Withholding and Withdrawing Life-prolonging Medical Treatment
Guidance for decision making
Withholding and Withdrawing Life-prolonging Medical Treatment
Guidance for decision making

THIRD EDITION

British Medical Association
Contents

Medical Ethics Committee viii
Editorial board for the third edition x
Acknowledgements for the third edition xi
Introduction xii

Part 1: How to use this guidance 1
1. Scope, purpose and structure of this guidance 1

Part 2: Defining key terms and concepts 3
2. The primary goal of medicine 3
3. Life-prolonging treatment 5
4. Capacity and incapacity 5
5. Duty of care 6
6. Quality of life 8
7. Benefit 10
8. Harm 11
9. Best interests 12
10. Futility 14
11. Basic care 15
12. Artificial nutrition and hydration 15
13. Oral nutrition and hydration 17
14. Foresight and intention 18
15. Withholding or withdrawing treatment 19
16. Conscientious objection 20
17. Resource management 21

Part 3: Legal and ethical considerations that apply to all decisions to withhold or withdraw treatment 23
19. Fairness and non-discrimination 28
20. Communication 31
21. Confidentiality 32
22. Legal review 34
Contents

Part 4: Medical considerations that apply to all decisions to withhold or withdraw treatment 36
23. Medical assessment 36
24. Medical decision making 39

Part 5: Decision making by adults with capacity 43
25. The law 43
26. Communication and information 47

Part 6: Decision making on behalf of adults who lack capacity 50
England and Wales 50
27. Patients with a Lasting Power of Attorney (LPA) 50
28. Patients with an advance decision about medical treatment 52
29. Patients without a Lasting Power of Attorney or advance decision 57
30. Patients in persistent vegetative state (pvs) 61
Scotland 62
31. Patients with a welfare power of attorney or welfare guardian 62
32. Patients with an advance decision about medical treatment 64
33. Patients without a welfare power of attorney or advance decision 67
34. Patients in persistent vegetative state (pvs) 68
Northern Ireland 69
35. Patients with an advance decision about medical treatment 69
36. Patients without an advance decision about medical treatment 69
37. Patients in persistent vegetative state (pvs) 71
All UK jurisdictions 72
38. Capacity and incapacity 72
39. Communication and information 73
40. Assessing best interests 77
41. Dealing with disagreement 80

Part 7: Decision making by young people with capacity 83
42. The law in England, Wales and Northern Ireland 83
43. The law in Scotland 88
44. Assessing capacity 91
45. Communicating with young people 92
46. Dealing with disagreement 95
Contents vii

Part 8: Decision making for children and young people who lack capacity 96
47. The law 96
48. Duties owed to babies and children 102
49. Communicating with parents 104
50. Assessing best interests 106
51. Dealing with disagreement 108

Part 9: Once a decision has been reached 109
52. Keeping others informed 109
53. Recording and reviewing the decision 109
54. Providing support 111
55. Respecting patients’ wishes after death 113

Appendix 1 Useful addresses 114
References 118
Index 123
Medical Ethics Committee

A publication from the BMA’s Medical Ethics Committee (MEC) whose membership for 2006/07 was:

Professor Parveen Kumar  President, BMA
Dr Michael Wilks*  Chairman of the Representative Body, BMA
Mr James Johnson  Chairman of Council, BMA
Dr David Pickersgill  Treasurer, BMA

Dr Anthony Calland  Chairman, Medical Ethics Committee; General Practitioner, Gwent
Dr Jonathan Brett  Junior doctor, general practice, Newcastle-upon-Tyne
Dr John Chisholm*  General Practitioner, London
Dr Peter Dangerfield  Medical Academic, Liverpool
Professor Bobbie Farsides*  Professor of Medical Law and Ethics, Brighton
Professor Ilora Finlay*  Consultant in Palliative Medicine, Cardiff
Professor Robin Gill*  Professor of Modern Theology, Canterbury
Professor Raanan Gillon*  General Practitioner; Professor of Medical Ethics, London
Dr Evan Harris*  Member of Parliament; former hospital doctor, Oxford
Professor John Harris  Sir David Alliance Professor of Bioethics, Manchester
Professor Emily Jackson*  Professor of Law, London
Dr Craig Knott  House Officer, London
Dr Surendra Kumar  General Practitioner, Widnes, Cheshire
Professor Sheila McLean*  Director of Institute of Law and Ethics, Glasgow
Professor Jonathan Montgomery  Professor of Health Care Law, Southampton
Professor Ruud ter Meulen  Professor of Ethics in Medicine, Bristol
Dr Peter Tiplady (deputy)  Retired, East Cumbria
Dr Frank Wells (deputy)  Retired, Suffolk
Dr Jan Wise  Consultant Psychiatrist, London
Dr John Jenkins  General Medical Council Observer
Ms Jane O’Brien  General Medical Council Observer
Mr Chris Chaloner  Royal College of Nursing Observer

*Sub-group of the MEC to discuss this guidance
Editorial board for the third edition

Head of Medical Ethics: Ann Sommerville
Project Manager: Veronica English
Written by: Veronica English
Editorial Secretary: Patricia Fraser

Information about major developments since the publication of this guidance may be obtained from the BMA’s website at: www.bma.org.uk/ethics or by contacting the Medical Ethics Department:

