Gardner; re BWV: Victorian Supreme Court makes landmark Australian ruling on tube feeding

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ABSTRACT

- The Victorian Supreme Court has decided that artificial nutrition and hydration provided through a percutaneous gastrostomy tube to a woman in a persistent vegetative state may be withdrawn.
- The judge ruled, in line with a substantial body of international medical, ethical and legal opinion, that any form of artificial nutrition and hydration is a medical procedure, not part of palliative care, and that it is a procedure to sustain life, not to manage the dying process.
- Thus, the law does not impose a rigid obligation to administer artificial nutrition or hydration to people who are dying, without due regard to their clinical condition. The definition of key terms such as "medical treatment", "palliative care", and "reasonable provision of food and water" in this case will serve as guidance for end-of-life decisions in other states and territories.
- The case also reiterates the right of patients, and, when incompetent, their validly appointed agents or guardians, to refuse medical treatment.
- Where an incompetent patient has not executed a binding advance directive and no agent or guardian has been appointed, physicians, in consultation with the family, may decide to withdraw medical treatment, including artificial nutrition or hydration, on the basis that continuation of treatment is inappropriate and not in the patient's best interests. However, Victoria and other jurisdictions would benefit from clarification of this area of the law.

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The issue of withdrawing or withholding artificial nutrition and hydration from incompetent patients has generated international concern in recent years. Its lawfulness has been considered in the United Kingdom,[1] Canada,[2] and the United States.[3,4] Recently, in Australia, Justice Morris, of the Supreme Court of Victoria, handed down an important decision. The case of *Gardner; re BWV*[5] (Box 1) related to withdrawal of life-sustaining treatment from incompetent patients as governed by the Victorian *Medical Treatment Act 1988* (Box 2). Justice Morris determined that the Public Advocate (who had been appointed guardian) had the power under the Act to refuse further nutrition and hydration administered via percutaneous endoscopic gastrostomy (PEG) to a 69-year-old woman in the advanced stages of dementia.[5]

The Act creates a problematical distinction between "medical treatment" and "palliative care", and judicial clarification of this distinction was sought. The judgment clarifies the meaning of the palliative care provisions in the legislation.[6] In line with an evolving international view in medical ethics, the Court found that artificial nutrition and hydration constitutes medical treatment. Consequently, it is subject to the same criteria of clinical appropriateness and consent as any other medical treatment, and is not a required sustenance measure in palliative care.[7,8] The decision is in harmony with fundamental Hippocratic duties of (i) alleviation of suffering, (ii) "lessening the violence of diseases", and (iii) refusal to treat those whose disease is too far advanced, and where medicine is powerless.[9,10]

The ruling

Justice Morris determined that the use of a PEG for artificial nutrition and hydration is a "medical procedure", because it involves "protocols, skills and care which draw from, and depend upon, medical knowledge", and careful choice and preparation of materials to be introduced into the body, dosage rates, and measures to prevent infection and regular cleaning of conduits. Viewed in this way, PEG feeding and hydration fall within the scope of "medical treatment" for the purposes of the Act.[11] The judge contrasted medical treatment to sustain life with palliative care to manage the dying process with minimum pain. He found that administering artificial nutrition and hydration falls into the first category of life-prolonging medical treatment. Therefore, in our discussion of this case, we have adopted the more precise term "medically administered nutrition and hydration",[12] in preference to "artificial nutrition and hydration".

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The statutory definition of "palliative care" includes "reasonable provision of food and water", which Justice Morris interpreted as reference to "ordinary feeding by mouth", carried out by the patient or non-medical personnel. Justice Morris noted that the purpose of the legislation was to ensure provision of food and water if desired, but not to force the consumption of food and water onto dying patients. For an incompetent patient with no hope of recovery, the ruling clarifies the division between non-optional medical treatment to palliate pain and discomfort, and medically administered nutrition and hydration, which an agent or guardian can refuse on the patient's behalf.

