



ARTICLES

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WITHHOLDING AND WITHDRAWING TREATMENT IN SOUTH AUSTRALIA WHEN PATIENTS, PARENTS OR GUARDIANS INSIST THAT TREATMENT MUST BE CONTINUED

ABSTRACT

The *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s 17(2) appears to prevent doctors from withholding or withdrawing treatment if patients or their representatives object, and to preclude court review. Patients would then have an unprecedented legal right to have medical treatment continued, however poor their condition and prognosis. One may question whether the Parliament intended to make such a radical change to the common law. In many reported cases, English judges have authorised withholding of futile or burdensome treatment, despite family objections and a Victorian court has recently sanctioned even the withdrawal of life-sustaining treatment. The author argues that s 17(2) is ambiguous and should be interpreted in a more limited way, to conform with common law. Though it is possible that South Australian courts might adopt a different and more radical interpretation of the provision, health care providers in that State probably face little legal risk if there is a unanimous, carefully considered, fully documented medical

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opinion, fully involving the family. However, for legal protection, a hospital could apply to the Family Court of Australia if the patient is a child (the Court would probably have jurisdiction despite the High Court's recent limitation of the Family Court's welfare jurisdiction, and could override the State Act). The *Family Law Act* applies only if the patient is a child. There is no equivalent federal legislation that would enable a federal court to intervene and possibly override State legislation if the patient is an adult, however 'disabled'. For adult patients, the Supreme Court or the Guardianship Board would be the only options and, if the State Act is literally interpreted, even they would seem to have no power to intervene. For that reason, the Act should be amended to allow court review if relatives object to treatment decisions.

I THE *CONSENT TO MEDICAL TREATMENT AND PALLIATIVE CARE ACT 1995 (SA)* s 17

The *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s 17 headed 'The care of people who are dying', reads as follows (emphasis added):

17(1) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress

(a) with the consent of the patient or the patient's representative; and
 (b) in good faith and without negligence; and
 (c) in accordance with proper professional standards of palliative care, even though an incidental effect of the treatment is to hasten the death of the patient.

(2) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, is, *in the absence of an express direction by the patient or the patient's representative to the contrary*, under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state.

(3) For the purposes of the law of the State
 (a) the administration of medical treatment for the relief of pain or distress in accordance with subsection (1) does not constitute an intervening cause¹ of death; and

(b) the non-application or discontinuance of life sustaining measures in accordance with subsection (2) does not constitute an intervening cause¹ of death.

Note 1 - *A novus actus interveniens*, ie a cause that breaks a pre-existing chain of causation.

II A *NOVUS ACTUS INTERVENIENS* — A CAUSE THAT BREAKS A PRE-EXISTING CHAIN OF CAUSATION

A *Literal Meaning of s 17(2)*

One interpretation of section 17(2) is that, if there is an express direction from a patient or from the patient's representative (a parent or guardian), then the medical practitioner and other staff *must* use life sustaining measures in treating the patient. This means that it would be the patient or, where the patient is a child or incompetent and is not capable of making the necessary decision, a parent or guardian, who would decide the treatment to be given, not the medical staff. Moreover — and this is the real crunch and the real divergence from the common law (discussed below) — no state judicial body would be able to review the case and order that only palliative care needs to be provided.¹ There would then be no scope for a court (or tribunal) to order that full life-sustaining measures need not be provided on the ground of 'futility', or their unduly burdensome nature. The court (or tribunal) would be bound to apply the statute. This would make South Australia unique. Even taking into account the most recent English cases in which judges have said that doctors and other health carers cannot ultimately decide whether it is in a patient's best interests to withhold or withdraw treatment, it has never been suggested that patients and their representatives are entitled to have all treatment continued indefinitely, with a right to oust judicial review as well as to determine the appropriate treatment. The matter has always been one ultimately to be determined by a court (or tribunal).

The argument against a literal interpretation of s 17(2) may be extended even further. Section 17(2) refers only to 'an express direction ... to the contrary'. It does not limit the time within which the direction should be given, the specificity of the direction, nor the vehemence with which the direction is given. Should my 'direction' now, while in full health, that 'I want "full" treatment if I am ever in a life-threatening state' be effective in ensuring that I have a right to be indefinitely artificially maintained and repeatedly resuscitated if I 'die'?

