“Do not resuscitate” orders in Queensland; examining the need to obtain consent

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While advances in the understanding and treatment of many medical conditions have extended the lives of many patients, there may still come a time when it is appropriate to consider limiting the provision of certain life-saving procedures, such as cardio-pulmonary resuscitation. In circumstances where it has been determined that such treatment would be futile, health care providers are able to institute a not for resuscitation order that communicates this decision to all members of the health care team. Currently, the law in Queensland requires that for those patients lacking capacity, consent be obtained prior to instituting such an order. This article examines the content of this law, and explores the ethical principles that underpin the need to obtain consent; ultimately concluding that it does not support autonomous decision-making.

INTRODUCTION

As a result of advances in medical science and the treatment of disease, health care decisions that 50 years ago would have never been contemplated by patients or their carers need to be made. In certain circumstances these decisions concern not only the sort of treatment that patients should receive, but also whether treatment should be limited. Typically the need for such decisions arises when a person is nearing the end of their life. Whereas clear and compassionate communication between health care professionals, patients and their families at this time is imperative, for a variety of reasons this has often been difficult to establish.¹

One aspect of end-of-life care that can potentially be difficult to address is whether cardio-pulmonary resuscitation (CPR) would be appropriate treatment for a patient in the event of a cardiac arrest.² Although this may not be foremost in the minds of patients or their families on admission to hospital, for those with chronic worsening medical conditions it is always a relevant consideration for those health providers involved in their care. In most Australian jurisdictions a doctor responsible for treating a patient in hospital assumes the responsibility for deciding whether or not that patient should be resuscitated.³ If under the current circumstances it is believed that the patient would not benefit from attempts at resuscitation then an order may be made to that effect. This is known as an NFR (not for resuscitation) order.⁴ By initiating such an order, the health care team is informed that in the event of a cardiac arrest, cardiac massage and ventilation will not be commenced; instead the patient will be offered measures to promote comfort during the dying process. While the health care providers may have perceived this decision as one promoting a peaceful death, there have

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³ All except Queensland and possibly South Australia. See Guardianship and Administration Act 2000 (Qld); Consent to Medical Treatment and Palliative Care Act 1995 (SA), s 17(2).
been recent cases where it has subsequently come to light that this order was either contrary to the
wishes of the patient, or inadequately explained and understood by those family members left behind.5

Given the gravity of the consequences of these decisions a number of guidelines have been
published to support health providers during this process. Most notably they stress that sensitive and
unambiguous communication around this issue is paramount.6 However, Queensland legislation
dictates health providers to go a step further. In this State, if an adult lacks capacity, consent to
institute an NFR order must be obtained. This article examines the content of this law and its
application in practice. In particular, it explores the principles that underpin the need to obtain consent
for medical treatment, and contemplates the impact of extending this to include non-treatment orders.

MEDICAL DECISION-MAKING IN CONTEXT

The notion that a medical officer must obtain consent from a patient prior to performing any medical
treatment is one that sits well in our current cultural, ethical and legal paradigm. However, this has not
always been the case. Despite pronouncements referring to the need for informed consent being
attributed to Plato in the 4th century BC, the concept was set aside as the paternalistic ideology of
Hippocrates emerged.7 During this time, patients routinely deferred decisions regarding treatment to
the “superior” knowledge of their doctors. Once a decision had been made patients were
unquestioningly obliged to comply with the doctor’s recommendations. To further support this
paternalistic discourse doctors were urged to “give necessary orders with cheerfulness and serenity,
turning [the patient’s] attention away from what is being done to him [sic] … revealing nothing of the
patient’s future or present condition.”8 Despite the fact this dated ethic may have seen the patient as
weak and incapable of functioning as a real moral agent9 the fact that many therapeutic interventions
were often useless, potentially dangerous and relied heavily on unquestioning faith in the doctor to
provide a “cure”, paternalism served these patients well.10

One of the precepts supporting this unilateral model of decision-making was that for centuries,
members of the scientific and medical community were the sole custodians of medical information.
Over time information and understanding about the benefits, as well as some of the dangers of medical
technology became more broadly disseminated and therefore accessible to patients.11 Concurrently,
discourse surrounding individual human rights elevated the importance of individual choice in
decision-making to a position of supremacy.12 This meant that in an environment where several
treatment choices may be present, the one deemed most appropriate would focus upon individual
patients’ values, goals and preferences rather than those which had unilaterally been determined by a
doctor.13 Consequently the paternalistic decision-making model became increasingly unpalatable.