Goals of treatment

To healthcare professionals, the legislative distinction between medical treatment and palliative care will seem odd. Clinically, pain and symptom relief usually require appropriate medical treatment, which is integral to palliative care, with a medical specialty known as "palliative medicine". Distinguishing between treatments to determine whether they should be used, on the basis that one is "palliative care" and the other "medical treatment", is

1 The case

BWV was a 69-year-old resident of a nursing home, in the advanced stages of dementia due to Pick's disease. Her husband had agreed to the PEG insertion while she was ambulant but incompetent and unable to communicate with anyone apart from him. She subsequently progressed to a persistent vegetative state. Apparently, BWV had stated years before to her husband that she would not want to be kept alive in such a condition. The general practitioner and the nursing home management were unable to agree to the husband's request that feeding cease, because they were uncertain about the lawfulness of such an action in Victoria. BWV's husband sought the assistance of the Public Advocate, who had been appointed BWV's guardian. He in turn requested clarification from the Supreme Court. It is important to note that the case did not result from any sort of criminal investigation.

2 The *Medical Treatment Act 1988* (Vic)

The Act was enacted to confirm that any adult person of sound mind can refuse medical treatment for a current condition. The broad purpose of the Act is to improve care and decision-making at the end of life, as set out in the Preamble:

(a) to give protection to the patient's right to refuse unwanted medical treatment;

(b) to give protection to medical practitioners who act in good faith in accordance with a patient's express wishes;

(c) to recognise the difficult circumstances that face medical practitioners in advising patients and providing guidance in relation to treatment options.

The rights and obligations of agents, guardians and medical personnel under the Act pertain to *medical treatment*, which is defined in section 3 as meaning:

(a) the carrying out of an operation; or

(b) the administration of a drug or other like substance; or

(c) any other medical procedure — but does not include palliative care.

The term *palliative care*, in turn, is defined to include:

(a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or

(b) the reasonable provision of food and water.

just as problematical and unclear as the now unfashionable distinction between ordinary and extraordinary treatments. A better approach is to define the goals of care, by asking, for example, whether the treatment phase is curative, palliative or terminal. It can then be asked whether the proposed treatment is proportionate, in terms of potential benefits and adverse effects, to those goals.[13]

Gradual reduction and eventual cessation of oral intake is a normal part of the dying process. In palliative care units (and home care) food and drink, as well as assistance with eating and drinking, are always available to satisfy a patient's thirst and hunger, but medical means are not routinely used when oral intake ceases. With adequate mouth care, clinical experience shows no evidence of unrelieved symptoms of starvation and dehydration.

There is also no evidence that medically administered nutrition and hydration enhances comfort or dignity during the dying process.[14] One study has shown some relief of agitated delirium in selected patients after rehydration, where the delirium is thought to be due to presumed opioid toxicity and renal impairment.[15] As might be expected, there is evidence that terminally ill patients have biochemical dehydration,[16] but a relationship between hydration or biochemical status and symptoms has not been established.[17] Therefore, there is very little evidence at present to show that rehydration relieves symptoms. Indeed, arguments have been made that fluid infusion might lead to fluid overload, and reduce comfort. Hence, in the absence of clearer evidence, the usual practice in palliative care is to omit medically administered nutrition and hydration during the terminal phase of care, although each case must be treated on its merits. Some competent patients who are receiving palliative care for advanced diseases, and are not yet dying, may choose to receive both nutritional and hydration support by whatever means required to maintain comfort. A typical example is a patient with advanced head and neck cancer who is unable to swallow and elects to be fed via a PEG tube. However, feeding is often stopped as death approaches.

Legal considerations

The legal differentiation between "medical treatment" and "palliative care" is a mechanism to limit the rights of third parties to refuse treatment for incompetent and dying patients. Including the "reasonable provision of food and water" within the legal concept of palliative care accords with the normal practice of oral provision of food and water where desired. Restricting the words "food and water" to oral intake brings Victoria into line with the South Australian *Consent to Medical Treatment and Palliative Care Act 1995*,[18] which defines palliative care that cannot be refused as limited to "the natural provision or natural administration of food and water". The parliament of South Australia took the view that it requires a very special level of courage and strength to reject oral (or natural) intake of food and water, even during the dying process, and no agent could be charged with this responsibility (Jennifer Cashmore, AM, Member of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying, South Australian Parliament, personal communication, 2001). The term "natural" in this context does not include medically administered nutrition and hydration.[19]

The *Gardner* judgment brings the law in Victoria closer to usual clinical practice. The law now makes withholding or withdrawal of medically administered nutrition and hydration a matter of clinical judgement concerning each individual patient, rather than barring agents and guardians from consenting to such decisions.