Such an interpretation could obviously lead to an untenable outcome and, if the section is to be interpreted in this way, it must certainly be amended. But the question remains — did the legislature *intend*, when s 17(2) was passed, to change the common law by allowing doctors to withdraw 'full' treatment only if there has been no objection? Or did it do that inadvertently, even if it seems to have done it clearly?

¹ The Family Court may have jurisdiction where the patient is a child, as explained below.

B *Is s 17(2) Open to Another Interpretation?*

It is a principle of statutory interpretation that, if a provision is clear on its face, it must be given that meaning, whatever the consequences of such an interpretation. But if there is an ambiguity, a court (or tribunal) may look at the history and purpose of the legislation, and other relevant matters, in interpreting it. In my view, it is possible to interpret s 17(2) in another way. In the context of the whole Act, one might argue that the words ‘in the absence of an express direction to the contrary’ do not mean that a patient can *require* that life-sustaining measures *must* be continued. The sub-section could be interpreted to mean that palliative care is appropriate — and doctors will have ‘statutory immunity’ — if the patient or representative has consented or not expressed an objection. However, if that is not the case (that is, if they have objected), then the sub-section does not apply at all. In other words, doctors are not required to undertake full active treatment where a patient or representative has consented to only palliative care being administered (or has said nothing about it). If the doctors give only palliative care in such circumstances, they will have statutory immunity from civil and criminal liability, provided they have acted in good faith, without negligence etc. The footnote to s 17 concerning the *novus actus interveniens* also relates to protecting doctors from liability.

This alternative interpretation is in accordance with the spirit of the legislation — ‘maintaining or improving the comfort and dignity of a dying patient, rather than extraordinary or heroic measures’.² In contrast, if s 17(2) is interpreted to mean that patients and their representatives can *require* that life-sustaining measures *must* be continued and that doctors must then act on those instructions, not permitted even to apply for judicial review, that seems not only inconsistent with the common law (discussed below) but also outside the purpose of the Act. It would be contrary to the underlying ‘philosophy’ of the Act, which is quoted in the next paragraph. Also, as a matter of statutory drafting, a statute that is intended to impose *duties* on health professionals (to continue full active treatment) should do so expressly, rather than by inference from the exemption in section 17(2) — ‘in the absence of an express direction by the patient or the patient’s representative to the contrary’.

Section 17(2) is part of a statute designed to deal with problems that arise in the care of people who are dying. It enables competent adult patients to make their own decisions (either directly or by appointing an agent) about having only palliative care and protects doctors who act on that instruction from liability for not providing ‘full active treatment’. As the Hon S J Baker, Deputy Premier, said in the Second Reading Speech for the Bill for the *Consent to Medical Treatment and Palliative Care Act*:

² South Australia, *Parliamentary Debates*, House of Representatives, 3 November 1994, 989 (S J Baker, Deputy Premier) (emphasis added).

The purpose of the Bill is:

- (a) to provide for medical powers of attorney under which those who wish to do so may appoint agents to make decisions about their medical treatment when they are unable to make such decisions for themselves;
- (b) to enable those who wish to do so to make an advance directive themselves about their medical treatment in subsequent circumstances when they are unable to make such decisions;
- (c) *to allow for the provision of palliative care*, in accordance with proper standards, to the dying and *to protect the dying from medical treatment that is intrusive, burdensome and futile*;
- (d) to consolidate the law relating to consent to medical treatment.

The Select Committee found *virtually no support* in the health professions, among theologians, ethicists and carers, or indeed in the wider community, *for highly invasive procedures to keep the patient alive, come what may and at any cost to human dignity*. Clearly, moral and legal codes which reflect such practices are inappropriate. ...

The Select Committee endorsed the widely supported concept of good palliative care that is, measures aimed at maintaining or improving the comfort and dignity of a dying patient, rather than extraordinary or heroic measures, such as medical treatment which the patient finds intrusive, burdensome and futile.

