Withdrawing, Withholding and Refusing Emergency Resuscitation

Following the advice of the State Crown Solicitor of New South Wales, issued in 1990, there has been doubt regarding the legality of "not-for-resuscitation" orders and the circumstances under which such orders may be made. Recent cases in England and New Zealand have considered the issue of the withdrawal of life-support treatment and it is suggested that the principles discussed in that context may have ramifications for Cardio-pulmonary Resuscitation (CPR) decisions.

In this article, those decisions are considered, along with various pieces of Australian legislation, in order to draw a conclusion as to when No-CPR orders are justified, and in what circumstances CPR may be lawfully withheld, withdrawn or refused. Proposals are advanced for law reform in order to give proper effect to the conclusions drawn.

Introduction

In 1990 the New South Wales State Crown Solicitor wrote an advice on the potential liability of medical officers and other health professionals in withholding potentially life-saving treatment from seriously ill persons. That advice was released in a discussion paper entitled Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process. The legislation which it proposed did not come to fruition and the area has remained unclear. In recent times, courts in New Zealand and the United Kingdom have looked at the issue of the withdrawal of life-support treatment, and the decisions have cast new light on the issue of withholding, withdrawing or refusing emergency resuscitation, such as Cardio-pulmonary Resuscitation (CPR).

CPR covers a number of practices. They range from "closed chest compression with mouth to mouth ventilation" to intervention by doctors and ambulance officers trained in advanced life-support with cardiac drugs and electronic cardiac defibrillators. As a result, CPR can be performed by people ranging from bystanders trained in first aid to medical practitioners.

Basic life-support is indicated in cases of respiratory arrest and cardiac arrest. In cases of respiratory arrest, the heart and lungs can continue to provide oxygen to the vital organs for several minutes. In cardiac arrest, the circulation ceases and vital organs are deprived of oxygen. Failure to intervene with mouth-to-mouth resuscitation or some other form of ventilation support in the case of respiratory

MICHAEL EBURN
B Com, LLB (UNSW),
Dip Soc Sci (UNE)
Associate Lecturer, School of Law
and School of Health, University of New England, Armidale

Correspondence to: Mr Michael Eburn, School of Law, Faculty of Economics, Business and Law, University of New England, Armidale, NSW 2351.

1 New South Wales Department of Health, Proposed Legislation to Give Legal Effect to Directions Against Artificial Prolongation of the Dying Process, Discussion Paper (North Sydney, 1990). The advice said: “In my opinion, it would be most imprudent for anyone to assume, in the absence of clear statutory authorisation, that the withdrawal or withholding of life saving treatment from a patient could not give rise to serious criminal liability on the part of the persons concerned with the medical welfare of such patient.” As a result of this advice, the New South Wales Department of Health proposed legislation based on the Natural Death Act 1988 (SA). This legislation, if passed, would have provided a statutory method whereby a person who was suffering from a terminal illness could refuse to be subject to “artificial life support measures”.


3 American Heart Association, Ibid at 2185.
arrest, or CPR in the case of cardiac arrest, will lead inevitably to the patient's death. As such, CPR is a treatment that is always administered in cases that can be described as an emergency, and failure to administer the treatment will result in death in a matter of minutes rather than hours, days or weeks. Cardiac arrest must also be considered in terms of the dying process. Death is inevitable, and all people will at some stage suffer a cardiac arrest. The cardiac arrest may be considered a medical emergency where it is unexpected or unanticipated. In cases where the patient is suffering a terminal illness, then the cardiac arrest is the final step in the dying process. This raises the valid question of when CPR should be initiated, and when it should be withheld or withdrawn.

This article will focus on CPR and the likely impact of recent developments in common law on the decision to withhold or withdraw CPR. It will conclude that there should be a system in place where people can identify themselves as having decided to forgo CPR so that the treatment is not imposed contrary to their wishes. Although the discussion here may have application for other life-saving treatments, for example, blood transfusions and connection to life-support systems, the discussion will be limited to CPR (which, by definition, will not include connection to long-term, artificial life-support systems).

