Guidance Statement 10.5.3 – Legal and Ethical Issues Related to Resuscitation – Withholding and withdrawal of resuscitation

Statement

This statement does not constitute legal advice.

This statement aims to *summarise* the key legal and ethical points in relation to consent in an emergency and to provide direction to relevant legislation across Australia and New Zealand. It should only be used as a *guide* to these legal and ethical issues. Individuals and/or organisations should obtain legal advice if required for their own jurisdiction.

Summary

This guidance statement is primarily intended for laypersons, bystanders, first responders, and off-duty health professionals who may choose to assist a person requiring emergency care.

This statement provides a summary of key legal and ethical points related to consent and medical decision-making across Australia and New Zealand.

The Australian and New Zealand Committee on Resuscitation (ANZCOR) further recommends that decisions to withhold or withdraw life-sustaining treatment should align with best practice, prioritise the best interests of the individual, and comply with any legally binding advance care directives (ACDs).[2]

In hospital settings, a 'Do Not Attempt Resuscitation' (DNAR) order (or equivalent directive) must not be made without appropriate consultation with the patient or their legally recognised substitute decision-maker, where the individual lacks decision-making capacity.[3]

Glossary

- **Advanced Care Plan / Advance directives:** The process of discussing and documenting future health preferences, including the refusal of specific treatments.[2,4]
- **Autonomy:** A fundamental ethical principle that upholds an individual's right to make independent decisions about their own healthcare without external interference, provided they have decision-making capacity.[5]
- **Beneficence:** The ethical obligation to act in ways that promote the well-being and best interest of others.[6]
- **Common Law:** Law that is developed through court decisions (judicial precedent) rather than being enacted by parliamentary legislation.[7] Common law forms a key part of the Australian legal system and has evolved over centuries through judicial rulings.
- **Consent:** The voluntary agreement of a competent person to medical treatment after receiving sufficient information, ensuring that individuals can make autonomous healthcare decisions. For incompetent individuals, substitute decision-makers must provide consent in line with their best interests.[2,8]
- **Doctrine of precedent:** A legal principle requiring courts to follow previous judicial decisions (precedents) when ruling on cases with materially similar facts.[5] This principle ensures consistency and predictability in the legal system.
- **Duty of care:** A legal obligation requiring individuals to take reasonable care avoid causing harm to others. A breach of duty of care occurs when:
    - A person is injured due to another's action (or inaction).
    - The harm was reasonably foreseeable.
    - A reasonable person in the same position would have acted differently.
    - The risk of harm was not insignificant.[8,9]
- **Duty to Rescue:** In Australia, there is generally no legal duty to rescue unless a person has a pre-existing duty of care (e.g., healthcare professionals on duty) or specific legal obligations apply under state laws.[4] However, Good Samaritan laws provide protection for those who voluntarily assist others in an emergency.
- **Ethics:** The study of moral principles that guide what individuals *ought* to do in various situations. Ethics encompasses universal concepts, such as autonomy, beneficence, non-maleficence, and justice.[6]
- **Good Samaritan:** A 'Good Samaritan' is defined in Australian legislation as an individual who provides emergency medical assistance in good faith, without expectation of payment reward.[9]
- **Jurisdiction:** A geographical area (e.g., country, state, or territory) where a specific set of laws apply and must be followed.[7]

- **Lay person:** An individual who does not have formal medical or legal qualifications but may still be involved in first aid or emergency care.[4]
- **Non-maleficence:** The ethical principle of 'do no harm', requiring healthcare providers to avoid causing unnecessary injury or suffering.[6]
- **Statute Law:** Law that is created and enacted by parliament rather than by judicial rulings (Common Law). It includes Acts and Regulations passed at the federal, state and territory levels.[5]
- **Volunteer**: A member of a volunteer organisation who engages in community service or emergency assistance without financial compensation.[4]

Discontinuation (Withdrawal) and Withholding Treatment

In the absence of a legally binding Advance Care Directive (ACD), Queensland and South Australia are the only Australian states with explicit statutory provisions governing the withholding or withdrawal of treatment without consent.[10,11]

However, this does not mean that treatment cannot be withheld or withdrawn without consent in other states and territories. In all jurisdictions, medical decision-making is guided by professional standards, common law principles, and ethical guidelines, which acknowledge that doctors are not legally or ethically required to provide futile or non-beneficial treatment.[4]

State	Legislation	Notes
QLD	*Guardianship and Administration Act* 2000 (Qld), *Powers of Attorney Act* 1988 (Qld)	In an acute emergency, life-sustaining treatment (e.g., cardiopulmonary resuscitation (CPR), assisted ventilation) may be withheld or withdrawn immediately without consent if continuation is inconsistent with good medical practice (GAA s63A). However, treatment must not be withheld if the healthcare provider knows the individual has objected to that treatment (GAA s63A(2)). If an objection was previously expressed (verbally, in writing, or through conduct), but the doctor still believes CPR is not good medical practice, consent to withhold treatment may be sought from a substitute decision-maker (GAA s63A(2)). In non-emergency cases, the withholding or withdrawal of life-sustaining treatment requires consent from an appointed guardian or statutory health attorney. If a substitute decision-maker refuses consent, the case may require intervention from the Office of the Public Guardian, which has the authority to appoint a new guardian.[12, 4.]

