General Guideline When Treatment Is Abated

Key questions to be addressed if treatment is to be abated:

- Are the clinical facts of the case well established? Is the diagnosis correct?
- Has sufficient time elapsed to be reasonably confident that there is no reasonable prospect of substantial improvement or recovery?
- Is there consensus among the clinicians about the diagnosis, prognosis and most course of medical action? Is a case conference necessary?
- Identify the key decision maker(s) in the family, or friends.
- Have the patient's family, carer(s) or legally appointed agent been advised of the above? Have they had a chance to express their opinions, and been involved in the decision-making process?
- Has the patient's general practitioner been involved?
- Has the abatement decision been documented? The plan for implementing it may involve a "time trial" of continued life-sustaining treatment. How will subsequent objections to the decision be dealt with?
- Has a consultative palliative care team referral been considered?

[Adapted from Editorial – Michael A Ashby, Allan Kellehear and Brian F Stoffell – 'Resolving Conflict in End – of – Life Care' (2005) 183 Medical Journal of Australia, 230.]

Cardio-Pulmonary Resuscitation (CPR)

CPR - Specific Recommendations:

It is important that vulnerable patient's feel in control and understood through a positive and frank process. Rather than becoming a victim to a series of poorly understood and often 'ad hoc' decisions made by frantic doctors in the midst of a crisis.

1. Resuscitation is clinically futile in the sub-group of frail people over 65 years with multiple organ failure, serious stroke or severe dementia

2. Resuscitation should not be seen as a choice between life and death, but rather as a medical intervention similar to any other requiring 'informed consent'

3. In order for patients to make clinically informed decisions, they require accurate and up-to-date information on their current conditions, prognosis and focused assistance in end-of-life decision-making

4. Reference to relevant guideline documents and professional staff recognized as having appropriate specialist expertise and clinical experience is crucial.

5. The process of communication (which requires specialist training) and involvement of key players (family members) is critical to this process, including timely communication with the family doctor (GP).

6. It is essential that a systematic and comprehensive approach be adopted. Medical recommendations should be fully explained to the patient and family. The final decision should then subsequently be recorded as a component of an agreed 'plan of management' (called an Advanced Care Plan in the RPC program) in the patient's medical record

7. The process of End-of-Life decision making generates strong emotions (in both practitioners and family members) and this must be channeled and proactively managed to ensure a just and positive outcome

8. Given resuscitation is unlikely to be clinically effective and a default blanket position of intervention is inappropriate, consideration should be given to the recent UK concept of an "opt-in" policy in specialist Aged care facilities

9. Referral to specialist services like the **RPC Program**, **Palliative Services** and the "**RECIPE**" Program in Northern Melbourne should be essential.

CPR Guideline Documents:

1. British Medical Association, **'Withholding and Withdrawing Life-Prolonging Medical Treatment – Guidance for Decision Making'** (2 nd , 2001).

2. Ian H. Kerridge, et. al. **Guidelines for No-CPR Orders**, (1994) 161 Medical Journal of Australia 270 ("MJA Guidelines").

3. **NHMRC –** ***Post – Coma Unresponsiveness*** **- Clinical** Guidelines.

Percutaneous Endoscopic Gastrostomy Feeding (PEG's)

PEG - Summary

- It is a normal part of the dying process for there to be a gradual reduction, and eventual cessation in oral intake.
- There is now overwhelming research evidence which demonstrates that most dying patients do not experience hunger, given the physiological process of 'shut-down'. (Van der Riet et. al., p-184)
- Further the process of medical hydration and nutrition (MH&N) is unlikely to alleviate the symptoms of dehydration such as thirst, headache, nausea, vomiting, and dry mouth. (ibid)
- Finally, there are no clinical studies to suggest that the absence of MH&N during the dying process causes suffering provided adequate palliative care, including mouth care is provided. (Van der Riet et. al., p-186).
- More importantly as Van der Riet et. al., note in their comprehensive research, family members were under the distinct impression that the non-provision of fluid and nutrition would result in suffering for the dying person.
- This confirms a strong need for ongoing public education and family support. (Van der Riet et. al., p-182)

PEG - Specific Recommendations.

1. The insertion of a PEG is not a choice between life and death. Rather a **medical intervention similar to any other requiring 'informed consent**', taking into account the benefits, as well as, the burdens of treatment.

2. All referrals for a PEG insertion should involve a multidisciplinary team with **staff recognized as having appropriate expertise and clinical experience.** This would ensure patients with reversible causes are addressed. (Indeed the hospital, in which my colleague Professor Schmidt works, has been trialing the concept of having a "PEG Advisory Committee").
 (BMA Guidelines – (2001)) (Sanders et. al. – 2002 – Am j Gastroenterology v.97, 2239)

3. Hospitals should adopt a policy incorporating a '**one week waiting list policy'** before PEG tube is inserted.
    - This 'cooling- off' period would allow time for those involved in the decision-making process to reflect on the implications of PEG insertion.
    - Critically ill patients in the process of dying could then be managed conservatively (Sanders et. al. – 2002 – Am j Gastroenterology v.97, 2239).