A fundamental principle inherent in such an approach, and indeed, an underlying tenet of the Bill, is patient autonomy. In this respect, the wishes of the patient should be paramount and conclusive even where some would find their choice personally unacceptable.³

Thus, the whole thrust and purpose of the Bill is to acknowledge that palliative care is appropriate in treating terminally ill people in the terminal stage of their illness; to enable them legally to refuse life-sustaining measures; and to provide statutory immunity for doctors if they administer only palliative care, provided that they act with ‘appropriate consent’, ‘in good faith and without negligence’; and ‘in accordance with proper professional standards of palliative care’.⁴ Patients’ ‘autonomy’ (their right to reject unwanted treatment) is to be respected. All of this is similar to the earlier Victorian Act, the *Medical Treatment Act 1988* (Vic), and to later legislation in other states, mentioned below.

³ Ibid 990 (emphasis added). Paragraph (b) (‘an advance directive’) and the last paragraph (‘patient autonomy’) might be argued to indicate a right to *require* treatment, in addition to refusing it. However, the statement that ‘the concept of the dignity of the individual requires acceptance of the principle that patients can reject unwanted treatment’ suggests that the ‘autonomy’ in question is a right to refuse treatment.

⁴ Ibid 990; see also *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(1).

The Deputy Premier also referred to the purpose of the part of the Bill that is now s 17(2):

The Bill also makes it clear that, where a patient is in the terminal phase of a terminal illness, with no real prospect of recovery, and in the absence of an express direction to the contrary, a medical practitioner is not under a duty to use, or continue to use, measures in order to preserve life at any cost.⁵

That is all that he said about this part of the Bill.

1 Unforeseen Consequences of a Literal Interpretation — Contrary to Ethical Principle

A literal interpretation of s 17(2) would lead to consequences that seem not to have been considered when the Act was passed. If s 17(2) means that a patient or the patient's representative can require that full life-sustaining measures must be taken against the advice of health professionals caring for the patient, then that it is contrary to the fundamental ethical belief of health carers that they should determine the clinical treatment that should be provided in a particular case, not the patient. As Neonatal Nurse Practitioner, Jackie Handley said:

[P]arental rights of decision over treatment or non-treatment for their child are not absolute^[6] ... Nonetheless parents are obligated to act in the child's best interests, so that their views should take primary importance.^[7] However if those views mean the continuing of treatment that is deemed to be harmful, futile and of no benefit to the child the doctor may be justified in refusing to provide it^[8]...

Ultimately, the parents will be responsible for their child's future care should the infant live and they will bear the burden of survival. This, however, does not give them the right to force inappropriate treatment on their child and neonatologists should not continue life-sustaining treatments because of parental preference.⁹

2 Inconsistent With Similar Legislation in Other States

A literal interpretation of section 17(2) would also make the South Australian legislation different from similar legislation in other states. That might, of course,

⁵ Ibid 989.

⁶ Citing L Doyal and G Durbin, 'When Life May Become Too Precious: The Severely Damaged Neonate' (1998) 3 *Seminars in Neonatology* 275, 275–84.

⁷ Citing J Lawrence et al, 'Ethics and Provision of Futile, Harmful or Burdensome Treatment to Children' (1992) 70(3) *Critical Care Medicine* 427, 427–33.

⁸ Citing Doyal and Durbin, above n 7.

⁹ Jackie Handley, 'Decision Making in the Face of Fatal Congenital Abnormality: When Not to Treat' (2003) 9(3) *Journal of Neonatal Nursing* 83, 84,.

have been the intention of the legislature when adopting different wording, but there was nothing in the Act's passage to suggest that was so.

Other jurisdictions have legislation enabling people to *refuse* treatment in advance for themselves,¹⁰ or enabling an attorney, agent or guardian to refuse on behalf of a patient.¹¹ But in none of them is there a commensurate right to *demand* that treatment be provided if the patient, agent or guardian does not opt for palliative care.¹² Even the South Australian section enabling an agent to 'make decisions' is in very similar terms to the legislation in other states and does not confer a right to demand treatment.¹³

3 *The Common Law*

Finally, a literal interpretation of s 17 would result in a radical departure from the common law. Again, this could have been intended. Legislation is frequently passed with the specific aim of altering the common law. However, if a radical change is made by legislation, one would expect that to be discussed during its passage and that did not occur.