5 Barnes, n 2; Clements C (Deputy State Coroner), Inquest into the Death of Margaret Florence Anne Bodell (Office of the State
2011; Hope A (State Coroner), Record of Investigation into the Death of Peggy Anne Nilon (Office of Safety and Quality
nilon%20finding.pdf viewed 06 January 2011.
6 See eg, New South Wales Department of Health Policy Directives and Guidelines, Guidelines on CPR – Decisions Relating to
Journal of Legal Medicine 91 at 95.
12 Stauch et al, n 11, p 38.
JL Med & Ethics 86.
As paternalism began to wane, it was supplanted by assertions that the welfare of the patient, or beneficence was a priority. It was often assumed this was identified by what doctors believed to be the correct choice or treatment, rather than by what patients might want. Perhaps because of the expertise of doctors, and its perceived lack in the patient, the assumption that “doctor knows best” was easily absorbed into medical practice. However, empirical research demonstrates that doctors are highly inaccurate at predicting the goals and preferences of their patients. One reason postulated for this difficulty relates to the fact that doctors cannot accurately predict the value that a patient may place on subjective aspects of their life such as interpersonal relationships or spiritual and mental wellbeing. For example, a patient may prefer to live with an increased level of pain in order to avoid the sedating effects of a particular analgesic. While to some, this may appear contrary to their best interest, it is a judgment that can only be made by the patient. This is only one of many examples that demonstrate why beneficence too has fallen out of favour in medical decision-making. In its place, respect for autonomy has surfaced as the leading medical decision-making paradigm. While it may be easy to assume that this change was driven by patients, in fact it has been due in part to strong arguments from lawyers, judges and medical ethicists that patients should determine what happens to their bodies as they ultimately have to experience the consequences of the chosen treatment decisions.

AUTONOMY

If it is currently believed that respect for autonomy provides the foundation for medical decision-making, it is appropriate to explore the content of this principle and consider the context in which it becomes relevant. The word autonomy comes from the Greek autos (self) and nomos (rule) and has been interpreted as representing the capacity of an individual for self determination. In regard to health care it requires that patients can and should, not only be active participants in any medical decision-making, but the ultimate authority. This means that, provided they are competent, an individual is entitled to make decisions on the basis of his or her own best interest, subject only to the caveat that they do not harm anyone else. This individualistic model of autonomy is largely unconcerned with what the decision is, only that a person has the right to make it. As most medical treatment involves some degree of interference with an individual’s body, autonomous decision-making ensures that patients are the only ones able to authorise this. The benefits of promoting autonomy in this way are that it allows the principle to easily be codified into a set of rules and regulations pertaining to health care and decision-making. This is reflected in the classic statement of autonomy articulated by Cardozo J in Schloendorff v Society of New York Hospital 211 NY 125 at 126 (1914):

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault.

In a strikingly similar vein, five Australian High Court Justices approved the principle in Marion’s case; Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 at 233:

16 Moulton and King, n 13 at 87.
18 Moulton and King, n 13 at 86.
20 McLean, n 14, p 17.
21 McLean, n 14, p 20.
The corollary of these provisions, which embody the notion that, prima facie, any physical contact or threat of it is unlawful, is a right in each person to bodily integrity. That is to say, the right in an individual to choose what occurs with respect to his or her own person.

In these cases personal inviolability is seen as paramount and vehemently protected. This is also reflected in provisions of Queensland statutes such as the Criminal Code, where an inalienable right to bodily integrity is reinforced in the definition of assault. Consent given by an individual permitting the physical contact however, ensures that it will not attract legal liability. Therefore, accepting that consent reflects an autonomous choice a reasoned application of these laws is facilitated. Nevertheless, in relation to health care decisions, this process has been criticised as being too individualistic; seldom are such decisions made in isolation. Even without conscious deliberation, the values and obligations that are inherent in social relationships will influence the decision-making process. Being cognisant of this fact, rather than focussing on an individual’s ability to make a decision, it is preferable to acknowledge that the context in which many health care decisions will be made has a profound influence. Therefore in order to ensure that autonomy is promoted, the capacity for individuals to pursue personal goals within acknowledged relationships and social structures should be nurtured. This may be of particular importance for those patients who are nearing the end of their lives, where ability to achieve personal goals may rely on support from other people.

