Is There a Role for Law in Medical Practice When Withholding and Withdrawing Life-Sustaining Medical Treatment? Empirical Findings on Attitudes of Doctors

Lindy Willmott, Ben White, Malcolm Parker, Colleen Cartwright and Gail Williams

The law regulates many aspects of decision-making around the withholding and withdrawing of life-sustaining medical treatment from adults who lack decision-making capacity and are approaching the end of their lives. For example, it governs whether an adult's advance directive is binding and applicable and, if not, who is authorised to make the treatment decision and the criteria that should guide the decision. Doctors who treat patients at the end of life should be aware of the prevailing law so that they can practise within those legal parameters. However, the law in this field is complex and challenging for doctors to know and understand. Doctors will be prepared to invest time into learning about the law only if they believe that the law is worth knowing and that practising medicine in a legally compliant way is a desirable goal. This article provides insight into doctors' attitudes about the role of law in medical practice in this field, and argues that education is required for doctors to reconceptualise knowledge of the law as constituting an integral component of their clinical expertise.

INTRODUCTION

The law that governs whether life-sustaining medical treatment at the end of life should be withheld or withdrawn is important as it affects decisions about life and death. This is no less the case, and possibly even more important, when these decisions are made for the vulnerable in society such as adults who lack decision-making capacity. The law that applies to this cohort is very complex and varies according to the specific circumstances of the person affected, differs across jurisdictions, and can turn on fine technical legal distinctions.

Notwithstanding these complexities, the law clearly governs medical practice in this area. If an adult has completed an advance directive before losing capacity, the law stipulates whether or not the directions in that document should be followed by the treating doctor. If the person has not completed an advance directive, the law governs who the doctor should approach to provide consent to treatment (or to authorise the withholding of treatment, if that is allowed by the prevailing law). Obtaining consent from the legally authorised person is particularly important where there is disagreement about the appropriate course of treatment. Acting in a manner that does not comply with the law can have serious consequences for both the patient and doctor. A patient may receive treatment that he or she has refused through an advance directive. Alternatively, if the doctor approaches the wrong substitute decision-maker, a decision may be made that is contrary to the decision of the lawful decision-maker.

* Lindy Willmott, Professor and Director, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology; Ben White, Professor and Director, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology; Malcolm Parker, Emeritus Professor of Medical Ethics, University of Queensland; Colleen Cartwright, Emeritus Professor, Southern Cross University; Gail Williams, Professor, School of Public Health, University of Queensland. The authors wish to thank Dr Loretta de Plevitz, Stephanie Jowett, Karen Nixon and William Isdale for their research assistance. The authors also acknowledge funding from the Australian Research Council’s Linkage Project Scheme (LP099329) and from the project’s seven partner organisations: Queensland Civil and Administrative Tribunal; Office of the Public Guardian (Qld); Office of the Public Advocate (Qld); New South Wales Civil and Administrative Tribunal; The Public Guardian (NSW); Victorian Civil and Administrative Tribunal; and Office of the Public Advocate (Vic).

Correspondence to: l.willmott@qut.edu.au.
This may result in treatment being provided that should not have been, or treatment being denied that should have been provided. Such scenarios could also potentially result in civil and criminal sanctions for the doctor.

To enable doctors to practise medicine in a lawful way, they need to know the relevant law. The authors have previously reported on research that indicates doctors have significant knowledge gaps in this field of law.1 However, knowledge is not the only key to this puzzle. What is critical, and possibly a barrier to achieving legally compliant medical practice, is for doctors to regard law as having a legitimate role to play in medical practice. Moreover it should be regarded as a routine element of their own clinical abilities. This is relevant for three reasons. First, if doctors do not think that law has a role to play they may not be motivated to learn about the law. This is particularly the case where the law is complex and difficult to understand. Second, if doctors do not regard law as being relevant to the clinical encounter, they will not be motivated to comply with the law, even if they know it. Third, even if doctors regard the law as clinically relevant, their knowledge and compliance will be uneven unless they come to regard it as constituting part of their clinical expertise rather than as something that is applied to that expertise from outside.

There has been some empirical research, albeit relatively limited, on doctors’ opinions about substantive aspects of the law including the law governing withholding or withdrawing treatment,2 the link between doctors’ knowledge of the law at end of life3 and concern about being sued,4 and defensive medical practices.5 Yet remarkably little is known about doctors’ attitudes about the role of law in relation to withholding and withdrawing treatment from adults who lack capacity.6 Indeed there is little evidence about doctors’ view of the role of the law in medical practice more broadly.7 This article therefore makes an important contribution to the literature in the field. It reports on empirical research conducted into the attitudes of Australian doctors from seven different specialties about the role that law governing the withholding and withdrawal of life-sustaining medical treatment from adults who lack decision-making capacity should play in medical practice.

**METHODS**

The data examined in this article are derived from a survey of doctors from seven specialties that regularly practise in the end-of-life field. The sample cohort comprised all specialists in Emergency Medicine, Geriatric Medicine, Intensive Care, Medical Oncology (hereafter “Oncology”), Palliative Medicine, Geriatric Medicine, Intensive Care, Medical Oncology (hereafter “Oncology”), Palliative Medicine, Social Science & Medicine 1639; M Bahus, P Andreas Steen and R Førde, “Law, Ethics and Clinical Judgment in End-of-Life Decisions – How do Norwegian Doctors Think?” (2012) 83(11) Resuscitation 1369.

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1 B White et al, “Doctors’ Knowledge of the Law on Withholding and Withdrawing Life-Sustaining Medical Treatment” (2014) 2014(4) Medical Journal of Australia 229. The data relied upon were drawn from the responses to surveys that are the subject of this article.


5 See also H Douglas, K Black and CD Costa, “Manufacturing Mental Illness (and Lawful Abortion): Doctors’ Attitudes to Abortion Law and Practice in New South Wales and Queensland” (2013) 20 JLM 566, which explores the link between doctors’ understanding of the law and practice in relation to the provision of abortion services.

