dying, no one has the (legal) right intentionally and directly to kill another human being. For without the addition of this point, it remains unclear why (a) withdrawing or withholding life-preserving treatment (because such treatment would be futile or overly-burdensome to the patient) when that will indirectly hasten the patient's death may be appropriate and thus legally-permissible medical care but (b) directly and intentionally hastening someone's death is illegal.

In addition a principle needs to be added about the goals of medical treatment. Such a principle is required to make sense of that crucial part of the guidelines where an attempt is made to explain what constitutes "futile treatment". Futile treatment is said to be "investigations and treatment which according to professional judgment will lead to inappropriate outcomes". But without a statement of the goals of medical care, the idea that some "outcomes" are inappropriate is empty. If guidelines are genuinely to assist doctors to make difficult decisions about when it is appropriate to forego life-preserving treatment, they cannot avoid the (admittedly difficult) task of clarifying those goals. Such a principle might be stated as follows:

Medical treatment ought always be directed towards the good of the patient. When medical treatment aimed at curing a disease or stabilizing a satisfactory condition is no longer to any avail, or when the possible treatment options are so burdensome and intrusive that they do not balance the probable benefits to the patient, then (provided that it is not inconsistent with the patient's informed will) the goal of treatment becomes symptomatic and palliative.

Let us turn now to the examples cited of occasions when further life-prolonging treatment would be futile. The guidelines say that futile treatment is "investigations and treatment which according to professional judgment will lead to inappropriate outcomes" and they go on to give three putative examples of such investigations and treatment. About the first (maintenance of a vegetative state with no

(contd. page 11)

What's wrong with assisted suicide?

Gerald P. Gleeson

Many people die peacefully in their sleep after a long and fulfilled life. Others are struck down by illness or accident which results in a painful and drawn-out death. Faced with certain, painful and untimely death, some people are tempted to end their lives quickly while they are still in command of their faculties, still able to relate to their loved ones, and before their last physical deterioration begins.

Do human beings have any such "right" to end their lives? And if they do, is the kindest and most humane way of caring for a dying person who so wills to assist them to take their own life? The case has been cited of a dying patient who, while on a weekend home visit, took his life by gunshot: would it not have been more humane, indeed more "ethical", to help him to end his life gently, accompanied by family and friends, and in a peaceful and supportive setting? At the very least, it has been urged, assisting someone to die should not be a criminal act.

The short answer to why "assisted suicide" is wrong is that it assists the taking of innocent human life. But more needs to be said if we are to understand the kind of failing which suicide and assisted suicide involves. Moreover, a persuasive ethical response to a dying person must take into consideration the reasons why assisted suicide can appear to be ethically defensible in some circumstances today.

Arguments from autonomy

Arguments in support of assisted suicide rely on the principle of patient autonomy - as taken to include the right to end one's life once it has become too burdensome to oneself and/or

others. If autonomy really extends this far, then it is a short step to conclude that others may be permitted - even obliged - to help one to end one's life in a dignified way. (Terminally ill patients usually need this help because their freedom of action is limited by their weakened condition or by the institutional context of their care.)

AIDS patients especially, and those who care for them, are more conscious than most of the importance of patient autonomy. Most AIDS sufferers are young and in the prime of their autonomous adult life. They wish to retain as much control as possible of their life-style and the treatment of their illness. They face a lingering death; they have seen others die of AIDS, and they do not want to be a burden to their friends who are accompanying them; in turn, many of those who care for dying loved ones are reminded daily that they too eventually face the same death.

Exaggerating autonomy

However, patient autonomy should not be understood as including control over the manner and timing of one's death. This exaggerated view fails to recognise the interdependence of human living. Even without a religious perspective, we ought recognise that interdependence is essential to what it is to be human. To be a person is not only to be distinct and unique. It is, more importantly, to be open to relationships, above all the relationship of love. For Christians this interdependence is underpinned by the possibility of a relationship with God as creator and sustainer. For them, life itself is God's gift which it is not up to us to end or destroy as we choose. But one does not have to be a Christian to recognise the irreducibly interdependent

dimension of human life and, thus, the limits to individual autonomy.