British Medical Association
BMA House
Tavistock Square
London WC1H 9JP

Tel: 020 7383 6286
Fax: 020 7383 6233
Email: ethics@bma.org.uk
Acknowledgements for the third edition

We would like to thank those individuals and organisations who generously gave their time to review an earlier draft of this guidance. Whilst these contributions helped to inform the BMA’s views, it should not be assumed that this guidance necessarily reflects the views of all those who contributed. We would particularly like to thank Anna Batchelor, Intensive Care Society; Beverley Taylor, Office of the Official Solicitor; Charlie McLaughlan, Royal College of Anaesthetists; Chris Chaloner, Royal College of Nursing; Donald Lyons, Mental Welfare Commission Scotland; Emma Wilbraham, Department of Health; Kathleen Glancy, Scottish Executive Health Department; Mike Hinchliffe, Children and Family Court Advisory and Support Service (CAFCASS); Ranald Macdonald, NHS Scotland Central Legal Office; Resuscitation Council (UK); Sandra McDonald, Office of the Public Guardian (Scotland); Sharon Burton and Roger Worthington, General Medical Council; Toby Williamson, Department for Constitutional Affairs.
In medicine, decisions are made on a daily basis about the provision, withholding or withdrawing of treatments, some of which could prolong life. Treatments which might provide a therapeutic benefit are not inevitably given but are weighed according to a number of factors, such as the patient’s wishes, the treatment’s invasiveness, side-effects, limits of efficacy and the resources available. The Intensive Care Society has estimated that approximately 50,000 patients are admitted to intensive care units in England and Wales each year. Of these, 30% (15,000 patients) die without leaving hospital, most as a result of active treatment being withdrawn [1].

Although not uncommon, few issues in medicine are more complex and difficult than those addressed by patients, their relatives and their doctors concerning the decision to withhold or withdraw potentially life-prolonging treatment. Technological developments continually extend the range of treatment options available to prolong life when organ or system failure would naturally result in death. Cardiopulmonary resuscitation, renal dialysis, artificial nutrition, hydration and ventilation prolong life and, in some cases, allow time for recovery but these techniques cannot, in themselves, reverse a patient’s disease. Patients with progressive conditions such as motor neurone disease can have their lives prolonged by the application of technology, but their underlying illness cannot be cured and deterioration in their condition is unavoidable. The condition of other patients, for example those with very severe brain damage, may remain stable for many years if life-prolonging treatment is provided but they may have no hope of recovering more than very minimal levels of awareness of their surroundings. They may lack the ability to interact with others or capacity for self-awareness or self-directed action. In such severely damaged patients, interventions to prolong life by artificial means may fail to provide sufficient benefit to justify the burdens of intervention (see Section 9) and the proper course of action may be to withhold or withdraw further treatment.

Most people accept that treatment should not be prolonged indefinitely when it has ceased to provide a benefit for the patient. But patients and their families, doctors and other members of the clinical team and society as a whole need reassurance that individual decisions are carefully thought through, based on the best quality information available and follow a widely
agreed procedure. Decisions need to be made on an individual basis, assessing the particular circumstances, wishes and values of the patient to ensure that treatment is neither withdrawn too quickly nor unnecessarily prolonged. It is essential that there are clear, robust and transparent procedures for making these decisions. The BMA is very pleased to note that, over recent years, comprehensive guidance has been developed outlining the criteria and steps to be followed in making these decisions, particularly where difficult assessments are required about the best interests of incapacitated patients. In addition to the BMA’s guidance, first published in 1999, there is now also detailed advice from the General Medical Council [2] and from the Royal College of Paediatrics and Child Health [3]. There is also statutory guidance for those providing treatment for adults who lack capacity, in the form of Codes of Practice under the Adults with Incapacity (Scotland) Act 2000 [4] and the Mental Capacity Act 2005 [5]. Nevertheless, there is only benefit in having guidance if it is available to, and used by, those responsible for making these decisions. Occasional media reporting has served to remind us that best practice is not yet universal and that we all have a responsibility to ensure that good communication and decision-making procedures are followed in all cases. In this document, the BMA seeks to provide a coherent and comprehensive set of principles which apply to all decisions to withhold or withdraw life-prolonging treatment. It is hoped that this general guidance will stimulate the development of accessible local policies and guidelines as part of a wider network of safeguards for doctors and patients.

The need for guidance in this area became clear from a wide-ranging consultation exercise undertaken by the BMA in 1998. This led to the first edition of this guidance being published in 1999. A second edition was published in 2001 to incorporate specific guidance on the impact of the Human Rights Act. This third edition includes subsequent developments in legislation – specifically the Mental Capacity Act (which at the time of writing was due to come into force in 2007) – and the common law. Although these changes have clarified some aspects of the law, some legal uncertainties remain and judicial review will still be required in particular cases. Part of the aim of this guidance is to identify the type of cases where decisions may be made by the patient, the health care team and/or those close to the patient and those where a declaration from a court is required. This guidance does not set out to give definitive legal advice but to explain the legal and ethical principles that underpin decision making in this area and to help health professionals to recognise when further advice is needed. Of course, the law will not remain static and information about any major developments following publication will be posted on the BMA’s website at www.bma.org.uk/ethics.