6 For a dated yet thoughtful consideration of doctors’ perceptions about the law and its influence on medical decision-making in the American context, see M Kapp and B Lo, “Legal Perceptions and Medical Decision Making” (1986) 64(2) Milbank Quarterly 163. While not exploring attitudes to the law in this field generally, doctors’ attitudes to Canadian legal processes to resolve end-of-life disputes were explored in the following study: P Chidwick and R Sibbald, “Physician Perspectives on Legal Processes for Resolving End-of-Life Disputes” (2011) 14(2) Healthcare Quarterly 69.

Medicine, Renal Medicine and Respiratory Medicine who were on the AMPCo Direct (a subsidiary of the Australian Medical Association) database in Queensland, New South Wales and Victoria at the time the survey instrument was distributed (n = 2,858). These specialties were chosen as they are likely to be involved in making decisions about whether to withhold or withdraw life-sustaining treatment. This was determined by a review of relevant literature, interviews undertaken with medical specialists in the pre-pilot phase and an analysis of pilot results.

The survey instrument used in this research was developed over an 18-month period and was informed by a detailed review of the law in each of the three States, focus groups, pre-testing and piloting of the instrument with specialists in each State. The accuracy of the responses to the legal questions were confirmed by independent legal experts in each State.

AMPCo Direct administered the survey mail-out, which began on 18 July 2012. Recruitment strategies included having the survey instrument professionally designed, providing incentives (continuing professional development points, educational material and a chance to win one of six prestige bottles of wine), engaging with all the colleges and specialist societies of the target specialties (except the Emergency Medicine Society given the overlap with the college) and publishing editorials in relevant professional journals to request participation in the study. Two follow-up requests were sent to non-responders and the survey was closed on 31 January 2013.

The project was approved by the Human Research Ethics Committees at Queensland University of Technology (1100001137), the University of Queensland (2011001102) and Southern Cross University (ECN-11-222).

MEASURES

The survey instrument had six sections: Part A (Q1-2) – Perspectives about the law; Part B (Q3-5) – Education and training; Part C (Q6-7) – Knowledge of the law; Part D (Q8-10) – Medical practice and compliance with the law; Part E (Q11-14) – Experience in making end-of-life decisions; and Part F (Q15-22) – Demographics. The survey concluded with an invitation for the respondent to provide further information:

If you have any further comments about the law in this area, how it could be improved and its role in medical practice, please tell us here.

Perspectives about the role of law in medical practice were examined in two ways. First, Q1 asked respondents to rate, on a five-point scale from “Strongly Disagree” to “Strongly Agree” with “Unsure” as the middle option, their level of agreement with a series of 11 statements about the role of law in this area of medicine. Responses to these statements were analysed to generate a score representing how positive each respondent’s attitude was to the role of law. Second, respondents’ perspectives about the law were examined through their responses to the open-ended question at the end of the survey.

For further detail about the process of designing the survey instrument, see L Willmott et al, “Doctors’ Perspectives on Law and Life-Sustaining Treatment: A Case Study on Survey Design and Recruitment Strategies” (2016) 24(4) Progress in Palliative Care 213.

For further detail about the recruitment strategies, see Willmott et al, n 8.

Part A of the survey also contained Q2, which asked respondents to rate their levels of agreement with 11 statements about knowing and following the law. Responses to Q2 were excluded from the analysis in this article because they provided insight into doctors’ perceptions about the law that were broader than the role of law in medical practice. For example, Q2 statements included whether doctors worried about legal risk, whether they thought knowing the law would assist them to manage that risk or help them follow the law, whether they thought the law was too complex or unclear, and whether they thought acting in accordance with good medical practice would always be lawful.
Statistical Analysis of Survey Question One

Questionnaires were coded and double-entered into an Access database, then transferred to SPSS 20 (IBM Corp) and SAS 9.3 (SAS Institute Inc) for analyses.

An “attitude to the law” score was calculated for the set of 11 statements in Q1 (Table 1), with a maximum possible score of 55 (reverse scoring negative statements).

Given the spread of scores from the 862 respondents, they were divided into eight “rational” groups using arbitrary cut-off points, as follows:
• Octile 1 – range 11-25, number in group 103;
• Octile 2 – range 26-28, number in group 93;
• Octile 3 – range 29-31, number in group 139;
• Octile 4 – range 32-33, number in group 114;
• Octile 5 – range 34 (only), number in group 75 (ie all 75 scored 34/55);
• Octile 6 – range 35-37, number in group 142;
• Octile 7 – range 38-40, number in group 105;
• Octile 8 – range 41-52, number in group 91.

Using these groupings, cross-tabulations and chi-square analyses were run by respondents’ demographic, education and training variables.

Analysis of Open-Ended Question

There were 252 responses to the invitation at the end of the survey to provide further comments about the law on this topic, and its role in medical practice. All responses were typed into a database, and data entry was checked for accuracy by a research assistant. One of the authors (MP) who has medical expertise provided input where the research assistant was unable to decipher the respondents’ handwriting.

The comments were analysed in two phases. In the first phase, the research assistant categorised each of the 252 responses and assessed the respondent, on the basis of their comment, as falling into one of three groups – having a positive, negative or neutral attitude towards the law regarding withholding and withdrawing life-sustaining treatment. A response fell into the neutral category in two circumstances: either the response did not relate to an “attitude” about the law (eg if a respondent’s only comment was that doctors were ignorant of the law); or a respondent made both positive and negative comments about the law and it was not possible to derive an “overall” impression of the respondent’s attitude.

The second phase was to break the responses into themes. The research assistant reviewed the categorised responses and divided each response, where necessary, into separate “comments”. This was necessary because some of the responses contained more than one comment and revealed different aspects of the respondent’s attitude towards the law.

