Victorian Institute of Forensic Medicine

Future leaders Communiqué

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GUEST EDITORIAL

Dr Bharathy Gunasekaran

This issue of the Future Leaders Communiqué describes two cases of end-of-life care and explores the issues surrounding withholding or withdrawing medical treatments that are deemed to be futile in situations involving patients without decision-making capacity.

The first case ('Knowing when to stop') illustrates some of the challenges that occur when family members and medical practitioners disagree with regards to continuation of medical treatments that are considered to be futile. It is important to recognise that it is a difficult situation, to build rapport with the family and to acknowledge the limitations of treatment. In Australia, there is no general duty on doctors to provide treatment that they consider to be futile and that would not be in the patient's best interests.

The second case ('End of life care – What is medical treatment?') highlights the importance of knowing what the legal definition of 'medical treatment' is and the necessary processes that need to be undertaken when treating a patient who is unable to give consent. The principle of consent is an important part of medical ethics and international human rights law. For consent to be valid it must be voluntary, informed, and the person consenting must have capacity to make the decision.

A study done by White et al* showed that there were significant knowledge gaps amongst doctors in Australia about the law on withholding and withdrawing life-sustaining treatment from adults who lack decision-making capacity. Although doctors receive some education regarding the legal issues in medicine, it is likely to be insufficient. As such, there is a need for the medical curriculum to address the legal context of medical practice and to provide clearer guidance on legal matters that doctors will almost certainly encounter. In addition, there is also a need for a national approach to the law to reduce the level of legal complexities between States and Territories to some degree.

End-of-life care decisions include the assessment of whether a patient has the capacity to make a treatment decision, the determination of who is the authorised decision-maker if the patient lacks capacity, and whether an advanced care directive is in place. The lack of knowledge and/or adherence to the law can result in unauthorized provision or cessation of medical treatment, compromise patient care and put healthcare professionals at legal risk.

* White B, Willmott L, Cartwright C, Parker MH, Williams G. Doctors' knowledge of the law on withholding and withdrawing life-sustaining medical treatment. Med J Aust. 2014;201(4):229-232.

EDITORIAL

Welcome to the fourth issue of the Future Leaders Communiqué, our sister publication to the Clinical Communiqué and the Residential Aged Care Communiqué. Since the launch of this version with junior practitioner inspired content, the response has been fantastic, with feedback telling us how well the issues are resonating with our recently graduated colleagues.

The important and hard work done by our guest editors has been recognised further with the recent announcement that the Victorian Managed Insurance Authority (VMIA) will support the production of another four issues of the Future Leaders Communiqué going into 2018. With subscriber numbers growing to over 2500 in such a short space of time, and the ongoing support of the VMIA, the future of this publication looks bright and strong.

Our guest editor for this issue is Dr Bharathy Gunasekaran, a Basic Physician Trainee in her fourth post-graduate year. Dr Gunasekaran works at a large metropolitan hospital in Melbourne and has a keen interest in palliative care, and public health. This issue addresses the clinical challenges of end-of-life care in situations where patients are unable to give consent.

We are fortunate to have an expert commentary from Dr Paul Eleftheriou, Deputy Chief Medical Officer and Medical Director for Quality Improvement and Innovation at Austin Health. He provides unique insights relevant to junior doctors including their role in end-of-life care management, their limitations as a junior staff member, and tips for junior doctors when confronted with challenging situations in a palliative care setting.

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DISCLAIMER
All cases that are discussed in the Future Leaders Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of, the individual Coroner, the Coroners Court, Department of Health, Department of Forensic Medicine, Victorian Institute of Forensic Medicine or Monash University. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroners Court jurisdiction.

FEEDBACK
The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: flc@vifmcommuniques.org

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CASE KNOWING WHEN TO STOP

Case Number:
D0223/2007 NT

Case Précis Author:
Dr Bharathy Gunasekaran

CLINICAL SUMMARY

Mr PM was a 29 year old male who sustained a high cervical spinal cord injury and brain injury following a motor vehicle crash. He was intubated, transferred to a major metropolitan hospital by air and admitted to the Intensive Care Unit (ICU) where he developed persistent high intracranial pressures that were unable to be reduced. Orthopaedic and neurosurgical opinions were sought and Mr PM was deemed to not be an appropriate surgical candidate. Multiple family conferences were held to explain the seriousness of his injuries and his poor prognosis. The family was provided with social work and chaplaincy assistance early on.

