Legal issues arising from the provision of end of life care

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Understanding death in critical care
9 December 2016

Overview

- Communication about death and dying
- Legal framework
- Advance care planning
- EPOAs
- Withholding/withdrawing treatment

Communication about death and dying

The new challenge

"*For all but our recent history, dying was typically a brief process. ... the interval between recognizing that you had a life-threatening ailment and death was often just a matter of days or weeks....*

These days, swift catastrophic illness is the exception; for most people, death only comes after a long medical struggle with an incurable condition – advanced cancer, progressive organ failure (usually the heart, kidney or liver), or the multiple debilities of very old age. In all such cases, death is certain, but the timing isn't. So everyone struggles with this uncertainty – with how, and when, to accept that the battle is lost.

...

In the past few decades, medical science has rendered obsolete centuries of experience, tradition and language about our mortality, and created a new difficulty for mankind: how to die."

Atul Gawande (2010) "*Letting go*"

Talking about death and dying

- As a society….
- As health providers….
- As health professionals….

Hospitals urged to talk more to families

nzherald.co.nz

Hospitals urged to talk more to families

9:25 AM Tuesday Apr 10, 2012

A Wellington coroner has reiterated concerns he has with hospitals and their lack of communication with the families of patients.

...

Mr Smith reiterated comments made by Robert Logan, the now retired chief medical officer at Hutt Hospital. During an inquest into the death of 85-year-old Kathleen Corbett, Dr Logan said the health system was not as sound and open as should be in dealing with patients' future prospects.

Families needed to be told in a "truthful manner" how their loved ones were and that they could die, so they were prepared for it, he said.

…they want to hear the truth

Dr Logan stated that he had recently attended a seminar on law and elderly patient care. He said one of the most inspired points that came out of this was that whilst medical practitioners cannot predict when a person is going to die, they would have a pretty good idea about how they were going to die, and that it was equally important to consider that as a process....

...what [patients] want to know is they want to hear the truth as is best known. This then allows them and their families to make appropriate arrangements.

Findings of Coroner Smith, 30 August 2011

Legal Framework

Promotion of choice and autonomy

- NZ law promotes choice and autonomy in planning and receiving health care
- For example:
  - Right to dignity and independence (Right 3)
  - Right to services of an appropriate standard (Right 4)
  - Right to effective communication (Right 5)
  - Right to be fully informed (Right 6)
  - Right to make an informed choice and give informed consent (Right 7)

Legal principles

- If a person is competent – make their own decision
- If the person is not competent:
  - Services may be provided or withheld in accordance with a valid advance directive
  - An EPOA for personal care and welfare or Welfare Guardian may consent to services on the person's behalf; however, **they may not refuse consent to standard medical treatment intended to save the person's life or to prevent serious damage to the person's health**
  - Services may be provided in accordance with Right 7(4) – best interests and person's views

Advance Care Planning

Advance Care Planning

- Advance care planning is a process of discussion and shared planning for future health care
- Opportunity to develop and express preferences for future that is care informed by:
  - personal beliefs/values; *and*
  - an understanding of current and anticipated health status and treatment and care options

Advance Care Planning

- Advance care planning differs to general health care planning:
  - Based around an anticipated deterioration in the person's health
  - Focuses on the person's wishes and preferences for the time when they lose capacity to make decisions
  - Encourages discussion around end-of-life care and end-of-life experiences (i.e. When should an ambulance be called; Where does the person wish to die; How would they like their body to be cared for after death)

Advance care planning

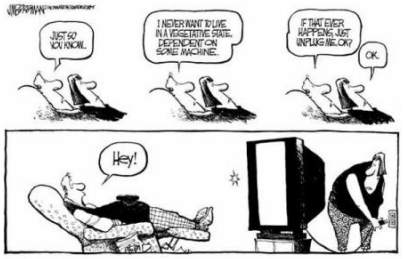
- Encourages conversations about what is important to the person
- Helps the person to achieve a sense of control
- Engages others, including family and caregivers, and helps them to understand the person's wishes and support them throughout the process
- Reassures the person that discussions and plans can change

Advance care plan

Advance care plan

- Advance care plan is an articulation of wishes, preferences, values and goals relevant to all current and future care
- Used to inform decision-making when the person becomes incompetent:
  - Decision-making by EPOA (if appointed)
  - Decision-making by health providers under Right 7(4)
    - Is it in the person's best interests
    - Is it consistent with the informed choice the person would have made if competent?