Next, the research assistant coded each comment into broad themes, which were confirmed or amended with input from the lead author (LW). These themes included perceived shortfalls of the legal framework, problems arising from the adversarial nature of the law, observations about the law and its relevance to clinical practice, and the need for better education both of medical practitioners and the broader community. Following this categorisation, a second research assistant carried out an independent categorisation based on the same themes. Any disagreement with the first research assistant was resolved by discussion with an author (LW).

Two authors (LW and BW) then undertook a detailed analysis of key themes and refined the categorisation to four themes relating to attitudes about the law: two relating to positive attitudes towards the law; and two relating to negative attitudes towards the law. Once these categories were settled, LW reviewed all comments and categorised them into one of these four categories. All comments that did not relate to an attitude about the law were discarded. The second author (BW)

12 Note that in some cases the respondent appeared to be commenting on the law more generally, not just about the law governing withholding and withdrawing life-sustaining treatment from adults who lack capacity.
independently reviewed a sample (one-quarter) of the comments to ensure consistency of categorisation. Differences were resolved through discussion, and categorisation was adjusted accordingly.

RESULTS

The final eligible respondent sample was 2,702. A total of 867 completed questionnaires were received, an overall response rate of 32%; 218/598 completed questionnaires were received from Queensland (37%), 335/1,147 from New South Wales (29%) and 314/957 from Victoria (33%). The highest response rate by main medical specialty overall was from Palliative Care (52%) followed by Geriatric Medicine (43%), and the lowest was from Emergency Medicine (25%). The highest response rate from any specialty by State was Palliative Care in Victoria (75%) and the lowest was from Respiratory Medicine in New South Wales and Emergency Medicine and Oncology in Victoria (all 24%).

Responses to Q1 Statements

Response options to the statements about the law in this area and its role in medical practice were scored on a 5-point scale: 1 = “Strongly Disagree” (SD); 2 = “Disagree” (D); 3 = “Not Sure” (NS); 4 = “Agree” (A); 5 = “Strongly Agree” (SA). Table 1 provides responses (for all three States combined) and all response options.

**TABLE 1** Extent of agreement with Q1 statements re perspectives on the law and its role in medical practice

<table>
<thead>
<tr>
<th>Q1 Statement</th>
<th>N</th>
<th>1. SD % (n)</th>
<th>2. D % (n)</th>
<th>3. NS % (n)</th>
<th>4. A % (n)</th>
<th>5. SA % (n)</th>
<th>Mean/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a The law is not relevant to making these decisions</td>
<td>857</td>
<td>25 (213)</td>
<td>52 (446)</td>
<td>8 (72)</td>
<td>12 (100)</td>
<td>3 (26)</td>
<td>2.16</td>
</tr>
<tr>
<td>b The law provides a useful framework for decision-making</td>
<td>858</td>
<td>5 (39)</td>
<td>21 (181)</td>
<td>27 (242)</td>
<td>42 (357)</td>
<td>5 (39)</td>
<td>3.21</td>
</tr>
<tr>
<td>c The law is out of touch with medical practice</td>
<td>857</td>
<td>1 (11)</td>
<td>24 (202)</td>
<td>39 (332)</td>
<td>28 (242)</td>
<td>8 (70)</td>
<td>3.18</td>
</tr>
<tr>
<td>d The law is helpful when making these decisions</td>
<td>854</td>
<td>4 (38)</td>
<td>28 (234)</td>
<td>28 (238)</td>
<td>38 (327)</td>
<td>2 (17)</td>
<td>3.06</td>
</tr>
<tr>
<td>e Resolving disputes through legal processes takes too long</td>
<td>858</td>
<td>&lt;1 (5)</td>
<td>3 (25)</td>
<td>14 (130)</td>
<td>41 (349)</td>
<td>41 (349)</td>
<td>4.18</td>
</tr>
<tr>
<td>f The law promotes good relationships between doctors and their patients and families</td>
<td>858</td>
<td>10 (87)</td>
<td>35 (300)</td>
<td>39 (336)</td>
<td>15 (125)</td>
<td>1 (10)</td>
<td>2.62</td>
</tr>
<tr>
<td>g Following the law can lead to inappropriate treatment decisions</td>
<td>859</td>
<td>2 (17)</td>
<td>21 (177)</td>
<td>27 (231)</td>
<td>41 (353)</td>
<td>9 (81)</td>
<td>3.35</td>
</tr>
<tr>
<td>h The law has a place in the practice of medicine</td>
<td>857</td>
<td>1 (9)</td>
<td>3 (28)</td>
<td>8 (65)</td>
<td>68 (584)</td>
<td>20 (171)</td>
<td>4.03</td>
</tr>
<tr>
<td>i The law impinges on doctors’ professional autonomy</td>
<td>857</td>
<td>4 (36)</td>
<td>42 (359)</td>
<td>24 (206)</td>
<td>25 (216)</td>
<td>5 (40)</td>
<td>2.84</td>
</tr>
<tr>
<td>j The law supports good medical practice</td>
<td>858</td>
<td>3 (27)</td>
<td>16 (135)</td>
<td>39 (333)</td>
<td>38 (328)</td>
<td>4 (35)</td>
<td>3.24</td>
</tr>
<tr>
<td>k Medical and family consensus matters more than the law</td>
<td>860</td>
<td>2 (15)</td>
<td>21 (183)</td>
<td>17 (144)</td>
<td>42 (362)</td>
<td>18 (156)</td>
<td>3.54</td>
</tr>
</tbody>
</table>
Overall, there was strong agreement that “the law has a place in the practice of medicine” and the majority of respondents disagreed that “the law is not relevant to making these decisions”. However, other responses were less positive about the law. For example, 60% agreed or strongly agreed that “medical and family consensus matters more than the law” and almost half (45%) did not agree that “the law promotes good relationships between doctors and their patients and families”, with a further 39% being unsure about this. While there was more agreement than disagreement with the other positive attitude statements about the law, there was not majority agreement (eg 47% agreed that the law provides a useful framework for decision-making, 26% disagreed with this and 27% were not sure; 42% agreed that the law supports good medical practice, 19% disagreed that it did and 39% were not sure). In addition, 82% of respondents said that “resolving disputes through legal processes takes too long” and 50% thought that “following the law can lead to inappropriate treatment decisions”.