In the following days, more family meetings were held and a consensus was not reached regarding the withdrawal of life support. The family was given more time to come to terms with the situation. In the interim, further specialist input was sought as Mr PM's family was not accepting of the prognostic information provided. They requested an independent opinion of Mr PM's prognosis and began contacting external doctors but were unsuccessful in getting any replies.

Twelve days after the crash, the ICU director made the decision to withdraw ventilation after discussions with her staff. This decision was based on the belief that prolonged futile therapy was not in the patient's best interest and that the family had been given sufficient time to come to terms with the situation.

Mr PM's family strongly disagreed with this decision and obtained an injunction by phone to stop withdrawal of care. The Supreme Court ordered the hospital to cease from withdrawing life support and the family was given 24 hours to obtain an additional opinion. An external neurosurgeon had been located, but was unable to give a definitive opinion until he had formally examined the patient in person and he was unable to do so in the time frame provided.

Mr PM was extubated when the order expired and his feeding tube was removed. He was given a small amount of fluid the next day as per the family's request and was commenced on morphine for comfort. Mr PM died fifteen days after the crash and approximately 16 hours after he was extubated.

PATHOLOGY

Mr PM's cause of death was blunt head and neck injuries sustained following a motor vehicle crash with bronchopneumonia whilst in hospital.

INVESTIGATION

Mr PM's death was reported to the coroner as his death was a result of injuries sustained in a motor vehicle crash. The coronial investigation included both the crash as well as Mr PM's hospital admission, reviewing the appropriateness of his medical care, his prognosis and the appropriateness as well as timing of the withdrawal of ventilatory care. An independent expert, the ICU doctors and neurosurgeon involved, as well as Mr PM's sister were among the people called to provide statements to the coroner.

The expert opinions in relation to Mr PM's prognosis took into account a range of factors including his hypotension and lack of consciousness immediately after the crash, persistently high intracranial pressures, and the transection of his spinal cord at the C5 level.

> *The ICU specialists believed that there was not any treatment that could benefit Mr PM to recover and considered that it was appropriate to withdraw as ongoing treatment was futile.*

It was agreed that Mr PM had a high chance of death, persistent vegetative state or severe disability. As Mr PM's prognosis was extremely poor, the ICU specialists believed that there was not any treatment that could benefit Mr PM to recover and considered that it was appropriate to withdraw as ongoing treatment was futile. They also agreed that their duty of care was first to the patient.

The neurosurgeon who had been contacted by the family was the only expert witness who stated that he was not in favour of the ventilator being turned off at the time as he believed that the family needed time to adjust. Instead, he thought that the ventilator should have been weaned off, or a tracheostomy performed and Mr PM moved to the ward and ventilated there. He did not agree that it was unethical to continue futile treatment as it was unclear what Mr PM's wishes were and there was a duty of care to the family as well. He also stated that he believed the only times a ventilator should be turned off was when a patient was brain dead or for consideration of organ transplantation.

The family was concerned about the reduction in feeding in anticipation of the planned withdrawal of ventilatory care and the decision to not give Mr PM fluids for the first night after his extubation. They were particularly concerned about the provision of morphine the morning of his death and whether this caused his death. The independent expert believed that the altered feeding or fluid regimen did not hasten Mr PM's death.

CORONER'S FINDINGS

The coroner believed that Mr PM received appropriate medical care throughout his admission and that his prognosis was poor. The post-mortem toxicology results for morphine were within the reported therapeutic range and the coroner found that the provision of morphine was reasonable and did not contribute to Mr PM's death.

The coroner did not believe that there was inadequate preparation with regards to the decision to withdraw ventilatory care as there were seven days between the first mention of withdrawal of care (on the third day) and the decision to actually withdraw care (on the tenth day).

The neurosurgeon indicated that the case should have been managed in a different way and the family were not aware of this divergent opinion.

The coroner also did not believe that the decision to withdraw ventilation should have been put off solely for the purposes of waiting for another opinion as the ICU team had sought the opinions of a wide range of specialists both internally and externally, and the family was made aware of the need to get an independent opinion in a timely fashion.

The coroner did find the lack of documentation by the external neurosurgeon concerning, particularly as the neurosurgeon indicated that the case should have been managed in a different way and the family were not aware of this divergent opinion. The first time the neurosurgeon's divergent opinion was clearly expressed was months after Mr PM's death in a statement to the coroner and then at the inquest. Therefore this information arrived too late to affect Mr PM's treatment. The coroner also stated that the neurosurgeon's views in relation to the withdrawal of care were completely at odds with the evidence as to the practices in ICU.