The common law has never recognised a right of patients or their representatives to any particular treatment. In no case has a *judge* ordered doctors to treat a patient contrary to their clinical judgment, much less recognised that a *patient* or patient's representative has a legal right to direct doctors to give particular treatment (though a patient is always, of course, entitled to withdraw from one doctor and seek treatment from another doctor who is prepared to give the treatment). A patient's well established right of 'autonomy' or self-determination¹⁴ enables the patient to choose one of a number of options that may be available to the patient, including

¹⁰ Cf *Medical Treatment Act 1994* (ACT) s 6; *Natural Death Act 1988* (NT) s 4(1),(3); *Medical Treatment Act 1988* (Vic) ss 3 (definition of 'medical treatment'), 5, Sch 1.

¹¹ Cf *Medical Treatment Act 1994* (ACT) ss 5(2), 13(1); *Powers of Attorney Act 1998* (Qld) s 32, Sch 2.2(h); *Guardianship and Administration Act 1995* (Tas) s 25(2)(e); *Medical Treatment Act 1988* (Vic) ss 5A(1)(b), 5B. These provisions do not cover parents refusing treatment for a child. See also *Gardner; re BWV* [2003] VSC 173 (Morris J), all discussed by Loane Skene, *Law and Medical Practice* (2nd ed, 2004) paras 10.37 (p 300).

¹² *Medical Treatment Act 1994* (ACT) s 23; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8(1), (7); *Medical Treatment Act 1988* (Vic) s 3.

¹³ The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 8 is headed 'Appointment of agent to *consent* to medical treatment' (emphasis added; but the section then sets out the type of treatment that the agent cannot *refuse*: see s 8(1), (7).

¹⁴ As noted above, a patient's right to autonomy was referred to in the Second Reading Speech for the *Consent to Medical Treatment and Palliative Care Act 1995*: South Australia, *Parliamentary Debates*, House of Representatives, 3 November 1994, 989 (S J Baker, Deputy Premier).

refusing all treatment. It has never been construed as requiring a health professional to provide a particular type of treatment.¹⁵

There are many judicial statements to the effect that courts cannot order doctors to give treatment against their clinical judgment. Lord Donaldson said in the English case *Re R*, ‘[n]o doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents of the child, or by anyone else’.¹⁶ Similarly, in *Re J (a minor) (wardship: medical treatment)*, Lord Donaldson said that ‘[n]o one can dictate the treatment to be given to the child — neither court, parents nor doctors. ... choice of treatment is in some measure a joint decision of the doctors and the court or parents’.¹⁷ Balcombe LJ said in a later case with the same name, *Re J (a minor) (wardship: medical treatment)*:

I find it difficult to conceive of a situation where it would be a proper exercise of the jurisdiction to make an order positively requiring a doctor to adopt a particular course of treatment in relation to a child.¹⁸

In *A National Health Service Trust v D*, Cazalet J said:

[I]t is well established that there can be no question of the court directing a doctor to provide treatment which he or she is unwilling to give and which is contrary to that doctor’s clinical judgment.¹⁹

It is true that some judges have recently expressed reservations about this broad principle but, in so doing, they have envisaged only that a court might direct that treatment must be provided, not a patient. In *R v Portsmouth Hospital NHS Trust ex parte Glass*,²⁰ Lord Woolf said that a court would not intervene ‘in areas of clinical judgment in the treatment of patients’ *if that could be avoided*; and that the ‘refusal of the courts to dictate appropriate treatment to a medical practitioner’ (in the words of the trial judge) ‘is *subject to the power which the courts always have to take decisions in relation to the child’s best interests*’.²¹ Lord Woolf then added that ‘in doing so [that is, in intervening], the court takes fully into account the

¹⁵ American health lawyer, Professor Robert Schwartz argues this with good examples in ‘Autonomy, Futility and the Limits of Medicine’ (1993) 12 *Bioethics News* 31, 32; see also L Skene, above n 12, para 10.58 (p 311).

