The *Messiha* and *Schiavo* cases: third-party ethical and legal interventions in futile care disputes

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ABSTRACT

- Relatives may increasingly demand that an incompetent patient's treatment be continued indefinitely, despite clinical advice that it is technically "futile" (offering no reasonable prospect of return to a meaningful quality of life). Third-party interventions may become a more frequent part of attempts to resolve such disputes where there is no formal advance directive.
- In the *Messiha case*, the Supreme Court of New South Wales upheld clinical judgement regarding the patient's best interests as most important.
- In the *Schiavo case* in the United States, clinicians' decisions on futility of treatment had received unwavering judicial support in more than 20 proceedings.
- Political differences between the US and Australia make it unlikely clinicians in this country will face *Schiavo*-type legislative challenges to individual clinical decisions and the judicial rulings upholding them.
- Consulting a clinical ethics committee in such scenarios is both legally recommended and clinically warranted as an important device for diffusing tensions between relatives and clinicians, as well as clarifying their respective ethical and legal responsibilities.
- In protracted or apparently irresolvable disputes with relatives, applying for a judicial declaration on futility of treatment has become a practical option for intensivists in Australia and should be a recognised part of their training.

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In the United Kingdom, termination of artificial feeding and hydration for patients in a persistent vegetative state generally requires the prior sanction of a High Court judge.[1,2] UK clinicians also routinely seek judicial resolution of protracted disputes with relatives about ceasing "futile" active treatment on incompetent intensive care patients lacking a formal advance directive.[3] The same has generally been true in the United States.[4] Until recently, however, Australian intensivists appear to have lacked either the training or the support to initiate or participate in these types of cases, and the discussion about what Australian courts would do has been largely confined to legal academia.[5] In this article, we examine the recent case of *Messiha v South East Health*[6] (the *Messiha case*), and the various judicial and political interventions in what has become known as the *Schiavo case* in the US, for their practical lessons about the role of ethical, legal and legislative interventions in physician approaches to resolving disputes about the technical "futility" of treatment.

The *Messiha case*

On 17 October 2004, Mr Isaac Messiha was admitted to the intensive care unit (ICU) of St George Hospital in Kogarah, New South Wales. He was diagnosed as having suffered an out-of-hospital asystolic cardiac arrest and resultant severe hypoxic brain damage. It was estimated that Mr Messiha's brain had been deprived of oxygen for 25 minutes before ambulance officers arrived and commenced cardiopulmonary resuscitation. Mr Messiha was 75 years old, had chronic obstructive pulmonary disease, an unspecified history of cardiac surgery 10 years earlier, and a prior hospital admission 3 months previously after a cardiac arrest. No formal advance directive had been prepared.

Over the next few days, the Glasgow Coma Score never rose above 5 and was generally 3, the lowest possible reading, consistent with non-purposeful occasional eye-opening. Dr Theresa Jacques, Director of the ICU, informed the family that there was no reasonable prospect that Mr Messiha would return to a meaningful quality of life.

On 21 October 2004, electroencephalography (EEG) showed the complete absence of cortical activity. At this stage, the patient was being mechanically ventilated via an endotracheal tube, was being fed via a nasogastric tube, had an indwelling urinary catheter, was incontinent of faeces, and required constant suctioning of saliva by the nursing staff.

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Dr Jacques proposed that it was in the best interests of the patient that treatment be withheld. This would involve extubation, cessation of pharmacological treatment and the institution of a do-not-resuscitate order covering subsequent cardiac or respiratory arrest.

The patient's relatives disagreed with this proposal. They believed that the patient had spontaneously opened his eyes to voice and demanded that everything possible be done. They arranged for an eminent independent neurologist to examine the patient on 27 October. The neurologist agreed with Dr Jacques's assessment of Mr Messiha's condition, and with her proposal to withdraw active treatment. At the time, the hospital did not have a clinical ethics committee that could be consulted (Dr Jacques, personal communication).

Dr Jacques informed the family that she would be withdrawing treatment. The relatives sought an order from the Supreme Court of New South Wales that medical treatment not be withdrawn. On 11 November 2004, Justice Howie found that the Court had the power to decide Mr Messiha's treatment under the *parens patriae* jurisdiction, which allows superior courts to oversee the care and treatment of children and incompetent adults. The guiding principle under this jurisdiction is the best interests of the patient, and medical opinion carries great evidentiary weight:

> [I]t seems to me that it would be an unusual case where the Court would act against what is unanimously held by medical experts as an appropriate treatment regime for the patient in order to preserve the life of a terminally ill patient in a deep coma where there is no real prospect of recovery to any significant degree. This is not to make any value judgment of the life of the patient in his present situation or to disregard the wishes of the family and the beliefs that they genuinely hold for his recovery. But it is simply an acceptance of the fact that the treatment of the patient, where, as here, the Court is satisfied that decision as to the appropriate treatment is being made in the welfare and interest of the patient, is principally a matter for the expertise of professional medical practitioners.[6]

