ELDAC
End of Life Directions for Aged Care

Futile and Non-Beneficial Treatment Case Study

Victor's story

Victor is a 92-year-old with hypertension, Type 2 diabetes mellitus and coronary heart disease. He lives alone and following a recent fall he mobilises using a walking stick. Since his fall he has required assistance with some activities of daily living (showering, housework, meal preparation and shopping) and medication management. To assist his rehabilitation he receives a weekly visit from a Home Care Provider team, and is transported once a week to appointments with a physiotherapist. He has capacity to make decisions about his healthcare, and does not have an Advance Care Directive.

One afternoon Victor experiences chest pain and presses the personal emergency alarm he wears around his neck. His son Patrick is alerted and rushes to Victor's house where he discovers Victor on the floor, unconscious.

Victor is transferred by ambulance to hospital where he is diagnosed as having suffered a cardiac arrest, with several minutes of cerebral hypoxia. He remains comatose, and is placed on artificial ventilation in the Intensive Care Unit (ICU). Within a few days his condition stabilises, but due to the extent of Victor's brain damage and his pre-existing chronic conditions, his specialists consider it is unlikely he will significantly improve, or be able to survive without artificial ventilation.

Dr Hughes, a member of the ICU clinical team, meets with Patrick, and Patrick's wife Claudia, to discuss Victor's prognosis. Dr Hughes explains that the clinical team's unanimous opinion is that continuing to provide ventilation would not be in Victor's best interests as it would be invasive, of little benefit in improving his condition, and may cause him pain and suffering. Patrick asks whether the doctors can continue Victor's life support for a few more days to allow more time for him to show improvement. Dr Hughes clarifies that in the unlikely event Victor did show improvement it would only be minimal, and that even if he could breathe independently he would most likely be immobile, with significant cognitive impairment and care needs. He discusses with Patrick and Claudia withdrawing Victor's ventilation and providing comfort care.

Points for reflection

1. Is it lawful for the clinical team to withdraw Victor's ventilation?
2. If Patrick disagreed with the clinical team's decision and insisted that Victor continue to be ventilated, does that request have to be followed?

Legal considerations on the points for reflection

1. Is it lawful for the clinical team to withdraw Victor's ventilation?

Health professionals generally have **no obligation to provide treatment that would not be in the person's best interests, or is inconsistent with good medical practice**. This type of treatment is known as 'futile' or 'non-beneficial' treatment.

'Futile or non-beneficial treatment' is not defined in law, but is generally used to refer to treatment that **is not in the person's best interests; not achieving its purpose; or not clinically indicated**.

Whether or not treatment is futile or non-beneficial is determined on a case-by-case basis by the person's treating doctor. Factors that may be considered in making this decision include:

- the person's treatment goals and the likelihood they will be achieved by providing treatment;
- the risks and benefits of further treatment;
- treatment alternatives; and
- the person's prognosis, quality of life, and preferences about palliative care and dying.

Dr Hughes and his colleagues consider that continuing Victor's ventilation would be of no benefit, and unlikely to result in significant improvement due to the extent of his injuries and pre-existing conditions. They believe that continuing treatment would carry risks and burdens, including that it would be invasive, and could result in Victor enduring further pain and suffering. They conclude that even if Victor's condition improved and he could breathe without ventilation, his quality of life would be impacted by significant cognitive impairment and immobility, with little prospect of further improvement.

These factors suggest that continuing Victor's ventilation would be futile and non-beneficial. In these circumstances it would be lawful for the clinical team to withdraw Victor's ventilation.

In Queensland however, Patrick's consent would be needed for the clinical team to lawfully withdraw the ventilation. The law on consent and futile and non-beneficial treatment is discussed in the next section.

2. If Patrick disagreed with the clinical team's decision to withdraw treatment, and insisted that Victor continue to be ventilated, does that request have to be followed?

A health professional is not required to provide treatment they consider to be futile or non-beneficial, even if a person, their family member or substitute decision-maker requests that it be provided. A person also cannot require in their Advance Care Directive that futile treatment be given. Therefore, if Patrick requests that ventilation continue, the clinical team has no legal obligation to ventilate Victor if they believe it would be futile or non-beneficial, or not in his best interests to do so.

Similarly, **a health professional does not need to obtain consent from a person or a substitute decision-maker to withhold or withdraw futile treatment**. However, **Queensland law is different when the person lacks capacity.** There, a health professional must obtain consent from the person's substitute decision-maker to withdraw or withhold treatment that is considered futile.

> The law in Queensland is complex. For further information on Queensland's laws on futile or non-beneficial treatment visit ***End of Life Law in Australia***. (https://end-of-life.qut.edu.au/stopping-treatment/adults/state-and-territory-laws/queensland#547985)

Though consent is not required (except for in Queensland if the person lacks capacity), it is still good practice for health professionals to involve the person or, if the person does not have capacity, their substitute decision-maker in discussions about futile treatment. This can assist in:

- finding out a person's wishes or the substitute decision-maker's understanding of the person's wishes,
- communicating the risks and benefits of continued treatment,
- explaining any reasons why the medical team believe treatment is futile, and
- coming to a shared view about the options.

If Patrick insisted Victor continue to be ventilated, the clinical team would most likely meet with him again later to try to reach consensus about Victor's treatment, before engaging in other dispute resolution options.

Find out more about managing disagreements about medical treatment decision-making in the *ELDAC Legal Toolkit's Managing disputes about medical treatment decision-making resources*. (https://www.eldac.com.au/tabid/5281/Default.aspx)

Final legal observations

The clinical team are able to lawfully withdraw Victor's ventilation on the basis that continuing to provide it would be non-beneficial and futile. They do not require consent to withdraw the ventilation (except in Queensland where Patrick's consent would be required), and may proceed to do so even if Patrick requested that it continue. However, it would be good practice for the clinical team to involve Patrick in discussions about Victor's treatment, and to try to reach consensus. If there is disagreement between Patrick and the clinical team, dispute resolution, such as mediation, could be undertaken.