Depending on the context that it will be applied, it is now evident in which the principle of autonomy may be constructed in different ways. For example, the predominantly individualistic construct demonstrated in Marion’s case has the benefit of being relatively easily subsumed into law. Although the law may have been implemented on this theoretical basis, that does not imply that it has done so perfectly for all situations. An alternative construction of the principle where interpersonal relationships are acknowledged, and afforded due consideration, reflects more closely the reality of medical decision-making. This need is highlighted in situations when treatment limiting decisions are made in consultation with family members as well as the patient. Respect for the autonomy of the patient in such situations inexorably requires acknowledging the holistic context in which the decision must be made.

“NOT FOR RESUSCITATION”

Having discussed the current ethical and legal basis for medical decision-making, it is relevant to consider its application in the health care setting. Even if a decision to consent to medical treatment may promote patient autonomy by countering medical paternalism, and provide a mechanism that transforms an illegitimate act into a permitted one, not all medical decision-making concerns what treatment should be provided. Some decisions concern setting limits on the types of treatment that should be offered. One such example is whether in the case of a cardiac arrest, CPR should be provided.

There are two predominant reasons why it might be deemed inappropriate to attempt to resuscitate a patient who has collapsed, either as a result of a cardiac or respiratory arrest. First, the patient may have refused CPR. It is well established, that a competent patient has the right to refuse CPR.
any medical treatment, and this of course would include CPR. In Re T (Adult Refusal of Treatment [1992] 3 WLR 782; [1993] Fam 95 at 116 Butler-Sloss LJ stated that “a decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered”. The fact that a decision to refuse treatment may shorten life therefore, does not negate this right. In these situations there can be no dispute, as the will of the competent patient will prevail. The second reason CPR may be withheld is that it may have been judged as being futile. While prima facie this may appear an entirely satisfactory reason for withholding CPR, futility is a concept that is very difficult to accurately define and entirely susceptible to subjective interpretation. For some it may mean that the treatment has no possibility whatsoever that it will reverse the illness or condition. Alternatively it may mean that the burden of the treatment could not possibly outweigh any potential benefit. Recognising that subjective value judgments abound in considerations of futility, paves the way for a range of conflicting opinions to arise. For example, there may be differing opinions between individual health care providers, and also between health care providers and the patient; if the patient no longer has capacity to make and communicate their wishes, then surrogate decision makers will be involved and they too may have opinions that differ. In order to facilitate a common understanding about which treatments will and won’t be provided, it is imperative that health care providers enter into an open and inclusive dialogue with all relevant parties. As this may be a highly charged and emotive subject there are numerous protocols, guidelines and statutes that inform the process, and assist determine the appropriate NFR status of patients. However, depending on the jurisdiction, the need for the patient to consent in this process varies.

In the United States for example, the State of New York has legislation mandating that the patient consent to NFR orders; without this consent it is presumed that the patient will be resuscitated. The effect of this legislation is that, in this jurisdiction, the patients become the definitive decision-makers regarding whether or not this particular treatment will be instituted. By way of contrast, in the United Kingdom, the recent joint statement by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing falls short of requiring patients consent to NFR orders, but does advocate “sensitive exploration” of the patient’s wishes regarding resuscitation. The ultimate decision therefore continues to rest with the health care providers. In Canada there is no clear direction regarding patient consent that could be gleaned from legislation although the College of Physicians and Surgeons of Manitoba released guidelines in 2008 stating that the final decision to withdraw life support lies with the medical officer regardless of the wishes of the family or the patient.

In Australia, the current position with respect to legislation informing the NFR process varies from State to State; the common law though, of course does not. If a competent adult decides that CPR should be withheld, this equates with a refusal of treatment and will be determinative regardless of whether or not the doctor believed that the treatment could provide a benefit. Even so, the competent patient’s wishes will not be determinative if they are requesting treatment that a doctor believes is futile. In these circumstances respect for the autonomous decision-making does not extend

52 Re B (Adult; Refusal of Treatment) [2002] 2 All ER 449.
53 Cavell, n 4 at 314.
56 Beigler, n 34 at 360.

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to enabling the patient to require a particular treatment be provided.\textsuperscript{40} While acknowledging that determinations of futility are subjective, the courts have held that the clinical expertise of doctors has them best placed to decide whether a particular treatment would be of benefit to the patient.\textsuperscript{41} If this assessment determines that treatment will not afford a benefit, then there is no legal or ethical obligation to offer or provide it.