Chi-square analyses of the responses to the statements by the demographic, education and training variables revealed that there were no significant differences by State, gender, years in practice, religion, country of birth or country of degree.

However, differences were very significant for specialty, and significant for age of the respondent, continuing professional development (CPD) training received by the respondent, and also for how helpful the respondent perceived the CPD training to be. The results are explored in more detail below.

Attitude Towards the Law by Specialty

As shown in Table 2, which divides respondents into eight groups depending on how positive their attitude to law was, Palliative Care physicians (29%) were significantly more likely than any of the other specialists to score 8 (ie a score of 41-52/55) and significantly less likely to score 1 (4%). Intensive Care specialists (20%) were significantly more likely than other specialists to score 1 (ie a score of 11-25/55). Combining scores of 1 and 2 and 7 and 8 found that Palliative Care physicians

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<table>
<thead>
<tr>
<th>Specialty</th>
<th>N</th>
<th>1. 11-25</th>
<th>2. 26-28</th>
<th>3. 29-31</th>
<th>4. 32-33</th>
<th>5. 34</th>
<th>6. 35-37</th>
<th>7. 38-40</th>
<th>8. 41-52*</th>
<th>Mean/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>269</td>
<td>14 (58)</td>
<td>9 (25)</td>
<td>21 (66)</td>
<td>17 (45)</td>
<td>8 (21)</td>
<td>16 (44)</td>
<td>8 (22)</td>
<td>7 (18)</td>
<td>4.10</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>107</td>
<td>6 (6)</td>
<td>9 (10)</td>
<td>11 (12)</td>
<td>11 (12)</td>
<td>7 (7)</td>
<td>24 (26)</td>
<td>19 (20)</td>
<td>13 (14)</td>
<td>5.17</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>124</td>
<td>20 (24)</td>
<td>16 (20)</td>
<td>15 (19)</td>
<td>13 (16)</td>
<td>6 (7)</td>
<td>11 (14)</td>
<td>8 (10)</td>
<td>11 (14)</td>
<td>3.92</td>
</tr>
<tr>
<td>Oncology</td>
<td>80</td>
<td>9 (11)</td>
<td>11 (9)</td>
<td>11 (9)</td>
<td>15 (12)</td>
<td>6 (5)</td>
<td>21 (17)</td>
<td>19 (15)</td>
<td>8 (6)</td>
<td>4.75</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>52</td>
<td>4 (2)</td>
<td>2 (1)</td>
<td>13 (7)</td>
<td>12 (6)</td>
<td>14 (7)</td>
<td>13 (7)</td>
<td>13 (7)</td>
<td>29 (15)</td>
<td>5.67</td>
</tr>
<tr>
<td>Renal Medicine</td>
<td>80</td>
<td>13 (10)</td>
<td>13 (10)</td>
<td>13 (11)</td>
<td>13 (10)</td>
<td>19 (15)</td>
<td>13 (11)</td>
<td>11 (9)</td>
<td>5 (4)</td>
<td>4.24</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>98</td>
<td>12 (12)</td>
<td>8 (8)</td>
<td>21 (20)</td>
<td>9 (9)</td>
<td>10 (10)</td>
<td>12 (12)</td>
<td>15 (14)</td>
<td>13 (13)</td>
<td>4.57</td>
</tr>
<tr>
<td>Total</td>
<td>810</td>
<td>12 (99)</td>
<td>10 (83)</td>
<td>17 (134)</td>
<td>14 (110)</td>
<td>9 (72)</td>
<td>16 (131)</td>
<td>12 (97)</td>
<td>10 (84)</td>
<td>4.45</td>
</tr>
</tbody>
</table>

* Highest score was 52.

χ² = 94.352; p < 0.001
(Mean 5.67/8) and Geriatricians (5.17/8) had the most positive attitudes to the law, while Intensive Care specialists had the least positive attitudes with 36% scoring 1 or 2 compared with only 6% of Palliative Care specialists, 15% of Geriatricians and 22% overall. Intensive Care specialists were the only group to record a Mean of < 4/8 (ie 3.92).

**Attitude Towards the Law by Age**

**TABLE 3 Q1 – Attitude towards law, octile scores by age**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>N</th>
<th>1. 11-25 % (n)</th>
<th>2. 26-28 % (n)</th>
<th>3. 29-31 % (n)</th>
<th>4. 32-33 % (n)</th>
<th>5. 34 % (n)</th>
<th>6. 35-37 % (n)</th>
<th>7. 38-40 % (n)</th>
<th>8. 41-52 % (n)</th>
<th>Mean/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>176</td>
<td>5 (9)</td>
<td>11 (19)</td>
<td>15 (26)</td>
<td>18 (32)</td>
<td>10 (18)</td>
<td>21 (37)</td>
<td>10 (18)</td>
<td>10 (17)</td>
<td>4.70</td>
</tr>
<tr>
<td>40-49</td>
<td>334</td>
<td>12 (41)</td>
<td>12 (40)</td>
<td>16 (53)</td>
<td>11 (36)</td>
<td>9 (31)</td>
<td>18 (59)</td>
<td>13 (43)</td>
<td>9 (31)</td>
<td>4.44</td>
</tr>
<tr>
<td>50-59</td>
<td>219</td>
<td>16 (35)</td>
<td>11 (24)</td>
<td>19 (42)</td>
<td>12 (26)</td>
<td>5 (12)</td>
<td>15 (32)</td>
<td>12 (27)</td>
<td>10 (21)</td>
<td>4.21</td>
</tr>
<tr>
<td>60+</td>
<td>116</td>
<td>13 (15)</td>
<td>6 (7)</td>
<td>14 (16)</td>
<td>15 (17)</td>
<td>11 (13)</td>
<td>11 (13)</td>
<td>13 (15)</td>
<td>17 (20)</td>
<td>4.77</td>
</tr>
<tr>
<td>Total</td>
<td>845</td>
<td>12 (100)</td>
<td>11 (90)</td>
<td>16 (137)</td>
<td>13 (111)</td>
<td>9 (74)</td>
<td>17 (141)</td>
<td>12 (103)</td>
<td>10 (89)</td>
<td>4.48</td>
</tr>
</tbody>
</table>

\[ \chi^2_{21} = 35.473; \ p = 0.025 \]