In states and territories with legislation enabling advance directives for refusal of medical treatment and appointments of agents and guardians, a court or tribunal is probably only likely to be called to intervene if the validity of the advance directive is in dispute.[20] The situation is different for "non-therapeutic" treatment where a patient is incompetent and has not executed binding advance directives, where agents or guardians have not been appointed, or a patient is disabled by age or mental capacity from giving valid consent. In such cases, court or guardianship approval is required to authorise the non-therapeutic procedure. The High Court (in a case involving sterilisation of an incompetent minor) stated this was due to the significant risk that such a decision would not be in the patient's best interests, and would have potentially grave consequences.[21]

To date, the rule that guardianship or court approval is needed for medical decisions relating to non-therapeutic procedures with potentially "grave consequences" has not been applied to with-

drawal of life-sustaining treatment from incompetent patients. Chances are that the requirement will be confined to minors undergoing procedures such as sterilisation. Nevertheless, the legal boundaries need to be clarified for medical practitioners, for whom the term "non-therapeutic treatment" will probably be unfamiliar and confusing. In the clinical context of incompetent patients, discontinuation of life-sustaining treatment would be considered in law non-therapeutic (ie, not for the purpose of treating some malfunction or disease), unless patients are either in the active dying process, in a persistent vegetative state, or in a permanent coma with no hope of recovery. However, these patients are beyond the capacity of medical treatment to effect a cure or relief. In such circumstances, neither withdrawal of treatment nor sustaining life by mechanical or biochemical means could be said to be in the best interests of the patient. Consequently, attending doctors should not be under a duty to persist with life-sustaining treatment, including PEG tube feeding.

This is the approach adopted in the South Australian legislation.[22] In the absence of a valid prior direction to the contrary, the medical practitioner responsible for a patient in the terminal phase of a terminal illness is under no duty to use or continue life-sustaining treatment if its effect would be merely to prolong life in a persistent vegetative state or in a moribund state without any real prospect of recovery.

Although it is usual medical practice in Victoria, and other jurisdictions, to consult the family before withdrawing treatment that cannot be justified on medical grounds, there is a need for amending legislation in Victoria to clarify the law in this area. It is arguable that, despite the decision in *Gardner*, the medical practitioner is under a common law duty either to obtain consent for treatment abatement from a family member with guardianship powers, or to seek judicial declaration.

Until a firm diagnosis is made regarding the transience or permanency of such conditions as vegetative state or coma, patients should be provided with life supports, including artificial feeding, as these form part of the diagnostic process and as such are therapeutic. In 2000, the New South Wales Supreme Court intervened to reverse a hospital's decision to withdraw treatment and nutrition from an incompetent patient on the basis of a prognosis that he would soon die.[23] This prognosis proved to be wrong on fuller medical assessment. In England, Wales and Northern Ireland, but not in Scotland,[24] the discontinuation of artificial nutrition and hydration for a patient who is permanently and irreversibly incompetent requires prior court sanction.[25] In Australia, in the absence of valid advance directives, where there is disagreement between treating physicians and the family or among family members about withdrawal of life-sustaining treatment from incompetent patients it would be prudent to seek the appointment of a guardian, and court or guardianship board sanction.

National implications of the decision

These are twofold. The decision will be of particular importance in the Australian Capital Territory, where the *Medical Treatment Act 1994* contains a very similar definition of "medical treatment" as including "the reasonable provision of food and water".[26] Moreover, the judicial definition of the content of such terms will serve as guidance when decisions at end of life are made in other states and territories. This happened in Queensland (which does not have equivalent legislation), where the Guardianship and Administration Tribunal referred to the *Gardner* case in determining whether hydration and nutrition via a PEG should be withheld from a dying patient in a persistent vegetative state secondary to multi-infarct dementia.[27] It may also assist in the Northern Territory, where the *Natural Death Act 1989* allows residents to make a living will and thereby reject "extraordinary measures" (defined to include medical measures that prolong life).