For those patients who no longer have capacity to make these decisions, guardianship legislation in each State provides that substitute decision-makers will be involved in the process. For example, if an adult is incapable of understanding the nature and effect of proposed health care or is incapable of indicating whether or not they consent,\textsuperscript{42} the Victorian guardianship regime empowers a “person responsible” to consent to medical and dental treatment on their behalf.\textsuperscript{43} In situations when the adult (or Guardianship Tribunal) has not appointed an alternate person to make decisions on the adult’s behalf the “person responsible” by default assumes the role of surrogate decision-maker. Even though it is possible for an appointed guardian to refuse consent to health care by completing a refusal of treatment certificate\textsuperscript{44} there is no general power for the person responsible to refuse treatment.\textsuperscript{45} This means that they cannot refuse resuscitation if it were to be offered, nor are they required to consent to the initiation of an NFR order. Consequently those decisions are made by the treating doctor once they have determined that resuscitation for a person is futile or is not in their best interests.

Similarly the NSW guardianship legislation does not make provision for a “person responsible” (who once again is the default decision-maker if there has been no appointment) to refuse treatment. Although it may be possible, depending on the drafting of the specific document for an enduring guardian, appointed by the adult before they lost capacity, to refuse consent to health care.\textsuperscript{46} As in Victoria the decision to institute an NFR order remains with the doctor caring for the patient.\textsuperscript{47} This assertion is supported by the NSW Department of Health whose guidelines state that a “No CPR” order is a medical order with similar authority to other medical treatment orders. Consequently compliance by other health professionals is required and brings certain legal protections to those who follow such orders.\textsuperscript{48}

In Western Australia the issue was critically examined by the Coroner investigating the death of Peggy Anne Nilon.\textsuperscript{49} While acknowledging that there was no legislation at that time that governed the making of CPR orders the Coroner commented that,
It is important to ensure that in respect of any “not for resuscitation” decision that informed consent has been provided. It is also important that the consent of the patient is adequately documented or, in the event that consent is made on behalf of that patient, the circumstances surrounding such consent are clearly identified and documented.  

Although the Guardianship and Administration Act in Western Australia was recently amended to allow consent to be given or refused, it still fails to address the issue of consent for NFR, and as such remains incongruent with the statements made by the Coroner. In Tasmania, a guardian can consent to life-prolonging treatments including CPR, to be commenced and continued, provided it is medically appropriate and remains in the best interests of the adult. However, once again there is no specific power granted that would allow consent to withdrawal of treatment, leaving decisions regarding NFR orders to rest once again with the treating doctor.

In South Australia, the Guardianship and Administration Act 1993 (SA) provides for a substitute decision-maker appointed by the adult or tribunal to consent or refuse consent to health care. Although, in situations where there has been no appointment, this power does not extend to specified relatives who may give, but not withhold, consent to medical treatment. However, s 17(2) of the Consent to Medical Treatment and Palliative Care Act 1995 (SA) appears to prevent doctors from withdrawing treatment if patients or their representatives object. One interpretation of this section is that, if there is an express direction from a patient or their representative, the health care professionals must use life sustaining measures in treating the patient. Nevertheless, given that the intent of the South Australian legislation was to “maintain or improve the comfort and dignity of a dying patient, rather than extraordinary or heroic measures” it appears that an alternative interpretation may be appropriate. For example, the subsection could be interpreted to mean that palliative care is appropriate, and a doctor will not be liable, if the patient has not expressed an objection or consented. Although there has as yet been no judicial interpretation of this section of the Act, judges have traditionally been reluctant to find that doctors have committed an offence when treating a patient, especially when they have acted collaboratively in what they believe to be the patients’ best interest.

THE QUEENSLAND POSITION

In contrast to other Australian states, Queensland requires that an adult who lacks capacity must provide consent before an NFR order can be instituted. The Guardianship and Administration Act 2000 (Qld) regulates how decisions about health care are made for adults with impaired capacity. Specifically, it articulates the appropriate person to provide consent for the provision of health care for an adult who lacks capacity. Consent for healthcare must be obtained in order to avoid contravention of section 79 of the Guardianship and Administration Act 2000 (Qld). The legislation defines “health care” decisions to include those decisions regarding withholding or withdrawal of a life-sustaining measure. As CPR is included in the definition of a life sustaining measure, prior to instituting an NFR order, consent is required for CPR.