Yes, we do suffer when our loved ones suffer. Yes, we suffer in knowing our loved ones suffer for us. Our interdependence in love and care is indeed an interdependence in "suffering-with" one another. But though it pains us to know our loved ones suffer for us, we really wouldn't want it any other way. To be unwilling to share another's pain is to be unwilling to really love that person.

Temptation to eliminate all suffering

Needless suffering ought to be eliminated. But there is a temptation to believe we can eliminate all suffering from human existence, especially the suffering of those we love. Parents know this temptation must be resisted, and later their children are glad their parents did resist it. Parents would like to spare their children pain, but out of love they allow them to undergo the trials which lead to growth in wisdom and grace.

To the extent that our lives are shaped by the interdependence of loving, they are vulnerable to suffering and shared suffering. The most fundamental and distinctively human attitude is trust which enables us to receive the gift of another's love. The sacredness of dying consists precisely in its being the breaking of those bonds of love and shared vulnerability which constitute our lives. It is a terrible illusion to think that one can assert control over one's death without undermining the relationship of interdependence which constitutes truly human existence as life received.

Short-circuiting a response to suffering

Suicide and assisted suicide are wrong because they "short-circuit" the pain of human loving. The dying person who requests assistance in suicide may well be testing the extent of his loved one's commitments to him. But in putting a quick end to suffering, assisted suicide falsifies the love and compassion which may well be its motive. Those who assist in suicide are denied, and deny themselves, the

chance to show their love to the full. When friends respond to the request for death they shirk the true demands of love, and settle for a short-sighted love which aims simply to avoid pain.

Our challenge today - especially in the face of those dying of AIDS - is to not short-circuit our love for those whose dying we accompany. Our challenge is to respond more imaginatively to the demands that untimely and painful death place on our interdependence in care and love.

We ought neither prolong nor hasten a loved one's dying. By allowing death to come when it does, not when we choose, we acknowledge the interdependence of human life which makes life a gift received from others, and ultimately from God. While the prospect of death accentuates the questions of life, it does not change the questions, nor does it overturn the moral insights which have guided our living. Not even an untimely and drawn out death should be allowed to weaken the conviction that the beginning and ending of life as a gift received do not fall within the scope of human autonomy.

Australian Bioethics Association

The next conference of the Australian Bioethics Association is to be held in Adelaide shortly after Easter next year. The conference is held every eighteen months, and the following conference will be held in Brisbane in 1995.

The objects of the Association are:

- 1 to promote the study of bioethics in Australia;
- 2 to provide a public forum for debate and discussion of bioethics; and
- 3 to promote awareness of bioethics and bioethical issues in the community and among all those involved in health care and related disciplines.

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Foregoing Life-Supporting Treatment: the Civil and Criminal Law

T K Tobin QC

The case of Anthony Bland: Anthony Bland was seventeen when his lungs were crushed in the Hillsborough Football Stadium disaster in 1989. As a result, he suffered catastrophic and irreversible damage to the higher centres of his brain which left him in what is called a "persistent vegetative state". After three years in this condition, his doctors applied to the Family Division of the High Court in England for declarations that all life-sustaining treatment and medical support measures designed to keep him alive might lawfully be discontinued and that the hospital might lawfully discontinue medical treatment except for the purpose of enabling him to end his life and die peacefully with the greatest dignity and the least pain, suffering and distress.¹

The case of John McEwan: In January 1985 John McEwan, then aged 29, had a diving accident which left him quadriplegic. He was admitted to the spinal unit of the Austin Hospital in Melbourne where his condition was found to be permanent. He was ventilator-dependent. Six months after treatment was initiated, he asked for the ventilator to be withdrawn. When that was refused, he put himself on a starvation diet. After six days he was certified insane in order to enable his doctors to assess his mental state. The certificate was later rescinded. He continued to express the wish to have treatment withdrawn. A psychiatrist assessed him as sane and remarked that his wish to die was a reasonable response to his circumstances. However his treatment was not withdrawn. In April 1986 he suffered a cardio-respiratory arrest and though resuscitation was attempted he died. (At a subsequent inquiry, his specialist physician said that, though he thought treatment should have been withdrawn when John requested it, he continued treatment on the legal advice of his medical insurers for fear of actions based in negligence.²)