The common law

At common law, an application of force to a person without that person's consent is, generally speaking, an assault. "The fundamental principle, plain and incontestable, is that every person's body is inviolate." A mentally competent patient is free to refuse consent to treatment even if such refusal will lead to death. As Lord Donaldson put it in Re T:

"An adult patient who . . . suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."

And later:

"Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent."

The other members of the court delivered similar judgments.

With respect to any treatment, including CPR, a patient has the right to refuse to accept that treatment, even if the refusal means that death will result. A patient in cardiac arrest will be unable, at that time, to say whether or not he or she wishes to be resuscitated. A patient may, however, before the event, direct that in the case of a cardiac arrest, he or she does not wish to be subject to CPR. In these cases, what must be asked is: has the patient refused consent to treatment and what treatment has he or she refused?
Refusal

In Re T, the judge at first instance stated the question that he had to answer as:

"Firstly, was that refusal to consent which was maintained throughout that period which culminated in the caesarean section a valid refusal of blood transfusions at the time it was expressed. Secondly, does it remain her settled intention in the emergency which has now arisen where her life may be forfeited if she does not undergo that treatment?"*

If that approach is to be followed in Australia, there will be a two-stage test: (1) Is the refusal a "valid refusal"? and (2) Does the refusal continue to apply in the circumstances that have in fact arisen?

In Re T, the court was faced with a patient who was refusing consent to a blood transfusion. The facts were as follows: the patient's mother was a Jehovah's Witness (a religion that prohibits blood transfusions); the patient professed to be a Jehovah's Witness though she did not actively practise that religion; the patient only expressed a refusal after she had been left alone for some time with her mother; the patient was told prior to entering the operating theatre for a caesarean section that it was unlikely that she would need a transfusion; she was told that if such a need arose, there were alternatives to a blood transfusion; she was not told that if she needed a transfusion but did not have one she would die; there was a debate as to whether, at the time of signing a refusal sheet, the patient was or was not under the effect of pethidine.

In these circumstances the court said that it was not a valid refusal because the patient was under the "undue influence" of her mother and had not been properly informed of the risks of the surgery. It was also held that the refusal, if valid, did not apply in the circumstances that arose as she had been told that there was an alternative available. It was, however, not a choice between alternative treatments, but between the transfusion and death. There was no evidence that, in those circumstances, she would refuse the treatment. Accordingly the doctors, having neither consent nor a valid refusal, were entitled to proceed in accordance with good medical practice; that is, they were entitled, acting in the best interests of the patient, to administer the transfusion. As discussed above, however, the court recognised that if there was a valid refusal, it would have continued to bind the medical staff.

Applying these principles, a patient may refuse CPR in advance, if he or she is mentally competent and properly informed. If a patient has declared that he or she refuses such treatment in particular circumstances, that declaration should bind treating medical practitioners. For example, a terminally ill patient may refuse to undergo CPR in the event that he or she has a cardiac arrest whilst in the hospice. Provided that it is a valid refusal and properly informed, then the refusal would be binding on the treating medical practitioners. If, however, circumstances other than those anticipated arose—for example, if the patient left the hospice and was then struck by a vehicle and brought to hospital requiring resuscitation—it remains unclear whether the refusal would be effective in this

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* [1992] 3 WLR 782 at 791.
“different” emergency situation. Whether it would or not depends in all likelihood on the exact nature of the refusal and the circumstances that were anticipated when it was made.

As the refusal must be informed, it must fall to doctors to provide the appropriate information. In *Rogers v Whitaker*, the High Court set out the law in relation to information that must be provided to obtain a proper or effective consent to medical treatment. The majority (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) said:

"The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

A doctor would be under a similar duty in respect of a decision to refuse treatment. The patient must be informed of the "material risks" that come both with the treatment and with refusing the treatment. Where the treatment involved is CPR, the only likely consequence of refusal is death. There may be adverse consequences of accepting the treatment, such as continued existence in a persistent vegetative state. It is only once the alternatives have been presented that a patient can give a valid refusal (though the refusal need not be reasonable). It is conceivable that, if a doctor did not give the appropriate information so that a patient does not withhold consent to treatment, then, in certain circumstances, there could be liability upon the doctor. Take, for example, a terminally ill patient in the last stages of dying. Assume that CPR is discussed and the patient is advised that if required it will be administered routinely, but that it may or may not be successful. Assume the patient were then to suffer a cardiac arrest requiring resuscitation. Assume also that the resuscitation was effective in restoring spontaneous circulation and respiration, but with increased pain due to rib fractures and increased disability due to a period of oxygen deprivation. Here the patient may be able successfully to sue on the basis that if the "material risks" had been explained, he or she would have decided to reject the treatment.