Respondents aged 60+ were significantly more likely to score 8 (17%) than the other three age groups (see Table 3). They also had the highest percentage (30%) of a combined score of 7 and 8 compared with the combined scores of the other age groups (20-22%), as well as the highest Mean score indicating that they had the most positive attitude of the four age groups.

However, respondents aged < 40 were significantly less likely than the other three groups to score 1 and also had the lowest combined score of 1 and 2 (16%). Respondents aged 50-59 had the highest combined score of 1 and 2 (27%) and the lowest Mean score, indicating a more negative attitude towards the law.

**Attitude Towards the Law by CPD Training**

Part C of the survey asked respondents what education or training they had received in relation to the law on withholding and withdrawing life-sustaining treatment in each of three phases of their careers: basic medical degree;\(^{13}\) postgraduate medical training;\(^\text{14}\) and CPD.\(^\text{15}\) There were two aspects to this question: whether they received training in any of the three phases (“Yes” or “No”) (see Table 4); and for those who had received such training, how helpful the training was (on a 4-point scale from 1 “Very Unhelpful” to 4 “Very Helpful”).

\(^{13}\) “Basic medical degree” was defined in the survey as “the degree, via either an undergraduate or graduate entry program, obtained from a medical school”.

\(^{14}\) “Postgraduate medical training” was defined in the survey as “received during intern and early postgraduate years as well as vocational training in a chosen specialty”.

\(^{15}\) “CPD” was defined in the survey as “ongoing education required to maintain registration as a medical specialist which may include ‘formal’ activities like conferences as well as self-directed learning.”
Respondents who had received CPD training were significantly more likely to score 8 (14%) or 7 (15%) than those who had not received any CPD training (6% and 8% respectively). However, there was almost no difference between the two groups in relation to scoring 1 or 2.

Scores did not reach significance on the basis of whether or not education or training was received as part of the basic medical degree or in postgraduate medical training, or how helpful respondents found that training to be. However, respondents who answered “Yes” to having received CPD training and who found their training “Very Helpful” were significantly more likely than the other three groups to score 8 (30% compared with 0-13% for the other groups who found the CPD training to be “Helpful”, “Unhelpful” or “Very Unhelpful”) and to have a much higher Mean score than the other groups (5.65/8 compared with 2.67/8-4.66/8 for the other three groups), especially those who found the training “Very Unhelpful” or “Unhelpful”.

Qualitative comments

Of the total sample, 252 respondents provided further comments about “the law in this area, how it could be improved and its role in medical practice”.

An assessment of their responses found that 113 respondents had a positive attitude and 85 respondents had a negative attitude towards the law; 54 respondents were not assigned to either category for the reasons explained above.

The comments of the respondents who provided insight into their attitudes, categorised into the relevant themes, are explored below.

**Express Support for Law Having a Legitimate Role in Medical Practice**

Only a very small number of respondents expressly acknowledged that the law has a role to play in the practice of this area of medicine. For example, one respondent noted that there needs to be an established “legal and ethical framework” within which medical practice should occur [#1004 – Emergency Medicine, Qld, < 40 male]; others agreed that compliance with the law is a necessary component of a society that is based on the rule of law. One respondent described this as follows:

Medicine and medical clinical decisions, cannot operate outside of a society’s legal parameters. [#1267 – Geriatric Medicine, NSW, 40-49, male]

Other respondents commented positively that the law can indeed be a helpful tool to guide medical practice. For example:

To my knowledge common law help [sic] guide what is correct law governing end of life decisions + respecting advanced [sic] care directives. [#1061 – Palliative Care, NSW, > 60, female]

16 However, significance needs to be treated cautiously as 13 cells have counts < 5, so chi-square analysis is unstable in this case. Note also that only six respondents found their training “Very Unhelpful”.

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**TABLE 4 Q1 – Attitude towards law, octile scores by CPD training**

<table>
<thead>
<tr>
<th>CPD Training</th>
<th>N</th>
<th>1. 11-25 % (n)</th>
<th>2. 26-28 % (n)</th>
<th>3. 29-31 % (n)</th>
<th>4. 32-33 % (n)</th>
<th>5. 34 % (n)</th>
<th>6. 35-37 % (n)</th>
<th>7. 38-40 % (n)</th>
<th>8. 41-52 % (n)</th>
<th>Mean/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>341</td>
<td>11 (39)</td>
<td>11 (39)</td>
<td>19 (63)</td>
<td>16 (54)</td>
<td>11 (38)</td>
<td>18 (60)</td>
<td>8 (28)</td>
<td>6 (20)</td>
<td>4.19</td>
</tr>
<tr>
<td>Yes</td>
<td>521</td>
<td>12 (64)</td>
<td>10 (54)</td>
<td>15 (76)</td>
<td>11 (60)</td>
<td>7 (37)</td>
<td>16 (82)</td>
<td>15 (77)</td>
<td>14 (71)</td>
<td>4.65</td>
</tr>
<tr>
<td>Total</td>
<td>862</td>
<td>12 (103)</td>
<td>11 (93)</td>
<td>16 (139)</td>
<td>13 (114)</td>
<td>9 (75)</td>
<td>16 (142)</td>
<td>12 (105)</td>
<td>11 (91)</td>
<td>4.47</td>
</tr>
</tbody>
</table>

