Withdrawal of artificial feeding from a dying patient

LOANE SKENE LLM, LLB (Hons)
Series Editor
PAUL NISSELLE AM, MB BS, FRACGP

Medical treatment, palliative care and futile treatment are considered in this discussion of the lawfulness of withdrawing artificial feeding from a patient who had been in a persistent vegetative state for three years and showed no signs of improvement.

The Victorian Supreme Court recently ruled that, under Victorian legislation, it is lawful to withdraw percutaneous endoscopic gastrostomy (PEG) feeding from a patient in a persistent vegetative state on the request of the patient while competent or the patient's State-appointed guardian (*Gardner; re BWV*).[1] The impact of this decision is not limited to Victoria. Although the judgment was based primarily on the Victorian Medical Treatment Act 1988, which gives patients and their agent or guardian a statutory right to refuse treatment, patients also have a common law right to refuse medical treatment – a right that exists throughout Australia. The judgment therefore suggests that doctors can lawfully withhold or withdraw artificial feeding from patients who have given an advance directive refusing all treatment. Artificial feeding is not in a special category of treatment that must continue to be given even if other treatment can lawfully be withdrawn or withheld.

The provision of food and water to a dying patient has traditionally been considered different from the provision of ventilator support, which has been withdrawn without objection from dying patients for many years, either at their request or because it is futile to continue. Canadian law academic Professor Margaret Somerville has observed that we have tended to see these situations differently because of the values and symbolism attached to the provision of food and drink for those in our care, especially babies and young children.[2] Yet she has also noted that respecting a refusal of this type of treatment is no different from accepting a person's refusal of respiratory support for a failed respiratory system.[2]

Justice Morris reached the same conclusion in *Gardner; re BWV*, in which he quoted Professor Somerville with approval (paragraph 85). He held that it was lawful to withdraw artificial feeding via a PEG from a 68-year-old woman (BMV) with a 'progressive and fatal form of dementia, probably Pick's disease', and that the Public Advocate appointed as her guardian (Julian Gardner) could lawfully refuse the PEG on her behalf.[1]

Right to refuse a medical procedure

Justice Morris's reasoning was based firmly on his interpretation of the Victorian Medical Treatment Act 1988 since 'parliament has turned its mind to the circumstances where an agent or guardian may refuse treatment on behalf of a patient…and [that] Act is part of the law of Victoria' (*Gardner; re BWV*, paragraph 36). He also examined in some detail the Act's legislative history, including reports of proceedings before the Legislative Assembly and Legislative Council and reports of parliamentary committees.

Medical treatment versus palliative care

The Victorian Medical Treatment Act gives people the right to refuse medical procedures but not palliative care. Justice Morris said that a medical procedure is one 'based upon the science, the diagnosis, treatment or prevention of disease or injury, or of the relief of pain, suffering and discomfort' (paragraph 75). PEG feeding met this test. It is life support, like ventilation. It is also like administering a drug because the substance used, Osmolite, is 'said to be a high nitrogen isotonic liquid nutrition…included in the 1998 edition of the *Australian Prescription Products Guide* and the *2000 MIMS Annual*', has a label specifying that it should be used only under physician supervision, and is highly concentrated so that high or low dosages would have consequences (paragraph 78). The Public Advocate could therefore refuse it under the Act provided it was not 'palliative care', which cannot be legally refused under the Act.

Justice Morris then considered the meaning of palliative care. He decided that PEG feeding is not palliative care within the statutory definition. Under the Act, he said, palliative care is 'a procedure to sustain life; it is not a procedure to manage the dying process, so that it results in as little pain and suffering as

Professor Skene is Professor of Law, Faculty of Law and Faculty of Medicine, Dentistry and Health Sciences; and Program Director, Medical Ethics, Centre for Applied Philosophy and Public Ethics, University of Melbourne, Melbourne, Vic.
Dr Paul Nisselle is Convenor of Medical Panels, Victorian WorkCover scheme, and a Consultant in Health Law and Risk Management, Melbourne, Vic.

possible' (paragraph 81). Although the Act defines palliative care as including 'the reasonable provision of food and water' (s 3), 'the intent of parliament [in making that exclusion]…was to ensure that a dying person would have food and water available for oral consumption, if the person [wanted it]' (paragraph 85).

Thus, Justice Morris said, because the PEG was held to be medical treatment and not palliative care, the Public Advocate could lawfully refuse it provided there was evidence that the patient would have considered such treatment 'unwarranted and unreasonable'. In the absence of such evidence, the Public Advocate (or other State-appointed guardian) could not refuse treatment under the Act and there would be no point applying for a guardian to be appointed to refuse treatment.