The case of Mrs N: Mrs N, a 45-year-old mother of two teenage children was admitted to St Vincent's Hospital in Melbourne with respiratory difficulties and soon suffered a respiratory arrest. She was resuscitated and maintained on a ventilator while being investigated for a suspected spinal tumour. She was diagnosed as having atypical motor neurone disease, atypical in that it affected her intercostal muscles first, causing her respiratory problems. Gradually all hopes of her being able to leave the hospital with ventilator assistance diminished. She quickly became

ventilator-dependent. After some time, Mrs N expressed the wish to her physician that her treatment should be withdrawn. She was unable to hold the suction tube well enough to undertake her own tracheal suctioning without assistance, and she lived in terror that the ventilator might fail, causing her once again to go through the distress of respiratory arrest. Her husband did not want her to discontinue treatment, but he nonetheless supported her decision. In the view of the psychiatrist she was not mentally ill. No one was coercing her to refuse treatment. If anything, pressure was being brought to bear on her to continue with treatment, especially as her two children were still young enough to be dependent on her. Six days after Mrs N first indicated her wishes to her physician, ventilatory treatment was withdrawn. In the presence of her husband and while she remained conscious, the ventilatory frequency was gradually turned down while the oxygen level of the inhaled gas was increased. Mrs N died from carbon dioxide retention. She remained conscious throughout all but the last hour of the seven-hour period of withdrawal of treatment.³

The Right to Treat

A doctor's right to treat a patient is based upon consent. If an adult is physically and mentally capable of making a choice, he or she must consent if the treatment is to be lawful. If the patient does not consent, then the medical treatment is unlawful.⁴ The decision of the patient may not be wise. In the opinion of the treating doctor, it may be quite irrational. Nevertheless, the wishes of the patient must be followed. If they are ignored, those treating the patient commit a civil wrong of trespass to the person and may commit a crime of assault.

The concept of consent is central to any understanding of how the law approaches problems associated with medical treatment. The removal of an organ from a living donor in a transplant operation will cause what in law is called serious bodily harm to the donor. If the

donor consents, then the operation is lawful. If the donor does not consent, it is unlawful. Were the donor to die as a result of the operation, the requisite elements of the crime of murder would be present because the doctor would have intended unlawfully to inflict serious bodily harm as a result of which death occurred.

If a patient requires a blood transfusion, but refuses it on the grounds of religious beliefs, or because he or she fears an HIV infection, that decision is a legal bar to the treatment.⁵ The apparent "unreasonableness" or "irrationality" of the patient's wishes does not provide a justification for ignoring them. However, if an exhausted patient were brow-beaten by a close relative into refusing consent to treatment, so that there was no real decision by the patient but only the outward forms of agreement to buy a quiet life, the "refusal" would not be binding on the doctor. On the other hand, if the doctor "tricked" the patient into consenting by misinforming him, by word or omission, the "consent" would not make the treatment lawful.

Consent by the patient presumes that he or she is capable of making the choice. An adult patient may be suffering from incapacity due to unconsciousness or confusion caused by shock, pain, or other physical impairment. This is a common event in casualty wards where unconscious accident victims are admitted requiring urgent treatment. In such cases, there will be no consent possible. Then the doctors who treat the patient must decide, in the exercise of their best clinical judgment, what is in the best interest of the patient and may lawfully administer treatment accordingly.

In some circumstances the absolute requirement of the common law that the patient consent to treatment has been modified by guardianship legislation.⁶ That legislation is concerned to ensure that patients are not deprived of necessary medical treatment because they lack the capacity to consent to it; and to ensure that treatment of such patients is carried out "for the purpose only of promoting and maintaining their health and well-being". In my view, the law was not designed to deal with decisions to forego life-supporting treatment. In such circumstances, the medical

practitioner is responsible for decisions as to treatment, although (as in the Bland case) the courts may be called upon to intervene and support, vary or reject those decisions.