$\chi^2 = 28.548; p < 0.001$
There were, unsurprisingly, different levels of agreement about the extent to which law should influence medical practice. Some respondents, while expressly recognising the importance of a legal framework, also noted what they perceived to be the limitations of the law in resolving particular cases:

In my view the law provides a useful but only general framework in this area. Innumerable clinical nuances are not covered, nor can they be without a legal system which was excessively prescriptive and impossible to keep up to date due to legislative inertia. Ultimately, clinicians must be able to balance (if necessary) conflicting or potentially conflicting clinical and legal issues — with the patient’s ultimate welfare the guiding light regardless of any legal blemish that might result. A legal perspective after all is only one of several human perspectives of life. [#1198 – Intensive Care, Vic, > 60, male]

**Implicit Support for Law Having a Legitimate Role in Medical Practice**

Few doctors commented expressly that the law should play a role in medical practice. Nevertheless, many of the comments implicitly acknowledged that medical practice is undertaken within a regulatory context, and that this was appropriate. This form of “implicit” support for the law was evident through comments that fell largely into three main themes.

First, many respondents suggested that the law should be reformed in a particular way. Often, very considered suggestions were made about how the law in this field could be improved. One of the sub-themes within this group was the recommendation that the law should be uniform across Australia. Such views point to respondents believing that the law, particularly if modified in the way suggested, should regulate practice. Interestingly, one respondent observed the need for the medical profession to be more influential in shaping the law by:

Attempting to keep legislators and judges informed to help shape decision making in the courts, that is in the best interest of the individual. [#1851 – Emergency Medicine, NSW, 50-59, male]

On a more negative note (given that the suggested approach does not reflect the reality of law-making), another respondent indicated something more than influence by the medical profession was needed to shape the law:

Law in this area should be developed by experienced doctors. [#1014 – Respiratory Medicine, Vic, > 60, male]

Second, many respondents commented that greater engagement with the current legal framework by doctors and others would achieve better clinical outcomes for patients. The bulk of these suggestions were that advance directives should be completed by individuals entering a residential aged care facility or being admitted to hospitals for the management of serious ailments:

Suggest that on entry to residential care at any level applicant and family have say one month to develop an Advanced [sic] Care Directive to which they all agree and ensure there is a current person with power of attorney (medical). [#1124 – Emergency Medicine, Vic, > 60, female]

Some respondents suggested that such a practice be broadened to individuals over a specified age:

I believe it should be mandatory for all patients to have a set of “advanced [sic] directives” once they have been given a potentially life-threatening diagnosis or > 80 years old. (eg; RESUS, CPR, Ventilation, hydration, antibiotics). [#1385 – Emergency Medicine, Vic, 40-49, male]

Finally, and reflecting by far the highest number of comments falling within the theme of “implicit” support for the law, were observations that doctors need to be better educated about the law, and that law should be available in a far more accessible form to better facilitate such education.

The strong and numerous statements by the respondents about the need for doctors to know the law again points to a recognition that the law has a role to play in medical practice. The comments generally did not elaborate on why they thought doctors should be better educated. Possibly doctors thought that knowledge was important to ensure they acted in a legally compliant manner. There may be a less admirable motive, however. For example, doctors may wish to know how to navigate a particular situation in a non-legally compliant manner but avoid legal sanction.

Indicative comments made about the importance of knowing the law include:

These decisions are always complex and multifactorial and a complete understanding of the laws would provide a better framework for me to work under. [#1109 – specialty not disclosed, Vic, < 40, female]
Definitely an area in which the medical & renal community need more clarification & education. From a renal perspective we often have a more elderly population, relevant to the subject of this questionnaire. [#1025 – Renal Medicine, NSW, 40-49, male]

The need to provide information to doctors in a more accessible format and for communication of that information to be improved was emphasised by the respondents. The following comment typifies the sentiment expressed by many:

The law should be summarised & available in succinct point form, laminated in the Drs write up area in resuscitation, so it can be easily referred to, when in doubt about clinical decision making within medico-legal boundaries. [#1025 – Renal Medicine, NSW, 40-49, male]

**Express Rejection of Law Having a Role to Play**

A small minority of doctors were dismissive of (or even antagonistic to) the law and believed that it did not have a role to play in medical practice. The major sentiment expressed by this group was that clinicians involved in treating patients at the end of life were able to do so satisfactorily without the intrusion of the law. Some expressed this view because, from their perspective, law, as a discipline, was not well suited to guide action where medical decisions at the end of life were being contemplated and that medical practice did not require a legal framework within which to operate. The following comments provide examples of this:

- The current practice works well – I’d prefer the law stay out of it. [#1092 – Emergency Medicine, NSW, 40-49, female]
- The law always “lags behind and limping a little”. Therefore trying to modify this area will always prove difficult and somewhat irrelevant. [#1367 – Emergency Medicine, Vic, 50-59, male]
- Others comments were worded more forcefully to indicate that law should stay out of the clinical encounter. These respondents did not articulate particular reasons for this position:
  - We leave law to the expert professionals, they should do likewise. [#1461 – Renal Medicine, Qld, > 60, male]
  - Leave us alone to practise medicine! [#1624 – Emergency Medicine, Vic, 50-59, male]
  - Bad laws come and go. Argumentative and veracious Lawyers come and go, as do families that pay them. Good medical practice is a constant. [#1838 – Emergency Medicine, Qld, 50-59, male]

One such comment was portrayed through illustration [#1199 – Emergency Medicine, Vic, 40-49, male]:

![Illustration](image-url)
Implicit Rejection of or Reservation About Law Having a Role to Play

In addition to the comments that expressly reject law as having a legitimate role to play in this aspect of medical practice (category 3 comments), there were a range of other negative sentiments expressed about the law itself and its undesirable impact on practice. These comments suggest that respondents believe that the law in its current form is not “fit for purpose” or helpful to them. A number of sub-themes arose from the comments that fell within this category.