That does not mean that the doctor in an emergency must explain all the details of the treatment. *Rogers v Whitaker* was an action in negligence and, as in all such cases, the question is what, in all the circumstances, is reasonable. In that case the patient chose to undergo elective surgery to correct a problem that she experienced with one eye. She had lived with the impaired vision for some time and she made it clear to the doctor that she was very concerned to ensure that her vision, restricted to one eye, would not be affected. A known risk of the surgery arose and she was left totally blind. Those facts are very different from a case where a person is brought into hospital with an acute cardiac condition and suffers a cardiac arrest before the treatment can be discussed. The High Court in *Rogers v Whitaker*...
specifically noted that a case of emergency or necessity was a different matter. In an emergency case it is likely that such a patient will not make her or his wishes known one way or the other. Even if a patient did express a wish, the need to provide urgent care would mean that it would be impossible to provide the required information or to decide whether the patient was properly informed. Any stated refusal in such a case may well be "invalid". Accordingly, the possibility of liability suggested above is unlikely to apply to an emergency admission, but could apply where there is a chronic, terminal illness where there are opportunities to discuss treatment options with the patient concerned.

Where the patient’s wishes are not known or the patient has expressed neither consent to, nor refusal of, treatment

In emergency situations (as all incidents requiring CPR must be), there is often no indication of whether a patient has or has not indicated a refusal to accept CPR. Doctors and paramedical staff are faced with a situation where the patient is brought into hospital in cardiac arrest and requires treatment.

The historical view has been to justify such emergency treatment on the basis of an "implied consent". This view has lost favour with the courts in recent times, and there is now a view that emergencies are merely an exception to the general rule that consent is required. Croom-Johnson LJ, on behalf of the court in Wilson v Pringle, cited with approval the decision of Goff LJ in Collins v Wilcock, when he said:

"This rationalisation by Robert Goff LJ draws the so-called 'defences' to an action for trespass to the person... under one umbrella of 'a general exception embracing all physical contact which is generally acceptable in the ordinary conduct of daily life'. It provides a solution to the old problem of what legal rule allows a casualty surgeon to perform an urgent operation on an unconscious patient who is brought into hospital. The patient cannot consent, and there may be no next-of-kin available to do it for him. Hitherto it has been customary to say in such cases that consent is to be implied for what would otherwise be a battery on the unconscious body. It is better simply to say that the surgeon’s action is acceptable in the ordinary conduct of everyday life, and not a battery."

This reasoning was followed in Re F (Mental Patient: Sterilisation), where Goff LJ set out the requirements that must be met to allow such treatment to continue. There he said:

"But from them can be derived the basic requirements, applicable in these cases of necessity, that, to fall within the principle, not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would, in all the circumstances take, acting in the best interests of the assisted person.

On this statement of principle, I wish to observe that officious intervention cannot be justified by the principle of necessity... nor can it be justified when it is contrary to the known wishes of

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12 (1972) 175 CLR 479 at 489.
15 [1984] 1 WLR 1172.
17 [1990] 2 AC 1 at 75-76.

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the assisted person, to the extent that he is capable of rationally forming such a wish.”

The doctrine of necessity cannot justify a medical practitioner overriding the patient’s autonomy. It is only relevant where the wishes of the patient are not known; where the patient has not expressed any wishes; or where the patient is incapable of forming a rational decision to accept or refuse treatment. The patient who has expressly, and validly, refused treatment is entitled to expect that such a refusal will be honoured, and to do otherwise can lead to liability. 18

If the patient’s wishes are not known, or the patient has expressed no wishes on the matter, then the doctrine permits the administration of the medical treatment, but the treatment must be in the person’s best interests. If, in the reasonable opinion of the medical practitioner, the treatment is not in the best interests of the patient, then the treatment is not authorised by the doctrine, and should not be administered. 19