There are circumstances in which the question of the lawfulness of conduct by a doctor, nurse or hospital staff is clear-cut, supported by long-established authority. The deliberate taking of a patient's life is unlawful killing. For example, a doctor who administers to a terminally-ill patient a lethal drug dose with the intention of bringing about death is guilty of murder, notwithstanding that he may be motivated by a desire to end the patient's suffering. The consent of the patient does not alter the legal consequences: a person cannot render a killing lawful by consenting to be killed.⁷ Assisting a suicide - with intent - is always unlawful.

Medical Treatment and the Law

What then is the position in Australian law of the three case-studies presented earlier? Before considering these cases in turn, let me note their common and disparate features. None of the cases involved the treatment of a terminally-ill patient, where that term means a person with a condition which will inevitably lead to death and where death will occur soon. Each of the cases involved a patient totally dependent on medical intervention to stay alive: Anthony Bland required feeding with a naso-gastric tube; John McEwan and Mrs N required a ventilator to perform lung functions. In the case of Anthony Bland, the patient himself was incapable of consenting to either treatment or its withdrawal. He was in a persistent vegetative state, which meant that he was completely insensate with no cognitive function. However John McEwan had expressly requested discontinuing treatment. He was mentally competent and had given informed consent to cease ventilation. Only in the case of Anthony Bland was a court order obtained. In his case it authorised the withdrawal of nutrition and hydration, without which death inevitably occurred within a month. In John McEwan's case, private legal advice was given to his health care team that he should be "re-hooked" to the ventilator if in any of his periods of respite from it he became distressed, cyanotic, unconscious - regardless of any wish he expressed to the

contrary. In Mrs N's case, ventilatory treatment was withdrawn at her request, and with private legal advice that her doctor had no right to treat her without her consent.

Anthony Bland's case

The issue in Bland's case was whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient (with no cognitive function) who had no hope of recovery, when it is known that if that is done the patient will shortly thereafter die. The medical evidence was that there could be no benefit to the patient in continuing the treatment because there was no prospect that he could recover his cognitive function. His cerebral cortex had degenerated into a mass of watery fluid. He would remain without feeling, without awareness, and without the ability to experience anything around him. The House of Lords accepted that nutrition and hydration of Anthony Bland was "medical treatment". Where a patient is unable to consent to having or to withholding or to withdrawing medical treatment,⁹ the doctor must act in accordance with the best interests of the patient.

That brings us to the nub of the matter. A doctor has a duty of care to a patient. If he acts contrary to his duty of care, he runs the risk of civil and even criminal sanctions. Were a doctor to disconnect a patient from a life-support system contrary to his professional duty, and with the intention of ending the patient's life, he would be committing murder.

However in Bland's case the professional duty depended on the circumstances and condition of the patient. The treatment designed to prolong life had to serve the best interests of the patient. The court held that the doctor and the hospital no longer had a legal duty to maintain nutrition and hydration because, in the patient's persistent vegetative state, such treatment would be of no benefit to him.⁹

The question to ask is not whether it is in the patient's best interests that he should die. Rather it is whether it is in his best interests that his life be prolonged by continuing a particular treatment which cannot improve his condition: treatment which in medical terms is futile.

Where a patient is incapable of consenting to or refusing treatment, there is no absolute legal duty upon a medical practitioner to initiate or continue treatment which is futile and of no benefit to the patient. The doctor is not obliged to prolong life by any means, merely to gain a few more days¹⁰, (for example, by amputating a dying patient's limb). Accordingly a doctor who ceased life support of a patient such as Anthony Bland in a persistent vegetative state, acting in the patient's best interests, would be acting lawfully.

John McEwan's case

In a legal rather than a medical sense, there was no John McEwan "case". However, the facts are sufficiently clear to draw some legal conclusions. John McEwan did not consent to the medical treatment whereby six months after his accident and contrary to his express wishes, he remained on a ventilator. He was mentally competent to make a choice to refuse further treatment. His refusal of treatment (which was ignored) was an informed decision apparently based on its burdensome nature and his concern for those responsible for his care. Based on the psychiatric assessment and the patient's reported belief that the ventilator treatment was an extraordinary means of continuing life, and one which he was not morally obliged to persist with, his decision to refuse the treatment was not suicidal because it lacked the necessary element of intent.¹¹

In these circumstances, the patient's wishes - as a matter of law - ought to have been respected and the ventilator treatment withdrawn. The concern of the health-care providers to avoid unlawful conduct was no doubt heightened by the fact that John McEwan went on a starvation diet more than once when his requests were refused.