50 Hope, n 5, p 42.
52 Guardianship and Administration Act 1990 (WA), s 45(2)(d).
53 Guardianship and Administration Act 1995 (Tas), s 43.
54 Guardianship and Administration Act 1993 (SA), s 25(5)(b).
55 Guardianship and Administration Act 1993 (SA), s 59.
56 Consent to Medical Treatment and Palliative Care Act 1995 (SA), s 17(2).
57 Skene, n 40 at 163.
58 SJ Baker, (Deputy Premier) South Australia, House of Representatives, Parliamentary Debates, 3 November 1994 at 989
59 Skene, n 40 at 164.
60 Skene, n 40 at 164.
61 Guardianship and Administration Act 2000 (Qld), s 79 provides that it is an offence for a person to carry out health care of an adult with impaired capacity unless the health care has been authorised, or consent has been given to the health care.

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order consent must be obtained. Under the provisions of the Act if there is no advanced health directive, power of attorney or guardian appointed by the tribunal, then the statutory health attorney (SHA) would provide this consent.

The requirement for consent for NFR orders has recently been highlighted in the cases of June Woo and Margaret Bodell. June Woo was an elderly woman who was admitted to hospital with a history of chronic respiratory disease and failure. After an initial assessment by the medical team an NFR order was instituted. Approximately 24 hours after her admission to the ward Mrs Woo stopped breathing, resuscitation was not attempted pursuant to the order, and she subsequently died. During the Coroner’s inquest that investigated the events surrounding Mrs Woo’s death, it was noted that the hospital policy in relation to NFR orders failed to address the requirements of the legislation and required only that “the patient and their family are involved”. Similarly, Mrs Bodell also suffered from chronic respiratory problems and was admitted to hospital after becoming increasingly short of breath with a productive cough. Although it was apparent to the medical team treating her that Mrs Bodell would be unlikely to survive any attempts at resuscitation should she arrest, the family were reluctant to engage in conversations addressing this. Consequently when Mrs Bodell’s condition deteriorated and she died, the appropriateness of withholding CPR was at issue. Once again the Coroner found that Mrs Bodell’s family had not been sufficiently informed about the risk of her demise, and the consequent treatment decisions that had been made. Additionally the variation in the hospital process of instituting NFR orders, and documentation regarding their implementation, meant that problems communicating this with the family were exacerbated.

To avoid repetition of these events Queensland Health formulated a comprehensive policy articulating the need for consent for an NFR order that is congruent with the legislative requirements. In addition, guidelines outlining the implementation of the policy were published. The guidelines confirm that “NFR orders have no legal status in Queensland and cannot be relied upon in the absence of other forms of consent to withhold or withdraw medical treatment”. Specifically in non-urgent situations, for adults who lack capacity, consent to withhold or withdraw medical treatment must always be obtained from the substitute decision maker.

The guidelines also indicate the appropriate approach for dealing with patients who have capacity. They state that where the patient has capacity to make health care decisions and is likely to require life-sustaining treatment, consent procedures should be put in place to ensure their views and decisions are respected when they lose capacity. Given that the need to obtain consent only arises as

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63 Guardianship and Administration Act 2000 (Qld), s 66.
64 Barnes, n 2.
65 Clements, n 5.
66 Barnes, n 2, p 23.
67 Clements, n 5.
68 Clements, n 5, p 16.
70 The Clinical Policy Unit of Queensland Health has circulated implementation guidelines for End of Life Care: Decision-making for Withholding and Withdrawing Life-Sustaining Measures from Adult Patients: Pt 1 – Legal Framework and Clinical Considerations, and Pt 2 - Ethical and Special Considerations (2010). s
73 Queensland Government, Queensland Health Implementation Guideline – Withholding and Withdrawing Life Sustaining Measures Part 1 – Legal Framework and Clinical Considerations, Section 4.2.1 Patients with Capacity, p 32.
a result of the statutory definition of “health care” in the Guardianship and Administration Act (Qld), and that would only apply to those adults who lack capacity, it is difficult to see where the need for consent in this situation arises. Where an adult has capacity the situation will be governed by common law principles. The common law has never recognised a right of patients or their representatives to any particular treatment. In no case has a judge ordered doctors to treat a patient contrary to their clinical judgement. This was reitered in the English Court of Appeal’s decision in Burke’s case, R (Burke) v General Medical Council (Official Solicitor and Others Intervening) [2006] QB 273, where the court made it clear that patients and their relatives have no general, legally enforceable right to direct what treatment they wish to receive. Consequently competent patients cannot demand treatment that their clinicians believe to be inappropriate under the circumstances, and this would include CPR. Therefore it is submitted, that this requirement has been established in the guidelines to ensure that the process is the same for adults with capacity as for those without.