¹⁶ *Re R (a minor) (wardship: medical treatment)* [1991] 4 All ER 177, 187.

¹⁷ [1990] 3 All ER 930; quoted in *Glass v The United Kingdom* [2004] European Court of Human Rights 102 (9 March 2004) s 4 [45].

¹⁸ [1992] 4 All ER 614, 625.

¹⁹ [2000] 2 FLR 677 (High Court of Justice: Family Division).

²⁰ [1999] 2 FLR 905; [1999] Lloyd’s Rep Med 367 (CA).

²¹ [1999] 2 FLR 905, 908 (emphasis added).

attitude of medical practitioners'.²² The European Court of Human Rights took a similar view when considering the case on appeal.²³

A reservation of the court's right to intervene could arise from the court's need to reach an objective decision about both the grounds on which the medical opinion is based; and also about what is in a child's best interests. There is growing recognition, especially in the UK after the passage of the *Human Rights Act 1998* (UK), that 'best interests' is a broader concept than best *medical* interests.²⁴ A life that seems 'demonstrably awful'²⁵ to a doctor²⁶ and so legally justifying palliative care only — may be acceptable to the child and parents. As Cazalet J said in *A National Health Service Trust v D*, 'even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable. People have an amazing adaptability'.²⁷ It may then be argued from such statements that, if there is a dispute about the length or quality of life, then the patient should decide which is to be preferred, not the doctors, but such a statement has not been made by any Australian court.

In a different vein, courts in other recent English cases have made orders that 'may indirectly result in [a] patient receiving treatment even though the courts are not strictly entitled to do this'.²⁸ However, these cases were based on what might be termed a failure to follow a fair decision making process (a '*Wednesbury*

²² Ibid.

²³ [1990] 3 All ER 930; quoted in *Glass v The United Kingdom* [2004] European Court of Human Rights 102 (9 March 2004) s 4 [45].

²⁴ Dr Cameron Stewart argued to this effect in his PhD thesis, *The Right to Die and the Common Law* (PhD, University of Sydney, 2002).

²⁵ 'Demonstrably awful' was the term used by Templeman LJ as justifying withholding of life-sustaining treatment: *Re B (a minor) (wardship: medical treatment)* [1990] 3 All ER 927, 929.

²⁶ A 'healthy, highly educated case-hardened medical practitioner': A Grubb, 'Withdrawal of Life Sustaining Treatment for a Child Without Parental Consent: *R v Portsmouth Hospitals NHS Trust ex parte Glass*' (2000) 8 *Medical Law Review* 125, 126–7.

²⁷ *A National Health Service Trust v D*, [2000] 2 FLR 677 (High Court of Justice: Family Division), 687.

²⁸ I Kennedy and A Grubb, *Medical Law* (3rd ed, 2000) 19. The cases include *R v North Derbyshire HA, ex parte Fisher* [1997] 38 BMLR 76; *North West Lancashire Health Authority v A, D and G* [1999] Lloyd's Rep Med 399 (CA); and *R v North and East Devon HA, ex p Coughlan* [1999] Lloyd's Rep Med 306 (CA); discussed by L Skene, above n 12, [2.121]–[2.126]; Cf *Northridge v Central Sydney Area Health Service*, [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O'Keefe J, (29 December 2000), discussed below.

challenge'²⁹). In *R v North Derbyshire HA, ex parte Fisher*,³⁰ for example, a patient applied for judicial review of a decision by a health authority not to provide a particular drug and the court said that the authority must take account of a circular issued by the National Health Service. The authority did not have to follow the advice in the circular, but if it chose not to do so, it had to give reasons and the court would examine those reasons. However, Dyson J acknowledged that clinicians should decide 'clinical matters' (my term) such as the needs of and likely benefit to the patient.³¹ By analogy, one might argue that if a hospital (or other body) established a procedure for making decisions about withdrawing treatment (such as requiring a 'team' decision, independent advice, and ethics committee approval) and appeared not to be following that procedure in a particular case, then a court might say that the hospital must follow the prescribed procedure or give reasons for not doing so. The court would not order the hospital to provide the treatment though the hospital might then choose to do so.