Nevertheless, once it was shown that he had the required mental capacity to make the decision and that it was an informed decision, the doctors were in my view obliged to carry out his request and withdraw treatment. It was no longer lawful to treat him contrary to his wishes provided the question of his mental capacity was resolved in his favour.

Mrs N's case

It will be clear from the discussion of John McEwan's case that medical practitioners should respect the wishes of a competent adult patient who makes an informed decision to cease a form of treatment. Without the intervention of the court (or in some circumstances the Guardianship Board) the doctor has no longer a lawful duty to treat such a patient. Thus no question of a breach of the criminal law would arise; the doctor so acting would be discontinuing treatment in accordance with and not contrary to his legal duty.

Not-for-Resuscitation Orders

Resuscitation as used in this paper means the treatment necessary to maintain life in cases of cardiopulmonary failure without which the outcome would almost certainly be death. Many patients owe their lives to cardiopulmonary resuscitation. However, such treatment may not be, in all cases, of real benefit to the patient. For example, (a) the procedure when performed on a terminally-ill patient in the last stages of life may be futile: the patient's condition may be such that the doctor is reasonably certain that, in the event of an arrest, recovery will be impossible; (b) the doctor may be reasonably certain that in the event of an arrest where resuscitation is achieved, the patient would be so severely disabled that the problems associated with the treatment would be disproportionate to the result; (c) a competent adult patient properly informed may request that she not be resuscitated in the event that her current condition results in an arrest.

The legal position where the patient declines resuscitation if such becomes necessary to redress cardiopulmonary failure is governed by the law relating to consent. In some jurisdictions statutes regulate the effect of advance directives by patients of the kind in question.¹² (I leave aside for present purposes statute law which allows an agent to be appointed to make decisions about treatment and to regulate the manner in which such decisions are to be implemented).¹³ However, in my opinion the common law as previously outlined makes it plain that a doctor who makes (or other health care providers who implement) NFR orders in the circumstances set out above act lawfully.

Futile procedures

A doctor is not under a duty to his patient to take every available measure to prolong life regardless of the benefit or lack of it to the patient. Amputation of limbs in a terminally-ill patient may be so burdensome to the patient as to render it not only unnecessary but undesirable. Resuscitation of patients in some circumstances may serve none of the traditionally accepted objects of medical care as stated by the presiding judge in Bland's case:¹⁴ (1) to prevent the occurrence of illness, injury or deformity before they occur; (2) to cure illness when it does occur; (3) where illness cannot be cured to prevent or retard deterioration of the patient's condition; (4) to relieve pain and suffering in body and mind. The presiding judge said "I doubt if it has ever been an object of medical care merely to prolong the life of an insensate patient with no hope of recovery where nothing can be done to promote any of these objects".

In most cases, the patient will not be in a persistent vegetative state, but may be so advanced in his final illness that resuscitation will be of no benefit. The law imposes no duty on a doctor to resuscitate a patient in such circumstances.

Resuscitation: prolonging life, adding to pain

Resuscitation may prolong the life of the patient, but also create severe disability with such poor prognosis as to be disproportionate to the result. If the treatment will simply prolong the life of the patient while adding to his or her burden with additional pain and disability, it is difficult to see how the doctor is under a legal duty to administer it.