First, respondents commented that the law was not appropriate or well suited to guide medical practice when a decision had to be made about whether to withhold or withdraw medical treatment. A number of reasons were given for this position. The law was identified by some as too complex and not helpful in resolving disputes that can arise. The following examples are illustrative:

Law too slow to keep up with medical advances. [#1544 – Oncology, NSW, 40-49, female]

Law needs to be clear and directive rather than using vague terms like “reasonable” or “depending on circumstances”. Currently there is no clear decision maker in cases that are “controversial” – and any/all cases can be controversial, this simply provides fodder for lawyers/ courts & produce [arrow pointing up] higher costs/ stress for all involved (except lawyers). If law cannot provide certainty then it has no role in any field, not just WWLST cases. [#1690 – Oncology, NSW, 50-59, male]

Many respondents expressed the view that these kind of disputes needed to be resolved in a timely way and they perceived that the law was unable to respond accordingly. Concerns about the lack of timeliness of a legal response appear below:

These decisions need to be made in a matter of minutes, not enough time to involve legal advice – access to timely advice would enhance decision making, risk, and communication with family in emergency situations. [#1378 – Emergency Medicine, Vic, 40-49, female]

The law needs to get with the times. We make difficult decisions 24/7. Decisions are needed quickly. [#1542 – Respiratory Medicine, NSW, 50-59, male]

Other respondents were more scathing in their views of the law, and suggested that the law is simply illogical:

The law on WLST is ridiculous/stupid/ill-conceived. I simply cannot believe that a group of intelligent people came up with this silly rubbish. [#1453 – Intensive Care, Qld, 50-59, male]

Another interesting perspective that came through strongly was that doctors may be more inclined to follow the law if they agreed with it. But if doctors perceive that the law would lead to an inappropriate outcome, they do not feel constrained to act in accordance with the law. This sentiment was often expressed in the context of the obligation to follow directions in an advance directive which would not, in their view, promote the best interests of the patient:

I have ignored completely inappropriate ACDs, and I honour appropriate ACDs – based on clinical circumstances + pt (family) needs/wishes. [#1417 – Intensive Care, NSW, 50-59, female]

The second theme under this heading is the perceived irrelevance of the law. Although relatively few respondents expressed the view that the law had no role at all to play in decisions to withhold or withdraw treatment, many expressed the view that legal issues simply did not arise in clinical practice. Alternatively, when some respondents expressly recognised that the law was relevant, they considered that other matters, such as achieving good clinical outcomes or acting in a way that was consistent with their ethical values, were more important than the law. See, for example:

Having to follow the law rarely comes to my mind in clinical decision making. [#1120 – Renal Medicine, Vic, 50-59, female]

Other respondents commented on the return for investment of time to get to know the law, especially for a time-poor doctor:

Should I attend training on this, or resuscitation skills workshop? Only so many hours in the day, who chooses for me, will you insist we need more training? I bet you will. Give me the Doctor who attended emergency education when I am sick please. [#1593 – Emergency Medicine, Vic, 40-49, male]

The following quotes illustrate the relative priorities that respondents place on law compared to other principles and values when making medical decisions in this context:
A Role for Law in Medical Practice When Withholding and Withdrawing Treatment? Attitudes of Doctors

[Withholding and withdrawing life-sustaining medical treatment is a] complex issue often needing wide consultation – the law is relevant but not overriding. [#1648 – Emergency Medicine, Qld, 50-59, male]

There needs to be less emphasis on the law and more emphasis on senior doctors taking a lead in appropriate clinical decision-making. [#1190 – Renal Medicine, Vic, > 60, male]

Less law, not more. We need to do what is best for the patient, not for others or the law. [#1408 – Respiratory Medicine, NSW, 50-59, male]

Respect for the law is not an absolute ethical value but is promoted by effective laws and undermined by ineffective laws. [#1262 – Palliative Care, NSW, 50-59, male]

DISCUSSION

All members of the community are obliged to act within the constraints of the law, and if we break the law by driving in excess of the speed limit or assaulting another person, we can expect to incur the legal consequences of such action. Doctors, of course, are no exception, and their obligation to act in accordance with the law applies to their roles as both citizens and clinicians. Doctors who make decisions about whether or not to withhold or withdraw life-sustaining medical treatment should know and comply with the relevant law. However, this research demonstrates that doctors’ attitudes to the law vary from strong support and compliance, to significant resistance and even cynicism. Where negative attitudes are articulated, for some doctors they often emanate from a preference for clinical-ethical expertise, which they see as good medical practice, as action-guiding in preference to the law; for a smaller group, the law should play no role.

Doctors’ attitudes to law are complex. We have shown that doctors generally think that the law has a role to play in medical practice at the end of life. There was strong agreement with the statement that “the law has a place in the practice of medicine”, and the majority disagreed that “the law is not relevant to making these decisions”. However, these are broad statements, and the qualitative responses were only marginally more positive than negative. More specific statements were less strongly supported. For example, more than half of the respondents thought that “medical and family consensus matters more than the law”, implying that some doctors are comfortable with a decision that is unlawful if their medical colleagues and the patient’s family agree with the particular course of action. Some doctors saw the law as not supporting their medical practice; some accepted that while the law is relevant, it can be ignored if it leads to what is judged to be an inappropriate outcome for the patient. Others were quite explicit in their preference for clinical-ethical expertise, stating that decision-making should be governed by medicine rather than the law, or simply that the law should stay out of medical practice.