The coroner recommended the establishment of a clinical ethics committee comprising liability-protected health professionals and possibly other persons, with the ability to convene at short notice in urgent situations. The committee would act as decision makers that are independent from the treating doctors and the family.

AUTHOR'S COMMENTS

This case demonstrates the importance of communication between medical practitioners and family members. Medical practitioners need to have open and honest conversations with family members early on and should try to provide families with accurate, current and frequent prognostic estimates.

This case also shows that it is sometimes necessary and appropriate to have different specialists evaluate the patient's management and prognosis.

The emotional needs of families should be addressed and the involvement of social workers and chaplaincy are vital in fostering communication and providing the necessary supports. The documentation in these situations is also important and should clearly include the dates and times of family meetings, persons present and issues discussed. This case also shows that it is sometimes necessary and appropriate to have different specialists evaluate the patient's management and prognosis. The family's wishes to obtain an external opinion should also be respected and facilitated where possible. In certain situations, like the one described in this case, a limited period of administering futile medical treatment may be required to enable the family to come to terms with the patient's condition.

Furthermore, it is not uncommon for family members and medical practitioners to disagree regarding the benefits of continued treatment to the patient.

Medical futility means that the proposed treatment does not have a reasonable chance of benefiting the patient and is highly unlikely to result in meaningful survival. Part of the problem with the concept of futility is that it is a subjective notion and there is no unanimity regarding the statistical threshold for a treatment to be considered futile. Furthermore, it is not uncommon for family members and medical practitioners to disagree regarding the benefits of continued treatment to the patient. In protracted futility disputes between medical practitioners and families, clinical ethics committees in hospitals and facilitative ethics consultations can be helpful. It would also be beneficial to have hospital futility policies in place that provide a fair process to settle disputes and embrace an ethic of care.

FURTHER READING

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Botha J, Tiruvoipati R, Goldberg D. Futility of medical treatment in current medical practice. *NZMA* 2013;126(1383):58-71.

Bernat JL. Medical futility: Definition, determination, and disputes in critical care. *Neurocrit Care* 2005;2(2):198-205.

KEYWORDS

Motor vehicle crash, communication, poor prognosis, medical futility, withdrawal of treatment

CASE END OF LIFE CARE - WHAT IS MEDICAL TREATMENT?

Case Number:
COR 2012 567 VIC

Case Précis Author:
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CLINICAL SUMMARY

Mr JC was a 40 year old male with cerebral palsy and severe intellectual disability who lived in a supported residence. His past medical history also included epilepsy, hydrocephalus and dysphagia. He was bed bound, had minimal communicative abilities and did not have an administrative or guardianship order in place. He presented to a major metropolitan hospital with complaints of an ongoing cough on a background of six recent hospital admissions with multiple occasions of aspiration pneumonia.

During one of the recent admissions, it was agreed that conservative management was the most appropriate approach for Mr JC following discussions between the treating team, his general practitioner, and the staff caring for him in the community. An advanced care plan was made suggesting that future admissions be directed to the Palliative Care Unit.

During Mr JC's final admission, he deteriorated on the ward and was not tolerating oral intake. It was believed that he would not benefit from further active management and he was subsequently transferred to the palliative care unit where he was given medication for comfort purposes via a subcutaneous cannula. Mr JC died 4 days after he was transferred to the Palliative Care Unit.

PATHOLOGY

The cause of the death on autopsy was aspiration pneumonia.

INVESTIGATION

Mr JC's death was reported to the coroner as he was 'in care' at the time of his death, in a supported residence managed by the Department of Human Services (DHS). Further, his 'in care' status mandated a coroner to hold an inquest into his death.

Mr JC was a patient with a disability who was incapable of giving consent to medical treatment and did not have a 'person responsible' identified.

The focus of the coroner's investigation was to determine whether during his hospital admission, Mr JC was provided with medical treatment.

When there is no 'person responsible', medical treatment can be provided if the practitioner believes on reasonable grounds that the treatment is in the patient's best interests, and the practitioner gives notice to the Office of Public Advocate (OPA) before carrying out the medical treatment in accordance with Section 42K of the Guardianship and Administration Act 1986 (VIC).

The focus of the coroner's investigation was to determine whether during his hospital admission, Mr JC was provided with medical treatment. Medical treatment is defined in the Guardianship and Administration Act 1986 (VIC) and includes palliative care but does not include the administration of a pharmaceutical drug. The coroner asked the hospital to outline what consideration had been given to Section 42K (S42K) of the Guardianship and Administration Act 1986 (VIC) regarding the decision to palliate Mr JC.