The guidelines acknowledge that throughout the process an individual’s autonomy must be respected and:

control over our body has been taken to be central to the interpretation of autonomy. In the context of end-of-life care, the right to refuse treatment places a recognised limit on interventions by medical officers, who must respect refusals even against their best clinical judgement and even if a patient’s life is at risk as a result.

The guidelines also indicate that respect for autonomy cannot be interpreted as an entitlement to every requested medical intervention. This is certainly congruent with the common law principles enunciated in Burke’s case, and also confirms that the rights of autonomy and self determination do not confer a right to demand treatment that in the view of the doctor is not appropriate.

It is stated subsequently, that a decision to withhold or withdraw life prolonging medical treatment is ultimately a clinical decision, and while the patient’s family can offer important insights into the patient’s beliefs, the clinician’s duty of care is always to the patient and their best interest, not those of the family. What this fails to acknowledge is that if an adult lacks capacity, consultation with family members by the health care professionals is more than an exercise aimed at ascertaining the patient’s beliefs. In essence, unless there is appointed attorney or guardian, a family member may become a statutory health attorney and act in this role as a substitute decision-maker. In this capacity expressions of consent carry the same legal effect as any consent that the adult could have provided if they had capacity. Essentially the family member who is the SHA is doing more than just offering an opinion as to what they wish for the adult; they are in effect providing or withholding the adult’s consent.

It is evident that the law in Queensland mandates that health providers obtain consent from patients or their substitute decision-makers before instituting an NFR order. Consent, concerns an agreement or permission, and may provide evidence of an autonomous decision about treatment choices. However, what the guidelines also make clear is that NFR orders are ultimately clinical decisions to be made by a health provider, rather than a choice to be made by the patient. In this way

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74 Guardianship and Administration Act 2000 (Qld) Sch 2, s 5.
75 Skene, n 40 at 167.
77 Queensland Government, Queensland Health Implementation Guidelines – End of Life Care: Decision-making for Withholding and Withdrawing Life-sustaining Measures from Adult Patients: Pt 2 Ethical and Special Considerations, Section 1.2 Autonomy and Obligation, p 5.
78 Queensland Government, Queensland Health Implementation Guidelines – End of Life Care: Decision-making for Withholding and Withdrawal of Life-sustaining Measures from Adult Patients: Pt 2 Ethical and Special Considerations, Section 4.2 Futile Medical Treatment and the Law Generally, p 13.
79 Guardianship and Administration Act 2000 (Qld), s 33(1).
the policy appears to be inconsistent with the legislative requirements. In order to clarify this ambiguity it is instructive to look at the history of the legislation.

When the Guardianship and Administration Act (Qld) was enacted in 2000 the Guardianship Tribunal was, in the absence of an advance health directive, required to consent to special health care.\(^{80}\) The withdrawal or withholding of special life sustaining measures\(^{81}\) was considered special health care and this included cardiopulmonary resuscitation.\(^{82}\) However, it became apparent that requiring all decisions regarding the withholding or withdrawal of special life sustaining measures to be referred to the Tribunal would be unduly burdensome. Additionally it was acknowledged that before the commencement of the Act it was not the practice of Queensland health providers to seek the sanction of the Supreme Court to withhold or withdraw life-sustaining measures.\(^{83}\)

Consequently a Bill to amend the Act was introduced seeking to clarify the circumstances in which a health provider may withhold life-sustaining measures without reference to the Tribunal. Passage of the Bill would allow the SHA to consent to the withholding or withdrawal of life-sustaining measures when a health provider reasonably considered that the commencement or continuation of those measures would be inconsistent with good medical practice. Further the Bill also included a provision allowing health providers, in the event of an emergency, to withhold or withdraw a life-sustaining measure without consent. In such circumstances it is a requirement that a decision needs to be made immediately, and that commencement or continuation of that measure is inconsistent with good medical practice. The Explanatory Notes state that this will allow health providers to take decisions immediately without subjecting persons, in violation of good medical practice, to futile and invasive procedures.\(^{84}\) In doing so, the legislature recognised that CPR is not a totally benign procedure and that it may entail considerable burdens to the patient.\(^{85}\) Throughout the Explanatory Note, the need to not submit patients to burdensome futile treatment or require health providers to provide care that is inconsistent with good medical practice is a strong, recurrent theme. These amendments were passed in 2001. However, one of the apparently unanticipated requirements that these amendments have enshrined, is that health care providers must obtain consent before initiating an NFR order.