Withdrawing futile treatments

Justice Morris based his decision in this case on his interpretation of the Victorian Medical Treatment Act and therefore did not have to consider whether it was reasonable to withdraw PEG on the basis that it was not in the patient's best interests to continue futile treatment. However, he indicated that if he'd been required to consider this, the withdrawal of treatment should be determined by 'the everyday judgment of a fair-minded person' (paragraph 93), and he would 'find that the further provision of artificial nutrition or hydration was not reasonable in all the circumstances' (paragraph 95). In deciding, he would consider:

- the patient's existing condition – BWV 'has not appeared conscious, or to have any cortical activity, for approximately three years' (paragraph 44) and she was doubly incontinent and was moved into the shower with a hoist (paragraph 6)
- the period for which she had been in her existing condition – BWV had been in the same condition for three years
- her prognosis – the damage to BWV's cortex was irreparable and there was no prospect of any improvement
- the fact that 'continued feeding is doing no more than merely postponing the natural dying process' (paragraph 95)
- evidence of medical witnesses who had observed the patient on whether the treatment had any prospect of improving the patient's condition (paragraph 8)
- any indication from relatives of the patient's wishes.

'…PEG was held to be medical treatment and not palliative care…'

Conclusion

This is the first case in Australia that considers the issue of when it is lawful to withdraw artificial feeding from a dying patient. Although this case focused on the wording and interpretation of the Victorian Medical Treatment Act in relation to the types of treatment that can be refused in advance under the Act, the judgment seems relevant in a wider context. Justice Morris acknowledged in his judgment that people have a common law right to refuse treatment, although he did not mention that the common law right is far more extensive than the statutory one. In particular, a competent patient can refuse even palliative care and there is no reason to believe that an advance directive could not be made to the same effect.

Justice Morris has also given an indication of the factors that might be considered in deciding when it is lawful to withdraw futile treatment, and said that artificial feeding is not in a different category from other medical procedures that sustain life, such as artificial ventilation.

Series Editor's comment

It could be questioned whether the *Gardner; re BVW* decision sanctioned withdrawal of futile treatment or passive euthanasia.

Active and passive euthanasia

In the 1957 trial for murder of Dr John Bodkin Adams, an English general practitioner, trial judge Justice (later Lord) Devlin directed the jury that murder was an act or series of acts, done by the accused *which were intended to kill* and did in fact kill.[3] He said it did not matter if a patient's death was inevitable and that his or her days were numbered; if life was cut short by weeks or months, it was just as much murder as if it was cut short by years.[3]

Interestingly, Justice Devlin did not say 'an act or omission'. Both medicine and law distinguish between active and passive euthanasia. The term 'active euthanasia' usually implies performing an act or series of acts with the sole or principal intent of hastening the death of a patient – for example, the administration of a fatal injection by a doctor to a suffering patient. In 1992, Dr Nigel Cox, an English consultant rheumatologist, was convicted of killing an elderly arthritis sufferer with an injection of potassium chloride. Administration of a bolus of intravenous potassium chloride in those circumstances was clearly intended to kill, but, because the charge was 'attempted murder', the Court was able to hand down a suspended sentence.[4] Likewise, Dr David Moor, an English general practitioner, was acquitted in 1999 after giving an elderly, terminally ill patient a massive overdose of diamorphine. The acquittal was achieved despite clear evidence of an intent to end life, albeit for compassionate reasons.[4]

The term 'passive euthanasia' also implies a deliberate intent to end life, but by omissions (such as withholding life-sustaining treatment) rather than by acts as in active euthanasia. We've all done it – would you treat pneumonia in a patient with disseminated malignancies?

These terms are controversial. Doctors who find the very concept of euthanasia anathema may well endorse the withholding or withdrawing of 'futile' life-sustaining treatment in some circumstances,

and vigorously resent using the term passive euthanasia to describe their (in)action. They would argue that they were just exercising professional judgment in assessing the most appropriate course of action. Withholding or withdrawing futile treatment does not *per se* mean passive euthanasia. That term, to me, should only apply if the principal reason for the withholding or withdrawing of treatment is to hasten the death of the patient.

Voluntary, involuntary and nonvoluntary euthanasia

Another important distinction in defining euthanasia is that between voluntary and both involuntary and nonvoluntary euthanasia.

Voluntary euthanasia is performed at the request of a patient, and is also called requested, assisted or consensual euthanasia. Involuntary euthanasia is euthanasia (active or passive) performed against the expressed wish of a patient or where the patient has not been given the opportunity to express a wish. Nonvoluntary euthanasia, on the other hand, covers euthanasia where the patient is unable, because of mental or physical incapacity, to request or consent to treatment (or nontreatment) to hasten death.

An example of what might be called involuntary euthanasia is the doctor not continuing active treatment of a patient with a terminal malignancy who will not accept his or her fate and keeps seeking more and more heroic treatment. We've all had such patients.

BWV was obviously in the nonvoluntary euthanasia category and, therefore, her legal guardian quite properly asked a Court to declare that PEG feeding represented futile treatment and hence its withdrawal did not signal a primary intent, by omission, to end life. Justice Morris chose to base his judgment largely on statute (parliament-made) law. While it resonates reasonably comfortably with medical ethics and practice, neither the pro- nor anti-euthanasia lobbyists will take much comfort from it. MT

References

1. Gardner; re BWV [2003] VSC 173 (Morris J).
2. Somerville MA. The ethical canary: science, society and the human spirit. New York: Viking Books, 2000: 163.
3. R v. Adams (Bodkin) [1957] Crim Law Rev 365.
4. Barkham P. Doctors of death. Guardian Unlimited, 2000 Jan 27 (www.guardian.co.uk).