In 1990, the Court of Appeal in England had to consider the case of a new-born with perinatal brain damage.¹⁴ At birth and at four months, the infant required ventilation to stay alive. The prognosis was that at best he had a considerably shortened life expectancy, he would become a spastic quadriplegic probably without sight, speech or hearing, and his only likely normal reaction would be that of pain. The consultant neonatalist recommended that in the event of a

further respiratory collapse, the infant should not be revived by means of mechanical ventilation. The medical advice not to resuscitate was based upon the invasive nature of mechanical ventilation in which the use of a naso-gastric tube, drips which would need resiting and constant blood sampling would cause the child distress. The procedures involved also carried their own hazards including the danger of causing even greater brain damage. The court applied the distinction between on one hand the intended outcome of the act being to cause death and, on the other hand, the intended outcome being to ease pain where death, as a side effect, was likely. It held that prolonged ventilation was not required.

What doctors and the courts have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so.¹⁵

Civil Liability

Once it is understood that the common law (a) imposes no duty on a doctor to provide futile medical treatment to prolong life where such treatment will be of no benefit to the patient; and (b) recognises the right of a competent patient duly informed to decline medical treatment, even if the treatment is necessary to maintain life, then the issue of legal liability with regard to almost all NFR orders simply will not arise. A doctor does not have a lawful duty to resuscitate in such circumstances. Only if the NFR order is made contrary to the patient's express wish or is made with the intention of ending the life of the patient, will an issue of criminal responsibility arise. It should be emphasised that where a patient has requested resuscitation and does not consent to its being withheld, a separate duty of care arises. If the doctor does not intend to treat the patient in accordance with the patient's express wish, he must tell the patient and give him the

opportunity to be treated by another doctor. If he fails to do so, he assumes a duty of care which includes resuscitation, and only a court order could relieve him of the duty. Intentional killing and withholding treatment contrary to the patient's express wish are exceptions which will give rise to serious issues of criminal responsibility.

The question of consent to treatment (or its withholding or withdrawal) is generally relevant to the civil liability of a doctor for trespass to the person - well-illustrated by the blood transfusion cases.¹⁶ However, in some cases, consent will also be relevant to civil liability for negligence. For example, the consent of a patient to undergo an operation must be "informed". The patient must be provided with sufficient information by the doctor to enable him or her to make a choice with knowledge of the risks and possible outcomes. The doctor may be negligent if he fails to provide the patient with relevant knowledge of the risks of an operation before the patient consents to it. These considerations are relevant in examining the advice by the doctor to a patient as a result of which the patient decides in advance that he or she does not wish to be resuscitated in the event of an arrest. Provided the doctor has not been negligent in the communication with the patient leading to the consent of the patient to a NFR directive, the implementing of the directive will not be negligent if based upon a reasonable diagnosis and prognosis. Thus if the patient would receive no real benefit from treatment in circumstances where it was futile, the doctor will not be acting in breach of the duty of care owed to the patient. Similarly if the patient had no chance of recovery, yet the treatment would be likely to cause serious disability to the patient, so that any benefit was disproportionate to the other consequences to the patient, the doctor would not be under a duty of care to administer the treatment.

"Dying with Dignity" Guidelines

Recently, the NSW Health Department issued interim guidelines on management of the terminally-ill. It is important to define their legal status. First, they do not alter the present law. Only legislation (or perhaps some judicial

lawmaking) can do that. Second, they are obviously intended to reflect and remain within the present law. Thus they state that fears of criminal or civil liability where life-prolonging systems are withdrawn should be assuaged if doctors "apply these guidelines in conjunction with the accepted clinical standards of their peers". However as *Rogers v Whitaker* shows, the duty of care owed by a doctor to the patient is not to be determined solely by reference to "accepted clinical standards".¹⁷ Third, although they assume the legality of the procedures and principles they promote, what is and is not lawful treatment is never stated explicitly. In my view, this is a major weakness in the document. The various principles which the guidelines "recognize" need to be understood in the legal context which has been the subject matter of this paper.

Conclusion

While changes in medical technology will in all probability overtake any legislative or administrative code to deal with NFR orders, the common law remains flexible to change and reflects at the same time the central traditions of the society as to the sanctity of life and the wisdom apt to its last stages.

"The strength of the common law principles governing this area lie in their flexibility in the rapidly changing world of medical technology, their regard for the opinion of the profession and their careful balancing of the responsibilities of health professionals and the rights of patients to be given reasonable medical care."¹⁸

It should be stated in conclusion that the ethical code of the medical profession informs and reflects those central traditions, and thus remains in harmony with the common law itself.