**DOES CONSENT FOR NFR SUPPORT AUTONOMOUS DECISION-MAKING?**

We live in a culture that zealously protects the ability of individuals to make decisions that control their lives which is reflected in the value placed on individual autonomy.\(^{86}\) For this reason the requirement that individuals consent to an NFR order, at first glance, can seem quite appealing. However, if autonomy is interpreted as an individual’s right to self determination, reflected in rational and logical decision-making, then it is apparent that the requirement for consent becomes problematic. If in all cases, prior to instituting an NFR order the patient’s consent must be obtained, this naturally implies that refusal is a viable option; that the patient can choose not to consent and in the event of a cardiac arrest they will receive CPR. Presumably this would only be done if survival was perceived to be the potential outcome. However, common sense dictates that true choice only exists within the frame of actual possibilities.\(^{87}\) It is submitted that in these situations the actual possibilities are

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\(^{80}\) Guardianship and Administration Act 1999 (Qld), s 68.

\(^{81}\) Guardianship and Administration Act 1999 (Qld), Sch 2, s 7(f).

\(^{82}\) Guardianship and Administration Act 1999 (Qld), s 16(1)(a).

\(^{83}\) Explanatory Notes, Guardianship and Administration and Other Acts Amendment Bill 2001 (Qld) p 2.

\(^{84}\) Explanatory Notes, Guardianship and Administration and Other Acts Amendment Bill 2001 (Qld) p 3.

\(^{85}\) Kerridge et al, n 19, p 345.


\(^{87}\) Drought and Koenig, n 86 at 115.
extremely limited most notably by the fact that research reveals the dismal survival rate following resuscitation attempts. Requiring consent for an NFR order therefore in this context does not support patient autonomy.

Nevertheless, acknowledging that autonomy may also be construed more broadly as supporting the capacity of individuals to pursue individual goals does little to alleviate these concerns. This may be particularly so in cases where family members, acting as SHAs may be involved, such as the previously mentioned case of June Woo. In that case, it was apparent that health providers explained the seriousness of Mrs Woo’s condition to her daughters on numerous occasions. Even though at the time they “nodded in response” when asked if they understood, it was apparent that they were struggling to accept that their mother was unlikely to recover.

It is arguable that had they been asked to provide consent for the NFR order, they may have refused. Requesting that their mother be prescribed diuretics and antibiotics indicates that they must have considered alternative treatments were available, and therefore consenting to such an order would effectively made them complicit in their mother’s demise. Consequently, individual autonomy in these circumstances would also have not have been promoted.

IS IT POSSIBLE TO REFUSE TO CONSENT?

Requiring consent for an NFR order suggests that there is an option to refuse to consent and attempts to resuscitate the patient will be made. This creates in a situation that is contrary to the common law, which has consistently indicated that healthcare providers are not obliged to offer, provide or continue treatment that is deemed to be futile. This premise was addressed most notably in the case of Airedale NHS Trust v Bland [1993] 1 All ER 821. In his judgment Lord Goff asserted that the legal basis for withdrawal of treatment was the futility of continuing treatment when the patient has no prospect of any improvement in his condition. The situation in Australia is the same following the decision of the Supreme Court of New South Wales in Messiha v South East Health [2004] NSWSC 1061. In that case, a 75-year-old man had suffered hypoxic brain injury following a cardiac arrest. The court held that the medical team who had a duty to provide treatment for him were best placed to determine his future treatment needs. This included a decision to withdraw treatment, which the court would not interfere with unless it could be demonstrated that it was clearly not in the patient’s best interest. Similarly a number of judicial decisions in other countries have found it lawful to withdraw care that was deemed to be futile.

Further, legitimately being able to refuse to provide consent is clearly contrary to the stated aims of the amendments as described above, and is not reflected in the implementation guidelines circulated by Queensland Health. The decision to withhold or withdraw life prolonging medical treatment is ultimately a clinical decision. It appears that it was never in the contemplation of the legislature that by requiring consent a person with capacity, or the SHA of an adult who lacks capacity, would ever refuse to give consent. If the SHA, after sensitive discussion, does not agree to consent to the order then recourse should be made to the Office of the Adult Guardian where the issue can be