The importance of the judgment also lies in its approach to the legal understanding of the dying process. Justice Morris pointed out that, although the law has recognised that the dying process frequently involves impairment of respiration (hence, the recognition that mechanical ventilation or resuscitation is often inappropriate at end of life), it has been slow to recognise that the dying process may involve cessation of oral intake. The judge's acknowledgement of this medical fact will be of importance when other courts decide the issue of withholding of artificial nutrition and hydration.

For people with a potentially reversible condition, or incurable conditions but who are not yet dying, medically administered nutrition and hydration must be considered. However, given evidence of the lack of any benefit from PEG tube feeding for incompetent patients with advanced dementia and irreversible brain damage,[28-30] careful consideration should be given to any evidence of the patient's prior wishes in the light of his or her best interests, rather than to the morality of withdrawal of hydration and nutrition *per se*.

Conclusion

The *Gardner* judgment accords with the growing international consensus that artificial nutrition and hydration should be considered a medical treatment like any other.[31] There is no medical, ethical or legal requirement for dying people to be subjected to insertion of feeding tubes or infusions, unless such treatment is indicated for relief of pain, suffering or discomfort. This approach was made clear in recent guidelines published by the General Medical Council in the United Kingdom.[32,33] However, these guidelines were successfully challenged in the High Court on 30 July 2004, and are now the subject of an appeal by the GMC.[34]

The case was brought by a man with spinocerebellar ataxia who feared future withholding or withdrawal of hydration and nutrition without court scrutiny.[35] Justice Munby determined that, under common law, doctors are under a duty to act on a valid advance directive of incompetent patients who had previously expressed a wish for continued medically administered nutrition and hydration, except in cases where such treatment would provide no benefit at all for the patient, or where the patient is dying. His Honour also held that, although the bulk of the GMC guidelines was "compelling" and should "greatly reassure patients and their relatives", they did not sufficiently "acknowledge the heavy presumption in favour of life-prolonging treatment and to recognise that the touchstone of best interests is intolerability",[36] by failing to state that it is necessary to seek a court ruling concerning the withdrawal of artificial nutrition and hydration where there is:

- any doubt or disagreement as to the capacity (competence) of the patient;
- a lack of unanimity among medical professionals as to the patient's condition or prognosis, the patient's best interests, the appropriateness and likely outcome of withdrawing the medically administered nutrition and hydration;

- evidence that the patient, when competent, would have wanted the medically administered nutrition and hydration to continue;
- evidence that the patient (even if a child or incompetent) resisted or disputed the proposed withdrawal of the medically administered nutrition and hydration; or
- a reasonable claim by people who assert that withdrawal of the medically administered nutrition and hydration is contrary to the patient's wishes or is not in the patient's best interests.[36]

In the US, the Florida legislature granted the governor power to reinstate tube feeding for a woman in a persistent vegetative state in circumstances of family discord, in spite of legal and medical agreement that tube-feeding should cease.[37] A subsequent court ruling has found the legislation unconstitutional, as it deprives Florida citizens of their constitutional right to privacy.[38]

These cases show the emotive nature of the debate, and some significant opposition to the consensus that regards artificial nutrition and hydration as medical treatment. In March 2004, Pope John Paul II stated that "cessation or interruption of *minimal care* including nutrition and hydration" for patients whose vegetative state is prolonged beyond a year cannot be ethically justified and is "euthanasia by omission". In sharp contrast to Justice Morris in *Gardner*, the Pope said that:

> . . . the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. . . . its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory (all italics in the original).[39]

Although not holding the force of a papal encyclical, this firm statement will present significant challenges for Catholics, and Catholic healthcare professionals and agencies around the world.[40]

In Australia, doctors, patients and their agents or guardians need to know that the law does not impose a rigid obligation to administer artificial nutrition and hydration to people who are dying, regardless of their clinical condition, or wishes, if known. Most medical practitioners will be pleased to hear that, in the *Gardner* decision, the law has acknowledged the importance of clinical judgement in deciding whether medically administered nutrition and hydration will alleviate the patient's suffering and "lessen the violence" of the disease, or whether the patient's disease is too far advanced for such treatment to be of any benefit. They will also recognise the responsibility this places on them, particularly with regard to rigour of clinical evaluation, and appropriate consultation.

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Competing interests

Michael Ashby was an expert medical witness in this case, called by the Public Advocate's legal team.

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