The hospital's clinical ethicist stated that it was not considered necessary to submit a S42K notification in this case, as where palliative care consists of the administration of pharmaceutical drugs, it was excluded from the definition of 'medical treatment'. The clinical ethicist also believed that submitting a notification would have inappropriately and unnecessarily delayed the provision of palliative care to Mr JC.

However, the administration of a pharmaceutical drug itself via the cannula is not considered 'medical treatment'.

The OPA stated that although it viewed palliative care as medical treatment, when palliative care consists of the administration of pharmaceutical drugs, it would be caught by the exclusion provision section 3(g) and so fall outside the definition. With regards to the insertion of a cannula, the OPA was of the view that the insertion of a cannula itself is 'medical treatment'. It cannot be described as administration of a pharmaceutical drug although it facilitates the provision of the drug. However, the administration of a pharmaceutical drug itself via the cannula is not considered 'medical treatment'. The OPA also noted that the medical profession's understanding of medical treatment was that the insertion of a cannula was part of the administration of the pharmaceutical drug and so would not be medical treatment.

CORONER'S FINDINGS

The coroner stated that the clinical treatment of Mr JC prior to his death was reasonable. However, it was noted that there was uncertainty in relation to the definitions of medical treatment, palliative care, and administration of pharmaceutical drugs, under S42K of the Guardianship and Administration Act 1986 (VIC). This affected the medical profession's understanding of when notice should be given to the OPA.

> *When a person lacks capacity to decide, care planning must focus on determining the person's best interest and any relevant advance care statement made prior to their loss of capacity should be taken into account.*

The coroner stated that in the absence of consent, the S42K process acts as an important procedural check with respect to the oversight of medical treatment provided for people who cannot consent and do not have a 'person responsible'. In Mr JC's case, the coroner thought it was unclear whether the process of notification to the OPA in accordance to S42K of the Guardianship and Administration Act 1986 (VIC) should have been followed.

The coroner also found that there was a misconception that a submission of notice under S42K would unnecessarily delay the provision of care to the patient. In actual fact, the treating practitioner may carry out the treatment as soon as a notice has been given.

AUTHOR'S COMMENTS

Capacity refers to the ability to make a decision about a particular issue at the time the decision needs to be made, or to give consent to a particular act. When a person lacks capacity to decide, care planning must focus on determining the person's best interest and any relevant advance care statement made prior to their loss of capacity should be taken into account.

'Medical treatment' is defined broadly by the Guardianship and Administration Act 1986 (VIC) to include any medical treatment normally carried out by, or under, the supervision of a registered practitioner.

Palliative care is not separately defined in the act but the Australian Medical Association definition states 'palliative care' to mean 'care provided for people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life'. As this case illustrates, it is important that medical practitioners are familiar with the different legislations across the states, what 'medical treatment' encompasses, and what needs to be done when there is a patient who is unable to give consent.

FURTHER READING

Willmott L, White B, Smith MK. "Best interests" and withholding and withdrawing life-sustaining treatment from an adult who lacks capacity in the parens patriae jurisdiction. *JLM.* 2014;920-41.

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KEYWORDS

Consent, medical treatment, palliative care, intellectual disability, capacity, guardianship and administration act

COMMENTS FROM OUR PEERS

"I was surprised to learn that the definition of 'medical treatment' varies by state, and interestingly does not include administration of medicines."

"The importance of knowing limitations as a junior doctor and asking for help when required, particularly for complicated management decisions such as end of life care. Nice to know people recognize that we are still learning."

"The second case itself was shocking and made for an interesting read. I could relate to the commentary as, I have been in almost this same situation, this year. The advice offered is practical and accessible, and serves to acknowledge the difficult situation junior doctors are often put in."

THE ROLE OF THE JUNIOR DOCTOR IN DELICATE END-OF-LIFE CARE DECISIONS

Dr Paul Eleftheriou
Deputy Chief Medical Officer

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Improvement and Innovation,
Austin Health

Junior doctors are commonly referred to as the workhorses of the hospital arena. They are at the coalface, are the intermediaries between consultants and the 'greener' interns, and are expected to make (sometimes) difficult clinical decisions from day to day.

However, in a society filled with litigation and complex informed consent laws[1], junior doctors need to be mindful of their medico-legal scope.