Futility

“Futile” is defined by the Concise Oxford Dictionary 20 as “Useless, ineffectual, vain, frivolous”. On 1 March 1993, the New South Wales Department of Health issued Interim Guidelines on Dying with Dignity. Those guidelines defined “futile treatment” as:

“Investigations and treatment which according to professional judgment will lead to inappropriate outcomes such as continued pain, unacceptable quality of life or maintenance of a vegetative state with no possibility of a reversal of that condition.” 21

In these circumstances, there is clear authority 22 that there is no duty on a doctor to administer treatment that, in the doctor’s professional opinion, is “futile”. There is some suggestion from the House of Lords in Airedale’s case that there is, in fact, a duty not to administer such treatment. 23 The Department of Health’s guidelines, whilst not having the authority of law, confirm this position. They say:

“Cardiopulmonary Resuscitation should not be instituted if it is contrary to the patient’s wishes or expectations, is likely to prolong suffering and is clearly medically futile.” 24

It can be concluded, therefore, that there is no obligation to perform CPR when the treatment will be futile, that is, it will achieve no result or a result that “will lead to inappropriate outcomes”. 25

Legislation

Legislation has been enacted in the Northern Territory, 26 South Australia 27 and Victoria 28 that allows a person to complete a statutory form that expressly refuses certain treatment and requires the patient’s medical practitioners to honour that decision. The legislation, however, reserves the patient’s rights under common law. Accordingly, in particular cases where the legislation does not apply and in those States without such legislation (for example, New South Wales and Queensland), the question of whether treatment should be withheld, or when it may be withdrawn, has been left to the common law.

23 See particularly the decisions of Lord Goff and Lord Mustill.
24 New South Wales Department of Health, op cit n 21, p 4.
25 Ibid.
26 Natural Death Act 1988 (NT).
27 Natural Death Act 1983 (SA).
28 Medical Treatment Act 1988 (Vic).
The terms of the legislation vary among the jurisdictions. In Victoria, the patient can sign a refusal of treatment certificate; in South Australia and the Northern Territory the patient can certify that he or she does not wish to be subject to "extraordinary measures" in the event of a terminal illness. Although it is not entirely clear, it is possible that CPR would not necessarily be included within the scope of the South Australian and Northern Territory Acts. The South Australian and Northern Territory Acts provide that a patient who is over 18 years and of sound mind and who desires not to be subjected to extraordinary measures in the event of his or her suffering from a terminal illness, may make a direction in the prescribed form: s 4(1), *Natural Death Act* 1983 (SA); and s 4(1), *Natural Death Act* 1988 (NT). For the direction to have effect, the patient must be suffering from a terminal illness defined as:

"any illness, injury or degeneration of mental or physical faculties—
(a) that death would, if extraordinary measures were not undertaken, be imminent;
and
(b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken."

Extraordinary measures are defined as:

"medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation."

It is arguable that a diagnosis of terminal illness could not be made at first instance, for there may be a reasonable prospect of recovery if CPR is applied. In such a case, the Acts may not apply to CPR.

The Acts expressly reserve the right of a patient to consent to or refuse medical treatment (s 5(1)) and do not affect other legal consequences of giving or refraining from giving treatment (s 5(2)). As such, the Acts add to the common law, by providing a statutory scheme to give effect to the patient's wishes. The common law provisions discussed herein will continue to have effect, regardless of whether or not CPR falls within the definitions of the Acts, and will also apply if the patient expresses wishes without reference to the Acts or the prescribed form.

Under the Victorian legislation, the refusal of treatment certificate could extend to include CPR. The *Medical Treatment Act* 1988 (Vic) allows a person to execute a refusal of treatment certificate that applies to all treatment, or a particular treatment, for a current condition. Accordingly, a person who suffered from a condition that predisposes her or him to a cardiac arrest could complete a form refusing consent to CPR. Under s 4(1), the Act provides that it does not affect any right of a person under any other law (which would include the common law) to refuse medical treatment. As such, if the common law provisions discussed herein do apply, the patient could refuse CPR even if it could not be classified as treatment for a current condition.

*Australian Health and Medical Law Reporter* (CCH, looseleaf), par. 22-360.