Notes

¹ *Airedale NHS Trust v Bland*, (1993) 2 WLR 316

² Tonti-Filippini, N.: "Some refusals of medical treatment which changed the law of Victoria", *Medical Journal of Australia*, Vol 157, p 277, 17 August 1992

³ Tonti-Filippini, *ibid*

⁴ *Schloendorff v Society of New York Hospital*, 103 NE 92 (1914) 93-93, per Cardozo J. See below as to legislative qualifications of this rule under guardianship laws.

⁵ A semi-conscious patient in Canada, admitted to casualty after a serious car accident, was given a transfusion notwithstanding that she carried a card stating that she was a Jehovah's Witness who would refuse a transfusion or blood products. The transfusion saved her life. The doctor was successfully sued for \$20,000 damages for trespass to the person. *Malette v Schulman*, (1990) 67 DLR (4th) 321

⁶ Disability Services and Guardianship Act 1987. The legislation runs to over fifty pages and these comments are meant to deal with its general and not its specific application.

⁷ *Marion's Case* [1992] 175 CLR 218 at 233.

⁸ The patient's consent or refusal of it may be based on a previously stated directive or request as to treatment; see for example the blood transfusion cases and the Disability Services and Guardianship Act 1987 Section 33(3).

⁹ These circumstances were contrasted by the court with the recent criminal prosecution of Dr Cox (*R v Cox*, 18 September 1992, Ognall J): "He injected a lethal dose which was designed to cause death and was an external and intrusive act committed by an outsider and was not in accordance with his duty of care as a doctor." *Airedale NHS Trust v Bland* [1993] 2 WLR 316 at 349.

¹⁰ *Airedale NHS Trust v Bland* [1993] 2 WLR 316 at 370.

¹¹ *Airedale NHS Trust v Bland* [1993] 2 WLR 316 at 340

¹² For example, Medical Treatment Act 1988 (Vic), Natural Death Act 1983 (SA), Natural Death Act 1988 (NT)

¹³ For example, Medical Treatment (Enduring Power of Attorney) Act 1989 (Vic)

¹⁴ *Bland* [1993] 2 WLR 316 at 335, per Sir Thomas Bingham MR, Court of Appeal

¹⁵ *In re J (Wardship: Medical Treatment)* [1991] Fam 33 at 46

¹⁶ *Malette v Schulman*, (1990) 67 DLR (4th) 321

¹⁷ 109 ALR 625 at 633-4: Such professional opinion is to be given due weight but is not necessarily decisive as to what constitutes the relevant duty of care.

¹⁸ A Commentary on the NSW Health Department Discussion Paper by Karin S.M. Clark, January 1991

Interim Guidelines (contd. from page 2)

possibility of a reversal of that condition), I have no argument (though the truth of this is still debated): on the account of the goals of medicine I have advanced, it emerges as an inappropriate goal of medical treatment. However the second, 'continued pain', does not decisively determine whether further treatment is futile. Both the person suffering from the final stages of an incurable cancer (for example) and the person suffering from painful but curative surgery (for example) may suffer continued pain. And about the third, 'unacceptable quality of life', much more needs to be said about this almost irredeemably vague concept before its use can be action-guiding.

Risks of shortening life?

In the discussion of "drugs which ameliorate symptoms but present a risk of shortening life", the guidelines start well. They begin by making the (often-misunderstood) point that when correctly prescribed (neither under-prescribed nor over-prescribed) drugs which relieve pain and the other distressing physical symptoms of illness do *not* shorten life. (Of course, many of the needs of people with terminal illness are unresponsive to *any* drugs: they need clear explanations, good palliative nursing, relaxation, comfort, diversion and attention to their psychological and spiritual needs.) However, in considering the remote possibility that the only way of relieving distressing symptoms is by the administration of drugs in such doses that they thereby hasten the patient's death, the guidelines do not make clear the essential point. In exceptional circumstances, it may be appropriate to administer drugs in order to relieve distressing symptoms of illness in the knowledge that this may hasten the patient's death. But it is illegal to administer symptom-relieving drugs with the intention of hastening the patient's death. In general, one cannot clarify the legal (nor, indeed, the ethical) status of what the doctor does without reference to his or her intentions.