Advance directives



Advance directives

- "Advance directive" means a written or oral directive-
  - by which a person makes a choice about a possible future health care procedure; and
  - that is intended to be effective only when he or she is not competent
- "Choice" means a decision to receive, refuse or withdraw consent to services
- A valid advance refusal of treatment is legally binding

Establishing validity

- Was the person **competent** to make the particular decision at the time the advance directive was made?
- Was the advance directive made **voluntarily**?
- Was the person **sufficiently informed** to make the advance directive?
- Did the person intend the advance directive **to apply in the present circumstances**?

Practical problems

- Identification – How do we know that a patient has an advance directive?
- Applicability – How do we know that the advance directive is still applicable, that the person has not changed his/her mind?
- Lack of prior relationship with patient/family
- Communication – breakdown in communication between providers and/or family members can lead to problems in identifying the existence of an advance directive and in determining validity
- Generality – How do we know that it applies to this treatment, in this situation?

Advancing individual autonomy

- These issues can be addressed/mitigated through:
  - Reflective discussions and open communication
  - Multidisciplinary approach
  - Involvement of family
  - Documentation of wishes
  - Recording and sharing the plan with appropriate others
  - Interface between primary and secondary, access to afterhours and ambulance services

Advance decisions regarding CPR

Advance decisions regarding CPR – patient

- Competent patient choice – Advance Directive
  - Individual autonomy and right to refuse
  - Still valid even if medically appropriate to attempt CPR
  - In effect – a consumer initiated Not for CPR order
- Note: no one other than a competent patient can give an advance directive (not even the EPOA)

Advance decisions regarding CPR - clinician

- By doctor – Not for CPR order
  - In the course of treatment planning
  - Ideally following discussion with person and/or family
  - CPR deemed clinically inappropriate
- Based on the principle – no requirement to provide futile treatment

Missing the point?

Incorporating advance care planning into treatment

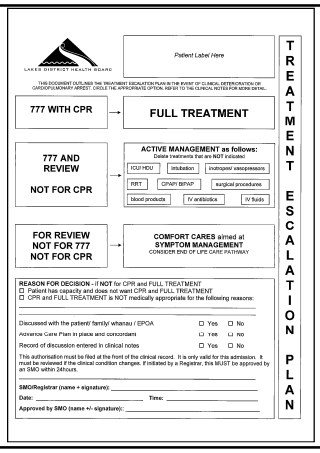
Scottish case study

- Taylor DR. 2014. COPD: End of life and Ceiling of Treatment. Thorax 69: 497–9:
  - Our failures centred on inadequate communication leading to discontinuity and inappropriateness of care. First, although the patient's notes documented that an end-of life conversation took place, and that palliative treatments were to be given, they did not include the fact that certain treatments were NOT to be given, including non-invasive ventilation (NIV).

Scottish case study

- Similarly, the hand over to night staff did not include what was NOT to be done. Third, in the absence of this negative but nonetheless specific information, the default position for the junior doctor, unfamiliar with the patient, was to 'go by the book'. This resulted in interventions which were futile, burdensome and contrary to the patient's and family wishes.

Change ahead



Treatment Escalation Plan

- Differ from advance care plans, which are patient-led decision-making tools to be used in the event the person loses capacity to make their own decisions
- TEPs are often clinician-initiated and informed by both the existence of the advance care plan and the individual patient's current clinical circumstances.

Treatment Escalation Plan

- The TEP is a form completed by medical staff soon after admission, ideally with the (competent) patient, or close relative, documenting what treatment options would be appropriate if that patient were to become acutely unwell
- Wider application than Not for CPR

Enduring powers of attorney

Enduring powers of attorney

- A person may appoint someone to act on his/her behalf in relation to the person's personal care and welfare and/or property
- An enduring power of attorney (EPOA) continues to have effect after the donor becomes mentally incapable

Enduring powers of attorney

- Donor may appoint one attorney to act in a general or specific manner in respect of personal care and welfare
- The donor may impose certain conditions and restrictions
- An EPOA cannot refuse consent to standard medical treatment or procedure intended to save the donor's life or prevent serious damage to the donor's health

When there is no EPOA or the EPOA has no power

Right 7(4)