4. In order for patients to make clinically informed decisions about PEG's, they **require accurate and up-to-date information and skilled assistance** in end-of-life decision-making.

5. Given the insertion of a PEG feed is unlikely to be clinically effective and a **default blanket** position of intervention is inappropriate.

6. Elderly demented patients can present formidable clinical challenges and a comprehensive **program of hand-feeding is the proper treatment**.(Refer to Finucane et. al, *'Tube Feeding in Patients with Advanced Dementia'* (1999) 282 (14) JAMA 1369 & recent study by Van der Riet et. al. 2006)

PEG Guideline Documents:

1. Thomas **Finucane et. al**, *'Tube Feeding in Patients with Advanced Dementia'* (1999) 282 (14) JAMA 1369.

2. Linda Rabeneck et. al., ***'Ethically justified, clinically comprehensive guidelines for Percutaneous Endoscopic Gastrostomy Tube Placement'***, (1997) 349 (9050) Lancet 496.

3. British Medical Association, ***'Withholding and Withdrawing Life-Prolonging Medical Treatment – Guidance for Decision Making'*** (2 nd, 2001).

4. **NHMRC – *Post – Coma Unresponsiveness* - Clinical Guidelines.**

References

British Medical Association, *'Withholding and Withdrawing Life-Prolonging Medical Treatment – Guidance for Decision Making'* (2 nd , 2001)

Frank **Cervo et. al**., *'To PEG or not to PEG – A review of evidence for placing feeding tubes in advanced dementia and the decision-making process'* (2006) 61 (6) Geriatrics 30.

De Legge M, *'PEG Placement: Justifying the Intervention'*, (2006) www.Up-to-Date.com

Alexandra **Easson et. al**., *'The role of tube feeding and total parental nutrition in advanced illness'* (2002) 194 (2) JACS 225.

Thomas **Finucane et. al**, *'Tube Feeding in Patients with Advanced Dementia'* (1999) 282 (14) JAMA 1369.

Marissa Galicia-Castillo, *'The PEG Dilemma'*, (2006) 61 (6) Geriatrics 12.

Muriel **Gillick**, *'Rethinking the Role of Tube Feeding in Patients with Advanced Dementia'*, (2000) 342 NELM 206.

Ian H **Kerridge, et. al**. Impact of written information on knowledge and preferences for cardiopulmonary resuscitation *MJA* 1999; 171: 239-242

Ian H. **Kerridge, et. al**. Guidelines for No-CPR Orders, (1994) 161 Medical Journal of Australia 270 ("MJA Guidelines")

Carol **Monteleoni et.al**. *'Quality Improvement Report, Using Rapid Cycle Quality Improvement Methology to Reduce Feeding Tubes in Patients with Advanced Dementia; Before and After Study'* (2004) 329 BMJ 491

*Linda **Rabeneck et. al.**, 'Ethically justified, clinically comprehensive guidelines for Percutaneous Endoscopic Gastrostomy Tube Placement', (1997) 349 (9050) Lancet 496.*

***Ranse J**, 'Cardiac Arrest: Can the in-hospital Chain of Survival be Improved?', (2006) Aust Emerg. N J, 9,p. 23.*

***Robinson GR**, Hess D. Post-discharge survival and functional status following in-hospital cardiopulmonary resuscitation. Chest 1994; 105: 991-994.*

Skene L, *Law & Medical Practice: Rights, Duties, Claims & Defences,* (2 nd, 2004) 307

Skene L, *'The Schiavo and Korp cases: Conceptualising end-of-life decision-making', (2005) 13 JLM 223 at 228*

Cameron Stewart & Paul Biegler, *'A Primer on the Law of Competence to Refuse Medical Treatment'*, (2004) 78 ALJ 325.

Pamela **Van der Riet et. al**., Nutrition and hydration at the end of life: Pilot study of a palliative care experience', (2006)14 JLM 182

Cases

Airedale National Health Service Trust v Bland [1993] ("**Bland**")

Gardner; Re BWV [2003] VCAT at 173 ("**BWV**")

Burke v General Medical Council [2005] EWCA Civ 1003 ("**Burke**")

Northridge v Central Sydney Area Health Service (2000) 50 NSWLR 549. ("**Northridge**")

Public Advocate; re RCS [2004] VCAT 1880. ("**RCS**")

Re C (adult; refusal of medical treatment) [1994] 1 WLR 290 ("**Re C**")

*Re T (adult; refusal of medical treatment)[1992] 4 All ER 649 (CA).("**Re T**")*

Rogers v Whitaker (1992) 175 CLR 479. ("**Rogers v Whitaker")**