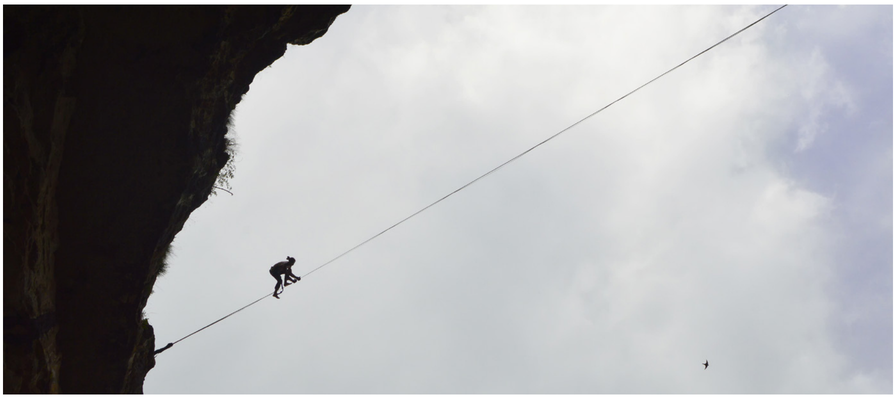
It is for example consistently practiced in Victorian health services that the only doctor who can sign a consent form is the one performing the procedure – an exception arises when a non-consultant has performed this said procedure many times and competently.

> *Thus the role of the junior doctor in these delicate end-of-life care decisions is to learn, not to make decisions.*

In the same vein, junior doctors need to be mindful when leading management plans in the palliative care context, since the outcome if they get it wrong is a matter of life and death. As with surgery, junior doctors should take the apprentice role in palliative care, gradually gathering the confidence and skills to make decisions autonomously.

Thus the role of the junior doctor in these delicate end-of-life care decisions is to learn, not to make decisions. Like with every specialty, there is a great deal to do before the decision is made such as: addressing the patient and family's goals and personal requests; determining who the substitute-decision maker is (i.e. person responsible[2]); build trust and rapport; lead the cultural competence on behalf of the team; and begin the grieving process in some cases. This is an incredibly important component of patient care and once again, junior doctors do the lion's share given their accessibility and proximity.

By the same token, this reliance on junior staff creates somewhat of a conundrum. Nursing staff depend on junior doctors to always be available but they are essentially the least experienced members of the medical team. Therein lies the secret to an effective junior doctor – understanding their scope and asking for help when that boundary is being challenged. An effective junior doctor will escalate the concern in every aspect of clinical care, and palliative care is not an exception – in fact, expeditious communication to senior colleagues is paramount when the end is nigh. Every health service – in particular palliative care physicians – should encourage their junior doctors to ask for help. For their own learning, junior staff should firstly develop a plan, think it through and then run it past their senior peers, rather than just calling on someone for an answer. In addition to the responsible consultant, junior doctors should also call on other key resources such as palliative care nurses (who will usually have a more in-depth understanding of the patient's history), allied health professionals i.e. social workers or psychologists, clinical ethics teams or religious leaders, and if there are any medico-legal concerns, they should also call on their medical administrators and/or hospital legal teams.



The key principle is that in the midst of these complex yet crucial end-of-life care decisions, junior doctors are never alone.

Sometimes difficulties arise when junior staff feel that the decision instituted on them or advised by a senior colleague may not be the best course of action. This is always a difficult situation to be in, however not uncommon.

This is a key learning opportunity and it is always in the junior doctors' best interests to act respectfully and professionally. There may be a component of the management plan that isn't well understood by the junior doctor. This may be part of a novel treatment, or perhaps a key part of the patient or family history isn't known to the junior doctor. The best advice in this case is for the junior doctor to modestly ask 'Just so I know for my own learning, can I ask why we wouldn't [insert management plan] instead of [consultant management plan]'. This way, the junior doctor is in the safe environment of pedagogy. If of course, the junior doctor feels that the senior colleague's treatment is unsafe or inappropriate then advice should be sought from either a trusted colleague, the hospital medical administrator or their medical defence organisation.

Despite the aforementioned advice, life as a junior doctor is tough. Lots of hours, lots of patient contact time and a lot of pressure to be the workhorse and the master. Some other useful resources junior doctors can turn to can be found at the Advance Care Planning Australia, Palliative Care Australia and the Australian Government's Palliative Care websites[3-5]. If local resources and education is lacking, ensure your hospital has a policy, procedure and/or guideline and encourage your palliative care unit to host education sessions as most doctors, let alone junior doctors, fear having that very difficult conversation with a patient when it involves talking about death.

REFERENCES

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