Justice Howie accepted that there was no reasonable prospect of active treatment offering Mr Messiha a return to a meaningful quality of life. On that basis, it could not be said that active treatment was in Mr Messiha's best interests, and the family's application was dismissed. Treatment was withdrawn in accordance with NSW Health Department Guidelines, which permit administration of sedation and analgesia to relieve distressing symptoms, irrespective of a family's objections.[7] The State Coroner subsequently reviewed the case and found no evidence for the death to be the subject of criminal proceedings. He advised that in similar cases, if the treating doctor becomes aware of accusations of unlawful death made by the patient's family or next of kin, he or she should consider not signing the death certificate, and recording the reasons for not completing it. This refusal will then activate the jurisdiction of the Coroner, who will advise the dead person's relatives or next of kin of the importance of having an autopsy conducted in these circumstances (R Kruk, Director-General, NSW Health, open letter to Dr T Jacques, undated).

The *Schiavo case*

On 25 February 1990, Terri Schiavo suffered severe anoxic brain damage after an asystolic cardiac arrest provoked by hypokalaemia that resulted from protracted bulimia. She was clinically diagnosed as being in a persistent vegetative state. Her husband, Michael, was appointed her legal guardian. In 1998, Mr Schiavo filed a petition with the court to discontinue his wife's feeding tube, a request that her parents, Mr and Mrs Schindler, devout Catholics, opposed. These parties became involved in more than 25 court rulings and interventions over 10 years, as a result of which Ms Schiavo's feeding tube was twice removed and reinserted. Contentious issues included whether Ms Schiavo made a formal advance directive (the courts concluded she had not) and who had the ultimate authority to withdraw futile treatment from her. Late in March 2005, Dr Stanton Tripodis, following the order of a Florida Supreme Court judge, removed the feeding tube that had kept Schiavo alive for 15 years, despite the extraordinary last-minute efforts of the Florida Governor Jeb Bush to seek Supreme Court review, and Republican congressional leaders issuing subpoenas for Ms Schiavo, Mr Schiavo, physicians and hospice staff to appear before them. Catholic organisations, including the Vatican, supported the Schindlers' case.

At a midnight sitting on 21 March 2005, the US Congress voted to allow a federal court to review the removal of Ms Schiavo's feeding tube. The legislation gave the parents legal standing, although it did not compel a federal judge to take up the case. The federal district denied the Schindlers' motion to recommence artificial nutrition and hydration. This ruling was upheld by the US Court of Appeals for the Eleventh District, and the US Supreme Court again declined to intervene. On 31 March 2005, Ms Schiavo died and her body was sent for autopsy, which confirmed blindness and cortical absence.[8] The *Schiavo case* was widely publicised in Australia.

1 Advantages and disadvantages of an ethics committee ruling or judicial declaration on futile treatment

Advantages

Clinical ethics committee review assists in diffusing tensions between relatives and clinical staff, as well as clarifying their respective ethical, legal and human rights responsibilities.

Judicial review provides a forum where all views can be impartially and definitively heard, tested and ruled upon to produce finality and closure.

Judicial review provides safeguards: clinical assessment of the best interests of the patient can be confirmed as independent, competent and procedurally fair.

Clinical ethics committee review and judicial declaration offer protection to clinicians. Once a committee or court has sanctioned withdrawal of treatment, clinicians who act under those rulings or orders are immune from suit or criminal prosecution.

Disadvantages

Costs and delay: if a clinical ethics committee does not have an emergency subcommittee able to convene rapidly and co-opt relevant expertise, events may overtake its capacity to properly consider them. Judicial proceedings have a reputation for protracted delays. In US states that have mandatory court review, many patients have died before the action concerning their treatment has been heard. However, the Australian experience so far has shown that the courts and tribunals can act with surprising speed and efficiency.

The adversarial nature of legal review may be inappropriate, especially if it exacerbates strained relationships between relatives and health carers. Clinicians should seek judicial declarations in support of decisions about futile treatment only in the small proportion of cases where consensus cannot be built with the relatives.

Publicity brought to the case by judicial review may involve clinicians in a public political debate about right-to-life issues. ◆

Lessons for clinical practice

Futile treatment, with which persistent vegetative state is commonly associated, is a notoriously controversial concept in clinical medicine, bioethics and health law.[9] Clinicians and relatives may disagree as to what level of probability and what type of evidence should be used to evaluate the chances of a treatment returning a patient to a meaningful quality of life.

Until recently, there has been little judicial discussion in Australia about the role of clinical ethics committees and judicial bodies in protracted futility disputes between clinicians and relatives. Clinical ethics committees with a range of liability-protected health professional, community and legal expertise are well positioned to assist the burden of professional responsibility in such cases (Box 1). In protracted futility disputes, they may gain assistance from other third parties, such as palliative and pastoral care consultative services, guardianship boards, community or public advocate offices and, in some cases, institutional processes of mediation and multidisciplinary case conferencing.