As previously noted, acting unlawfully risks negative consequences for patients, including receiving unwanted treatment or not receiving treatment that is wanted, and legal sanctions for doctors. Despite this, at least some doctors did not appear to be troubled by the notion of practising medicine outside legal parameters. We suggest that this reflects the persistent perception on the part of some respondents that it is the medical profession with its obvious expertise that should be seen as the primary or even the only appropriate authority for clinical decision-making, not an external institution like law that lacks the appropriate expertise. Expertise is often expressed in terms such as “clinically appropriate practice”, “appropriate clinical decision-making” or “good medical practice”. These terms integrate what is traditionally thought of as (medical) facts and values, so the insistence on medicine as the appropriate authority for decision-making amounts to the claim that the moral expertise for this area resides entirely with those with the medical expertise.

However, this claim has been challenged and largely abandoned over the past few decades. As one Australian example, the legal standard for information disclosure to patients for decision-making as derived from the medical profession17 was replaced 23 years ago in Australia by the particular patient-centred standard in the High Court case of Rogers v Whitaker,18 sideling medical expertise in favour of patient values as the source of decisional authority. Consistent with this trend, we suggest

17 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582; [1957] 2 All ER 118.
18 Rogers v Whitaker (1992) 175 CLR 479.
that a more appropriate conceptual understanding of the relationship between law and medicine is not that “there needs to be less emphasis on the law and more emphasis on senior doctors taking a lead in appropriate clinical decision-making”,19 but that doctors should regard the law, where it has been introduced to govern a particular area of practice, as having intervened to mandate a course of action, leaving the doctor with no choice in the matter. As Foster and Miola point out, this most frequently occurs when the law determines that the choice should belong to the patient rather than the medical profession or individual practitioner,20 as in the case of disclosure. Given the fact that laws are distillations of community consensus in the widest sense, with considerations of medical expertise being taken into account in their formulation, the law should be accorded overarching authority for action, especially by those senior doctors who are being asked to take the lead in decision-making. The law should not be seen as something that might or might not figure in clinical deliberation (ie as a discretionary factor applied to that expertise from outside) but as prescriptive and as helping to constitute their clinical expertise. We suspect that our observation that respondents who had received CPD training were significantly more likely to have a positive attitude to the law than those who had not received any CPD reflects the acceptance by this cohort of something along the path towards this conceptualisation.

It may be objected that failing to comply with the law governing this area of end-of-life decisions amounts to making a conscientious objection that falls into the category of objections to participation in procedures such as abortion or assisted dying in jurisdictions where these are lawful. It has traditionally been accepted that there are some legitimate exceptions to participation in provision or facilitation of services because it conflicts with private beliefs. But even in these cases, doctors should not be permitted to merely assert that their personal beliefs justify a particular practice, given that through their registration and practise as health professionals they have undertaken to participate in the lawful provision of health services.21 The laws on withholding and withdrawing life-sustaining treatment have been enacted to achieve certain goals, including the protection of the rights of individuals who lack decision-making capacity, based on community consultation and reflecting community values.

Even if doctors consider that compliance with the law is not in the patient’s best interest, they have an obligation to act differently in these circumstances from how they would act, for example, if they thought that following a clinical practice guideline (CPG) was not in the patient’s interest. In the latter case, they may need to justify having diverged from the CPG on the basis of evidence for a particular course in the circumstances. In contrast, if they are considering acting without lawful authority, they should prospectively seek legal adjudication on their intentions, either from a court or other body charged with such decisions.

CONCLUSION
Practising medicine at the end of life is challenging. Decisions to withhold or withdraw life-sustaining treatment from adults who lack capacity are often difficult and can occur in an emotionally charged environment. The situation is further complicated by the fact that the law governing decision-making is complex and differs in significant ways across jurisdictions. Moreover, in some cases, acting in a way that is legally compliant may not achieve outcomes that doctors perceive to be in the best interests of the patient.

The authors have argued elsewhere that the law in this field needs to be improved, and have identified aspects of the law that could be simplified.22 Further, more work needs to be done in making the existing law more accessible to doctors so they can more easily appraise themselves of their legal obligations. However, problems with the current legal framework and unevenness in education...
programs do not exempt doctors from an obligation to both be familiar with existing frameworks and practise accordingly. An important barrier to achieving this is the negative attitude that some doctors have towards the law and its role in practice.

We have argued here for a reconceptualisation of the law from being seen as a clinically relevant but discretionary factor in clinical decision-making to a routine component of doctors’ clinical abilities ranking with clinical expertise – indeed as constituting part of that expertise. This does not make lawyers of doctors. Whether it is in the matter of what the law has to say, or what an expert colleague may suggest in relation to the medical facts, doctors should always be ready to request advice.

The following respondent response presupposes the legitimate role of law, while pointing to some structural changes needed to make the existing law more accessible:

It is awful knowing that a decision has to be made immediately (literally do I intubate this person, do I give adrenaline or CPR.) and feeling like I am alone in making it if no family are present or there is no AHD to provide guidance. Often the “right” answer is obvious (this 20 year old from a car accident needs resuscitation) but sometimes it is not obvious. I don’t feel I have enough knowledge of the law to know whether a decision I make is necessarily legally right. I once had a man in his late 90s who was trying to gently die and his family wanted full CPR & life support. I felt this was morally and clinically wrong but where do I go to find out what is legally correct? I don’t know how to find this answer at 1pm let alone 1am. In the end I do what I think is right for the patient, based on experience and training. What would help me is knowing how to access advice about legalities. [#853 – Emergency Medicine, Qld, 40-49, female]

Law will have found its rightful place in clinical practice, when this response can be recast as:

Acute decisions at the end of life are often difficult (literally do I intubate this person, do I give adrenaline or CPR), but I am not alone in making it, even if the family is not present and there is no AHD. Often the “right” answer is obvious (this 20 year old from a car accident needs resuscitation) but sometimes it is not obvious. I once had a man in his late 90s who was trying to gently die and his family wanted full CPR & life support. I felt this was morally and clinically wrong, based on experience and training, and knew that allowing him to die was consistent with the law. But I am also reassured that there is clinical and legal support available, should I feel this is needed.