It is also conceivable that a patient or a patient's representative could challenge a decision not to provide treatment on the basis of anti-discrimination legislation,³² but acting 'reasonably' would be a defence (for example, withholding or withdrawing treatment because of a patient's condition and prognosis; or even the resource demands of other patients).³³

The only circumstance in which health care providers may find themselves indirectly constrained to provide particular treatment against their clinical judgment is where a court has ruled that it would be unlawful not to provide that treatment. There are three grounds on which treatment may be lawfully withheld: where it is 'futile' to initiate or continue treatment;³⁴ where the burdens of the treatment exceed the potential benefits that may be gained;³⁵ and where the patient's expected

²⁹ That is, an examination of the case of 'unreasonableness' of the decision of a kind recognised in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 as a basis for judicial review of administrative action.

³⁰ [1997] 38 BMLR 76.

³¹ *Ibid* 91; he included resource allocation as a matter for clinicians to decide: 91–2.

³² *Cf In the Matter of Baby K*, 832 F Supp 1022 (Va, 1993), *aff'd* 16 F 3d 590 (4th Cir, 1994).

³³ Even if the complaint was upheld, the remedy would generally be compensation for unlawful discrimination, not an order that the treatment be given: *Pearce v South Australia Health Commission* (1996) 66 SASR 486; *Re McBain: Ex parte Australian Catholic Bishops Conference*; (2002) 209 CLR 372; L Skene, above n 12, [2.127]–[2.129].

³⁴ *Airedale National Health Service Trust v Bland* [1992] AC 789 (a unanimous decision of the House of Lords); *Re BWV* [2003] VCAT 121, *Gardner*; *BWV* [2003] VSC 173 (Morris J).

³⁵ *Re J (a minor) (wardship: medical treatment)* [1990] 3 All ER 930.

quality of life is so poor that that patient would not choose to live such a life;³⁶ and courts have upheld clinical decisions to withhold treatment in such circumstances.³⁷ If the court took a different view from the doctors in respect of any of these grounds, stating that it is not lawful in the circumstances to withdraw treatment of a particular kind, then the doctors would no doubt feel compelled to offer that treatment; or to refer the patient to another hospital that is willing to do so. Thus, in *Northridge v Central Sydney Area Health Service* ('*Northridge*'),³⁸ if the hospital had not readily agreed to remove the patient's 'do not resuscitate' order,³⁹ the court could have indirectly required it to do so by ruling that it would be unlawful not to provide that treatment in the circumstances.⁴⁰

III OPTIONS FOR HOSPITALS AND PROFESSIONAL CARERS WHERE PATIENTS DEMAND THAT TREATMENT MUST BE CONTINUED

Where there is a dispute about the withdrawal of treatment there are two alternatives for hospitals and professional carers. The first is to continue only palliative care and accept the risk of liability; the second is to apply for judicial

³⁶ *Re C (a minor) (wardship: medical treatment)* [1990] Fam 26, 1 FLR 252; *Re J (a minor) (wardship: medical treatment)*, [1990] 3 All ER 930; *Re B (a minor) (wardship: medical treatment)* [1990] 3 All ER 927, 929.

³⁷ *Airedale National Health Service Trust v Bland*, [1992] AC 789; *An NHS Trust v M*, *An NHS Trust v H* [2001] 2 FLR 367 (High Ct, Fam Div, Butler-Sloss P); *Re R (Adult: Medical Treatment)* [1996] 2 FLR 99; *Re AK* (2000) [2001] FLR 129 (High Ct, Fam Div, Hughes J); *Re G* (persistent vegetative state) [1995] 2 FCR 46, 52; *Auckland Area Health Board v Attorney General (Re L)* 1993] 1 NZLR 235, 341. In Australia, *Bland* was followed by the Victorian Civil and Administrative Tribunal in *Re BWV* [2003] VCAT 121; its decision was upheld by the Supreme Court of Victoria: *Gardner; re BWV* [2003] VSC 173; see also the 'standard declaration' in such cases: see text, below n 84. There is also judicial support in Canada and the United States for doctors withdrawing treatment: *Child and Family Services of Central Manitoba v Lallalee* (1997) 154 DLR (4th) 409 (Man. CA); *Cruzan v Director, Missouri Department of Health* 497 US 261(1990) (US SC).