In the UK, there is a large body of cases recognising the legality of the withdrawal of technically futile treatments, including artificial nutrition and hydration, ventilation, antibiotics and dialysis, in the best interests of incompetent patients lacking an advance directive.[1] Recent legislative changes under the Mental Capacity Act 2004 (UK) have created a Court of Protection to deal specifically with these

issues. Courts have ruled that they do not need to be involved in every withdrawal-of-treatment case.[2] The Official Solicitor for England and Wales has issued a Practice Note to assist clinical decisions about obtaining judicial interventions.[10]

In the US, greater emphasis is placed on "substituted" judgment, where the decision-maker has to use "clear and convincing" evidence of what the patient would have decided, in making a decision to withhold or withdraw treatment.[11] Many jurisdictions in that country encourage routine referral of futility determinations to clinical ethics committees or courts.[12] Legislation encouraging the completion of an advance directive on arrival at a US health care facility makes them more commonly available to clinicians in these circumstances.[13]

The *Messiha case* adds to a growing Australasian jurisprudence on futility determination (Box 2). Of particular importance is its emphasis on supporting clinical judgement. Suggestions by the State Coroner that doctors in such circumstances should refuse to sign a death certificate where relatives allege unlawful death are equally significant.

Increasingly, a case can be made that formal medical education should impart knowledge of such cases and the relevant procedural skills and normative understandings required to properly activate and navigate clinical ethics committee and judicial review of futility decisions. Where possible, this should include students' practical experience of these and other relevant third-party interventions in protracted futility disputes.

Both the *Messiha case* and the *Schiavo case* confirm a growing international consensus in clinical medicine, bioethics and the law, that artificial nutrition and hydration can be withdrawn in appropriate cases as futile treatment.[14] They suggest that clinicians are entitled to some confidence that the courts, even under considerable community and political pressure, will understand and respect clinical judgement in protracted or apparently irreconcilable disputes with relatives over futility of treatment. In the recent Korp attempted murder case, the Victorian Public Advocate defended in the media his decision as legal guardian to authorise cessation of a comatose patient's artificial nutrition and hydration after 5 months, partly on the basis of clinical, ethical, family and religious concurrence on its futility.[15] It is surprising and unacceptable that many hospitals in Australia still do not have clinical ethics committees with emergency subcommittees capable of responding rapidly to these situations.

These cases also provide a timely reminder to clinicians of increasing public scrutiny of end-of-life decisions. If greater numbers of relatives demand indefinite prolongation of futile treatment, then a consistent chain of decision-making should be established for a procedurally fair assessment of the patient's best interests or previously expressed intentions. Related resource allocation questions will need to be rationally addressed at the legislative level.

The publicity accorded such cases appears to have generated increased interest in advance directives. It may help clinicians if these focus on describing the minimal level of quality of life an individual patient would consider acceptable, rather than attempting to nominate particular forms of futile treatment.

2 Principles from key judicial cases in Australia and New Zealand on futility disputes

Messiha v South East Health [2004] NSWSC 1061: the Supreme Court of New South Wales held that a court will rarely act against medical opinion that treatment is futile for a terminally ill patient in a deep coma with no real prospect of recovery.

Re BWV [2003] VSC 173: the Supreme Court of Victoria held that provision of artificial nutrition and hydration is medical treatment under the relevant legislation and could be withheld if clinically deemed "futile".

Northridge v Central Sydney Area Health Service [2000] NSWLR 1241: relatives successfully applied to the NSW Supreme Court to prevent withdrawal of treatment from a patient suffering severe brain damage after a heroin overdose 10 days earlier. The treating intensivists considered further treatment unlikely to lead to a meaningful quality of life. The relatives felt the medical staff had inadequately considered their views about the patient's level of function. The judge held the diagnosis of "chronic" vegetative state "premature", and subsequent expert neurological assessment showed some clinical improvement. He later ruled that the hospital should provide necessary and appropriate medical treatment and make no do-not-resuscitate order without court approval. The decision made no reference to relevant judicial authorities and was based on affidavit evidence not subject to cross-examination.

Re PVM [2000] QGAAT 1: the Queensland Guardianship and Administrative Tribunal (GAAT) found a 39-year-old man with severe brain and spinal injuries competent to request the removal of artificial ventilation and to refuse further treatment.

Re RWG [2000] QGAAT 2: the GAAT agreed to the no-CPR order requested by the wife of a 73-year-old man with an acquired brain injury, but would not consent to the refusal of antibiotics, as the patient was not suffering from an infection at the time so it would be premature to examine the issue.

Re MC [2003] QGAAT 13: the GAAT found that artificial nutrition and hydration was of no benefit to an 80-year-old woman in a persistent vegetative state and could be ceased.

Auckland Area Health Board v Attorney General (Re L) [1993] NZLR 235: a New Zealand judge held that treatment could be withdrawn when it was no longer in the best interests of the patient as determined by "prevailing standards . . . which command general approval within the medical profession". The case is particularly important for emphasising the role of clinical ethics committees in protracted futility disputes.

CPR = cardiopulmonary resuscitation. ◆

Competing interests

None identified.

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