SA	*Consent to Medical Treatment and Palliative Care Act* 1995 (SA)	A medical practitioner or a person acting under their supervision is not legally required to provide or continue life-sustaining measures (e.g., CPR, artificial ventilation, nutrition or hydration) if such treatment would merely prolong life in a moribund state or in a persistent vegetative state (CMTPCA s17(2)). If the patient or their legally recognised substitute decision-maker requests withdrawal of life-sustaining measures is legally considered an intervening cause of death (CMTPCA s17(3)).

1.0 | 'Do Not Attempt Resuscitation' (DNAR) Orders

In health institutions and facilities, a decision not to provide resuscitation, including a 'Do Not Attempt Resuscitation' (DNAR) order, also known as a 'Not for Resuscitation' (NFR) order, or 'A medically initiated DANR order' should be clearly documented in the patient's medical records. This decision must be explained to the patient (where possible) and/or their substitute decision-maker and formally signed by the treating physician.[2,3,4]

The legal status of DNAR orders vary across Australian states and territories. A DNAR order is valid within the institution where it was issued, but its applicability between different institutions and in out-of-hospital settings is unclear.[4] A legally binding Advance Care Directive (ACD) or an Acute Resuscitation Plan (ARP) is preferable, as these documents reflect the patient's prior discussions and informed decisions about resuscitation before an acute event.

Healthcare professionals are not legally obligated to provide futile or non-beneficial treatments, including CPR, but the rationale for withholding resuscitation should be documented in the patient's clinical record.[4]

In out-of-hospital settings emergency services are frequently activated for patients experiencing cardiac arrest, including those with chronic disease or have life-limiting illness. Where possible, rescuers should determine whether an Advance Care Directive exists and whether a substitute decision-maker has been appointed and is available to provide guidance.[2,10]

The International Liaison Committee on Resuscitation (ILCOR) recommends the implementation of standardised out-of-hospital physician orders for patients with chronic disease or life-limiting illness. These orders should be clearly understandable by all healthcare professionals and include specific instructions on whether life-sustaining interventions should be initiated or continued in both cardiac arrest and near-arrest scenarios.[13]

As legislation and protocols governing DNAR orders and Advance Care Directives differ across Australian states and New Zealand jurisdictions, healthcare providers must be aware of the relevant laws, regulations, and institutional policies applicable in their location.[4]

To ensure consistency and respect for patient autonomy, the development of standardised DNAR orders across healthcare settings should be considered. Such orders should be detailed, transferable and easily understood, ensuring futile resuscitation attempts are minimised and

patients' end-of-life wishes are upheld.

The Australian and New Zealand Committee on Resuscitation (ANZCOR) recommends that in hospital a DNAR order (or equivalent) should not be formulated without consultation with the patient, or where the patient lacks decision-making capacity, their legally authorised substitute decision-maker.

2.0 | Voluntary Assisted Dying

The Voluntary Assisted Dying Act 2017 (Vic) came into effect on 19 June 2019, making Victoria the first Australian state to legalise voluntary assisted dying (VAD) (*Voluntary Assisted Dying Act 2017 (Vic)*). However, since then, all Australian states **have passed VAD laws, with implementation occurring at** different times across jurisdictions.

As of February 2025, VAD is legal in all six Australian states (Victoria, Western Australia, Tasmania, South Australia, Queensland, and New South Wales) but not in the Northern Territory or the Australian Capital Territory.[4]

State	Legislation	Commencement Date
Victoria	*Voluntary Assisted Dying Act 2017 (Vic)*	**19 June 2019**
Western Australia	*Voluntary Assisted Dying Act 2019 (WA)*	**1 July 2021**
Tasmania	*End-of-Life Choices (Voluntary Assisted Dying) Act 2021 (Tas)*	**23 October 2022**
South Australia	*Voluntary Assisted Dying Act 2021 (SA)*	**31 January 2023**
Queensland	*Voluntary Assisted Dying Act 2021 (Qld)*	**1 January 2023**
New South Wales	*Voluntary Assisted Dying Act 2022 (NSW)*	**28 November 2023**

The Australian Capital Territory (ACT) has introduced a bill to legalise VAD, and the Northern Territory (NT) is also considering reform after the repeal of federal laws that previously prevented it from legislating on VAD.[4]

Key Principles of Voluntary Assisted Dying in Australia

Voluntary Assisted Dying is a process that allows an eligible person who is in the final stages of a terminal illness to choose the timing and manner of their death by following a strictly regulated process.[15, 16]

- VAD **must be voluntary** and **initiated by the person themselves**.