³⁸ *Northridge v Central Sydney Area Health Service* [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O'Keefe J, 17 Jan 2001(29 December 2000)).

³⁹ None of the orders was disputed by the hospital: *ibid*, [117]–[118]; there was no order requiring medical staff to do anything they considered contrary to their clinical judgment. The judge's attitude seemed to be that the patient should be treated for a long enough period to enable the diagnosis to be more certain, as required by the hospital's guidelines: *ibid* [6], [115].

⁴⁰ O'Keefe J did acknowledge the court's role in giving effect to the right of vulnerable patients to medical treatment; but he said that the only treatment a court would direct is 'ordinary reasonable and appropriate (as opposed to extra-ordinary, excessively burdensome, intrusive or futile) medical treatment, sustenance and support'. Note that it is the *court*, not the patient's relatives, stating the appropriate treatment.

review. If the hospital chooses the first, there may be several types of legal action. The patient, or his or her representative, may apply for a court order requiring the treatment to be given and the court procedure and the matters to be considered by the court will be similar to those where the patient (or a representative) initiates judicial review (discussed below). If that does not happen and the patient dies, the hospital or the treating staff may be subject to a coronial inquiry, sued, prosecuted or the subject of disciplinary action for unprofessional conduct.

Coroners investigate certain deaths to determine their circumstances, cause and who might have contributed to the death. They are unusual in cases where treatment is withheld or withdrawn from a critically ill patient, especially a newborn infant; and Coroners are likely to support concerned medical carers who have been required to make difficult decisions.⁴¹

In a civil action claiming damages for negligent treatment of a patient, the plaintiff would have to prove a failure to take reasonable care, which almost always requires medical evidence that the care given fell short of the standard of a 'reasonable' practitioner. Failure to provide care is not negligence in itself as there is no duty to provide treatment that is futile⁴² or where 'a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by [continuing treatment]'.⁴³ The plaintiff would also have to prove that the patient's death was caused by the acts or omissions of the hospital or the professional carers. In such cases, judges have acknowledged that death is not caused by a failure to provide full active treatment, but rather by the patient's underlying condition.⁴⁴ Finally, in the case of a child or other person on whom the plaintiff was not dependent at the time of death, any damages would be minimal as the plaintiff would suffer little or no financial loss arising from the patient's death. If a plaintiff sued in respect of injury to *himself or herself* rather than the care of the deceased patient, then it is conceivable that damages might be awarded, as in *Marchlewski*.⁴⁶ In that case, parents recovered damages for their own injury because the doctors led them to believe their baby was improving and so deprived them of an opportunity to challenge the decision to withdraw her treatment. The hospital was held to have a duty to the parents as well as to their child. However, such an action would be available only if the plaintiff could prove that he or she had suffered 'psychiatric injury' as legally defined (previously called 'nervous shock') and that it was negligently caused by the defendant. The facts of a case where the family was fully

⁴¹ As the Victorian Deputy State Coroner did in the highly publicised *Baby M Inquest*: *Baby M*, Record of Investigation into Death, Case No 3149/89, State Coroner's Office, 1991.

⁴² *Airedale National Health Service Trust v Bland* [19932] AC 789, 871(Lord Goff); *Gardner*; *re BWV* [2003] VSC 173 ED QUERY – see footnote 38.

⁴³ *Airedale National Health Service Trust v Bland* [19932] AC 789, 858 (Lord Keith).

⁴⁴ *Ibid* 879 (Lord Browne-Wilkinson).

involved in the procedure of decision making and was not misled about the patient's prognosis, could readily be distinguished from the facts in *Marchlewski*.

An investigation into alleged professional misconduct by a doctor or other health professional — or other complaint mechanisms such as those involving health services commissioners — are based on what is 'improper' or a failure to take due care.⁴⁵ Whether this is judged from the viewpoint of the community or peer professional opinion, it is inconceivable that health care providers acting in collaboration with each other and with an ethics committee, endeavouring to involve the patient or his or her representative or family in the decision, would be found to have committed a disciplinary offence.