Terminology

There is much talk in the guidelines about a patient's 'advocate', a person nominated by the patient to speak on his behalf should he become incompetent. This is unfortunate. The metaphor of advocacy distorts the contribution

that a family member or friend of an (incompetent) patient can make to the doctor's decision-making. It suggests that the relationship between family member or friend and the doctor is adversarial. Surely this is the wrong paradigm.³ The contribution of such a person to discussions about the care of a patient is aimed at helping the doctor to know and to appreciate the patient's wishes about further treatment (or more frequently what the patient's wishes would have been) so that the doctor can decide what is in the best interests of this particular patient. Better then to think of the family member or friend as the patient's 'representative'.

Patient Competence Undefined

The guidelines talk of incompetent patients who are not able to take part in decision-making about their own treatment. Nowhere, however, are competence and incompetence explained. Nor is any guidance given to clinicians about how to decide that a patient is incompetent and (thus) that consultation with his or her representative(s) is appropriate.

Conclusion

Some people doubt the desirability of either new legislation (of the kind promulgated in Victoria) or guidelines. But given the confusion felt by some practitioners in New South Wales about the ramifications of the law in respect of foregoing life-preserving treatment, guidelines could be useful. However, if they are genuinely to clarify what constitutes appropriate (and thus legally-defensible) medical treatment in difficult cases, they themselves need to be clearer than sometimes these guidelines are.

Notes

¹ For an account of this law, see T K Tobin: "Foregoing life-supporting medical treatment: the criminal and civil law" in this volume of *Bioethics Outlook*.

² Cf John Quilter: "Nursing Ethics: A New Challenge", *Bioethics Outlook*, Vol 3, No 2, 1992

NOTEBOOK

Director Appointed

Dr Bernadette Tobin has been appointed to the position of Director of the John Plunkett Centre for Ethics in Health Care. The appointment is for three years.

Second Annual Ethics in Nursing Practice Seminar 20th September 1993 St Vincent's Hospital, Sydney

The Division of Nursing, St Vincent's Hospital Sydney, will hold its Second Annual Ethics in Nursing Practice Seminar in September 1993. The theme of the seminar is Ethical Decision Making in Health Care and will include updates on topical issues.

For further information contact Christine Lennon phone (02) 361 2322

St Vincent's Hospital First Annual Mental Health & Psychiatry Conference Integration: The Future of Mental Health Services

Hosted by: St Vincent's Hospital Department of Psychiatric Services and Inner City Health Service

Thursday 17th - Friday 18th June 1993
Sydney Marriott Hotel, 36 College Street,
East Sydney

Contact Marie McMillan
Phone (02) 361 2100 Fax (02) 361 2384

Sir William Osler: eminent physician!

In an article in the last edition of *Bioethics Outlook*, reference was made to "the eminent surgeon, Sir William Osler". Professor John Hickie has written to inform us that Sir William, described by the *Lancet* as "the greatest personality in the medical world" and regarded by many as the father of modern internal medicine, was not a surgeon but a physician. John Hickie writes:

"In 1892 Sir William Osler wrote one of the most famous textbooks of medicine, *The Principles and Practice of Medicine*". This is still being published and is extensively quoted... He was responsible for founding the Association of Physicians of Great Britain and Ireland and the *Quarterly Journal of Medicine*. He published extensively and was the first to study the platelets, to describe hereditary haemorrhagic telangiectasia (Osler-Rendu-Weber disease), and polycythaemia vera and he wrote several major papers on infective endocarditis. Many of his philosophical papers are frequently quoted..."

We apologise for this error. And we are grateful to John Hickie, himself an eminent physician, for pointing it out to us.

WHAT SHOULD PATIENTS BE TOLD?

The Duty to Inform and Advise Seminar

Tuesday 22nd June (3.30-6.30 p.m.)

John Plunkett Centre for Ethics in
Health Care

Contact Heather Curry on
361 2869 or 361 2793 for registration details

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