- Under Right 7(4) services may be provided if:
  - A consumer who is not competent to make an informed choice AND
  - There is no person entitled to consent AND:
    - Services are in the **best interests** of the consumer; and
    - Reasonable steps to ascertain **consumer's views**; and
    - **Views of consumer or other suitable person** taken into account

Withholding/withdrawing treatment

Withholding/withdrawing treatment

- Statutory definition of homicide – "killing by any means whatsoever" – includes an omission to act
- The law only takes account of omissions to provide life-prolonging treatment where there is a duty to provide such treatment
- In a great many cases would be very difficult to prove that if treatment had been provided, death would not have occurred

Withholding/withdrawing treatment

- But – will be many circumstances where can be shown there is a causal link between withholding or withdrawing treatment and occurrence of death (eg withdrawal of life support)
- "Homicide is culpable when it consists in the killing of any person—"(b)By an omission without lawful excuse to perform or observe any legal duty"

Murder/manslaughter

- When an omission to provide life-prolonging treatment amounts to culpable homicide, it will normally be murder if the person responsible meant to cause the death of the person killed
- Where the person did not mean to cause the death of the person killed, culpable homicide by omission would usually be manslaughter

Is there a duty to act?

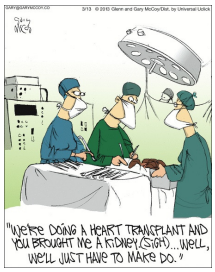
- Duty to provide necessaries and to protect from injury (sections 151 and 152 of the Crimes Act) – need to have actual care or charge of a person
- If don't require necessaries or would be ineffective in prolonging life, no duty
- But what if they are or would be to prolong life?

Is there a duty to act?

- Other statutory and common law duties:
  - anyone who undertakes (except in case of necessity) to administer surgical or medical treatment is under a legal duty "to have and to use reasonable knowledge, skill, and care" in doing any such act (section 155)
  - anyone who has in their charge or under their control "anything whatever" (or who operates or maintains "anything whatever"), which, in the absence of precaution or care, may endanger human life are "under a legal duty to take reasonable precautions against and to use reasonable care to avoid such danger" (section 156)
  - a duty on anyone who undertakes to do any act, the omission of which is or may be dangerous to life (section 157)

Major departure required

- In any prosecution for an omission to prolong life, a major departure from the standard of care has to be proved, whatever the source of the duty



Lawful excuse

- Refusal of consent by competent patient
- Advance directive
- Views of others about what the patient would have wanted usually doesn't amount to a lawful excuse (reliability)

Lawful excuse

- A decision in good faith that withdrawal of the life support system is in the best interests of the patient
- Consistent with good medical practice (conformity with prevailing medical standards and with practices, procedures and traditions commanding general approval within the medical profession)

The role of family

The role of family

- No legal authority to consent or refuse consent
- In practice providers frequently consult with family members before withholding or withdrawing treatment that could well prolong the patient's life

Shortland v Northland Health Ltd (CA)

- "To require the consent of the patient's family to the cessation of a particular form of treatment, or to a decision not to give the patient a particular form of treatment, gives the family the power to require the treatment to be given or continued irrespective of the clinical judgment of the doctors involved. The law cannot countenance such a general proposition."

Shortland v Northland Health Ltd (CA)

- "In a case such as the present, the criterion should not be to require consent from the patient's family. The appropriate course is to expect, where circumstances permit, that there will be reasonable consultation with the patient and such members of the family as are available. Indeed the patient's wishes about who else should be consulted, if the patient is able rationally to express those wishes, should ordinarily be respected."

Shortland v Northland Health Ltd (CA)

- Emphasis is on consultation, not on the consent of the family being a legal requirement
- "Those responsible for the patient's care should bear in mind the views expressed but ultimately they must decide what in clinical terms and within the resources available is best for their patient."

Patient's request

- The fact that a patient requests life-prolonging treatment does not necessarily create a duty to provide it:
  - If not consistent with good medical practice
  - Resource constraints

Assisted dying

- Health Select Committee is taking public submissions on assisted dying and suicide
- The terms of reference are:
  - The factors that contribute to the desire to end one's life
  - The effectiveness of services and support available to those who desire to end their own lives
  - The attitudes of New Zealanders towards the ending of one's life and the current legal situation
  - International experiences

Questions/comments?

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