88 Drought and Koenig, n 86 at 116.  
89 Barnes, n 2, p 9.  
90 Barnes, n 2, p 9.  
91 Airedale NHS Trust v Bland [1993] 1 All ER 821 at 870.  
92 Messiha v South East Health [2004] NSWSC 1061 at [25].  
93 Messiha v South East Health [2004] NSWSC 1061 at [25].  
95 Queensland Government, Queensland Health Implementation Guidelines End of Life Care: Decision-making for Withholding and Withdrawing Life-sustaining Measures from Adult Patients, Pt 1 Legal Framework and Clinical Considerations, Section 2.5.2, p 16.
investigated or mediated. If following mediation, a satisfactory result cannot be obtained it is possible for the case to be referred to the Queensland Civil and Administrative Tribunal. It is suggested that if this step is required, then it is possible that an alternate guardian for the adult could be appointed that would provide consent. Resort to this solution suggests that choosing to refuse to consent to an NFR order may not be a realistic option. It therefore appears that although there is a legal requirement to obtain consent for an NFR order, there is no corresponding realistic capacity for the patient to refuse. This creates an incongruent situation.

This situation has recently been acknowledged by the Queensland Law Reform Commission in the course of their review of Queensland guardianship legislation. The Commission identified that the current consent requirements may not be appropriate in light of the fact that at common law, the health provider would not have a duty to provide the measure. To rectify this anomaly, the Commission sought inter alia, to determine whether this legislative requirement should be changed so that a health provider would no longer be required to obtain consent, in order to withhold or withdraw a medically futile life-sustaining measure. In response to this inquiry a submission was received from a large metropolitan hospital commenting that such a requirement raised practical and professional concerns for clinicians. It stated for example that:

- grieving relatives, including those in the anticipatory grief phase, may use denial as a method of coping – this may significantly impact their decision-making, and may preclude their ability to make a decision in the best interest of their relatives. The refusal of consent to withhold intervention may subsequently deny patients (and their families) dignity in the dying process.

Statements such as these recognise that in addition to preserving the autonomy of patients, the law has a role to play in protecting patients from an undignified and prolonged death. Appropriately instituting NFR orders is one step aimed at achieving this goal.

Following detailed consideration of all of the submissions, the Commission recommended that the guardianship legislation should be amended to “provide that ‘withholding a life-sustaining measure’ does not include not commencing a life sustaining measure if the adult’s health provider reasonably considers that commencing the measure would not be consistent with good medical practice”.

Amending the legislation in this manner would bring Queensland back into line with other Australian States and the common law, where health providers become the ultimate decision-makers regarding the NFR status of their patients.

Although it is difficult to concede the need to require consent before an NFR order is instituted, it is possible that the recent issues surrounding the obligation may have highlighted the importance of clear and compassionate communication between health providers and patients and/or their families on this important treatment issue. Recognising that respect for individual autonomy is important, it may not always be paramount. Therefore, it has been suggested that some health care decisions should depend less on respecting autonomy and more on providing care and compassion. This view has been supported by studies that demonstrate it is not so much “decision-making” that patients want to

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96 Guardianship and Administration Act 2000 (Qld), s 174.
97 Of course this would be subject to an inquiry as to whether the SHA was correctly applying the Health Care Principle and General Principles. Guardianship and Administration Act 2000 (Qld), s 174(2)(d).
99 QLRC, n 98, p 227.
101 QLRC, n 98, p 233.
102 QLRC, n 98, p 233.
103 QLRC, n 98, p 237.
104 Kerridge et al, n 19, p 285.
be involved in, but rather to be treated with respect and dignity and to have confidence and trust in their carers. While it is possible that the legislative requirement to obtain consent for NFR orders may have gone some way to support improved communication, it is postulated that such an outcome could also be achieved more simply and effectively by promoting and supporting the education of health providers around this issue.

CONCLUSION

Decision-making, particularly in regard to health care can be a complex and at times a challenging task. The vast numbers of factors that impact upon each situation have the potential to create significant hurdles for patients, their families and those who care for them. Recognising that over time respect for autonomy in decision-making has been strongly fostered, it is evident that in certain situations supporting this ethical principle has created significant tension. In Queensland this is evident in the current situation regarding NFR orders. Having a legislative framework where it is mandatory for health providers to obtain consent before instituting an NFR has created a situation where patients are faced with an illusory choice; one that plainly does not support autonomous decision-making. In addition, compelling health providers to seek consent not to do something they perceive as futile places them in an extraordinary position should consent be refused. This is a position that no other health provider in Australia would be faced with. It is apparent that the difficulties associated with this process have now been identified by the members of the Law Reform Commission in Queensland, and it is hoped that the recommendations made by them are given due consideration.


106 Murray and Holmes, n 22, p 21.