- The individual **must have decision-making capacity** and be **suffering from an incurable, advanced, and progressive illness** that is **causing intolerable suffering**.
- VAD is **usually self-administered**, but in some states, it may be **clinician-administered** if the patient is unable to take the medication themselves.[17]
- The law **provides clear guidelines** for healthcare professionals, outlining their **legal responsibilities, eligibility criteria, and procedural safeguards**.
- **Healthcare providers are not obligated to participate in VAD if they object on conscientious grounds.**

Voluntary Assisted Dying in New Zealand

New Zealand legalised **voluntary assisted dying** with the **End-of-Life Choice Act 2019 (NZ)**, which came into effect on **7 November 2021.**[19,20]

Eligibility Criteria:

  - The individual must be **18 years or older**.
  - They must have a **terminal illness that is likely to cause death within six months**.
  - They must be **suffering intolerably** and have **full decision-making capacity**.
  - The request must be **voluntary and informed**, without **coercion**.

- **Process:**

  - The patient must make **three separate requests** for VAD.
  - Two independent medical practitioners must confirm eligibility.
  - The person may **self-administer** or have a **healthcare professional administer the medication.**[20]

- **Healthcare practitioners are not required to participate**and may **conscientiously object** to involvement in VAD. However, they must **inform the patient of their legal options.**[19]

3.0 | Termination of Resuscitation Attempts

The decision to stop resuscitation can be complex and ethically challenging. While some patients recover well after successful resuscitation, others who remain unconscious after cardiac arrest may either not survive or have significant neurological impairment. However, it is important to recognize that unconsciousness immediately after the return of spontaneous circulation (ROSC) does not always indicate a poor outcome, as some patients may regain consciousness and achieve good neurological recovery over time.

Out-of-Hospital Termination of Resuscitation (TOR)

There is substantial variability in the approach to either withholding resuscitation or ceasing resuscitation attempts after out-of-hospital cardiac arrest (OHCA). Ambulance service guidelines across Australia and New Zealand outline factors that influence this decision including:

- Whether the cardiac arrest was witnessed (and by whom).
- Patient factors such as age, presence of co-morbidities and functional status.
- Whether bystander CPR or defibrillation was provided.
- The duration of cardiac arrest.
- Initial arrest rhythm.
- Presumed causes of cardiac arrest.
- Response to resuscitation efforts such as end-tidal carbon dioxide ($EtCO_2$) or periods of ROSC.
- Signs of life during resuscitation efforts such as respiratory effort, gasping, or other signs of CPR-induced consciousness.
- Cardiac rhythms or other findings suggestive of potential low-flow states.

A **prospective study** demonstrated that the **Basic Life Support Termination of Resuscitation (BLS TOR) rule**—which includes **no shockable rhythm, unwitnessed arrest by emergency services, and no return of spontaneous circulation (ROSC)**—is **highly predictive of death** when applied by **defibrillation-only emergency medical technicians (EMTs)**. The **survival rate** when this rule was applied was **0.5% (95% CI: 0.2-0.9%).**[21]

However, research suggests that the **reliability of this termination of resuscitation threshold is lower in hospital and emergency department settings.**[22] **Two in-hospital studies** and **one emergency department study** found that applying the **BLS TOR rule in these settings** was **less predictive of mortality or poor outcomes.**[23]

ANZCOR recommends that prospectively validated termination of resuscitation (TOR) rules such as the Basic Life Support Termination of resuscitation (BLS TOR) rule be used to guide the cessation of pre-hospital CPR in adults.[1] The TOR criteria include factors such as absence of ROSC, no shockable rhythm, and no bystander-initiated CPR before emergency services arrive.

Abbreviations

Abbreviation	Meaning/Phrase
ACD	Advanced Care Directive
ANZCOR	Australian and New Zealand Committee on Resuscitation
ARP	Acute Resuscitation Plan

BLS TOR	**Basic Life Support Termination of Resuscitation**
CPR	Cardiopulmonary resuscitation
DNAR	Do Not Attempt Resuscitation
EMTs	Emergency medical technicians
$EtCO^2$	End-tidal carbon dioxide
ILCOR	International Liaison Committee on Resuscitation
NFR	Not for resuscitation
NT	Northern Territory
OHCA	Out-of-hospital cardiac arrest
VAD	Voluntary assisted dying
ROSC	Return of spontaneous circulation
TOR	**Termination of Resuscitation**

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