A fortiori, it would be very unusual for a prosecution to be initiated if life-sustaining treatment was withheld or withdrawn from a dying patient on medical advice but against the wishes of the family. However, if health carers were prosecuted, they are very unlikely to be convicted. Judges (and juries, where a case is heard by jury) have traditionally been reluctant to find that doctors have committed a criminal offence when treating a patient, especially when they have acted collaboratively in what they believe to be the patient's best interests.⁴⁶ As noted earlier, Lord Goff said in *Bland* that 'if the treatment is futile ... it is no longer in the best interests of the patient to continue it'.⁴⁷ Similarly, one might say that doctors have no legal duty to continue treatment that is not in a patient's best interests because there is no prospect of any improvement in the patient's condition, though that elides the 'futility' and 'best interests' tests.

Nevertheless, it seems unfair that hospitals and treating staff should have to face the risk of a coronial inquiry, civil suit, disciplinary action or criminal prosecution when acting collaboratively after full consideration in what they believe to be their patients' best interests, even if they are ultimately vindicated.

The second option open to a hospital and professional carers is to apply to a court for a declaration that it is in the best interests of a patient to offer only palliative care, or to a guardianship tribunal or board for a guardian to be appointed. To date, it has not been customary to apply for judicial directions in Australia; indeed, it

⁴⁵ See, for example, *Medical Practitioners Act 1983* (SA) s 5, definition of 'professional misconduct'.

⁴⁶ This is especially the case after a patient has died. Even a court that is inclined to be conservative in giving directions for the care that is appropriate for a living patient will not readily convict medical carers when viewing the case after the patient's death. Dr Arthur was acquitted, for example, but one can readily imagine that a court might have taken a different view of the appropriate course of treatment if court review had been sought before the child died: *R v Arthur* (1981) 12 BLMR 1.

⁴⁷ Note 35 above, at 870.

seems to have been generally thought that these decisions are better kept out of the courts.⁴⁸ There are two avenues that may be appropriate.

A Family Court

Most of the English cases mentioned earlier were heard in the Family Division of the High Court; and, if the patient is a child, the Family Court of Australia may be able to hear an application to grant a declaration concerning the care to be offered to a critically ill infant or child.⁴⁹ In South Australia, initiating proceedings in the Family Court, if that court has jurisdiction, would have particular benefits for health care providers. A federal court could authorise a course of treatment for a child even if that would otherwise be contrary to state law.⁵⁰ It might therefore be argued that the Family Court could make an order in the ‘best interests’ of a critically ill infant, stating that it would be lawful not to resuscitate a child who stops breathing, if resuscitation would be futile or unduly burdensome, even if withholding resuscitation would not be lawful under the South Australian Act if the parents objected.⁵¹ Also, the Family Court has procedures for appointing a person to act as an advocate for the child’s interests; this may appease some of the concerns of disability groups about the withholding or withdrawal of treatment on what are perceived to be solely ‘medical’ grounds.⁵²

Though the issue is not beyond doubt, the Family Court would probably have jurisdiction in such cases. A unanimous judgment of the High Court of Australia handed down on 29 April 2004 (*Minister for Immigration and Multicultural and Indigenous Affairs v B* (*‘B’s case’*))⁵³ identified limits on the broad welfare or *parens patriae* jurisdiction of the Family Court (the jurisdiction arising under the

⁴⁸ Baby M, Record of Investigation into Death, Case No 3149/89, State Coroner’s Office, 1991; similarly in New Zealand: *Auckland Area Health Board v Attorney General (Re L)* 1993] 1 NZLR 235, 341.

⁴⁹ The Federal Magistrates Court would not have jurisdiction. The jurisdiction conferred on that Court under the *Family Law Act 1975* (Cth) s 39 is limited to a ‘matrimonial cause’, as defined in s 4(1).

⁵⁰ In *P v P* (1994) 181 CLR 583, for example, the High Court confirmed the power of the Family Court to authorise the sterilisation of a minor, contrary to the *Guardianship Act 1987* (NSW).

⁵¹ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(2), on a literal interpretation of that sub-section.

⁵² Victoria Legal Aid et al, *A Question of Right Treatment, The Family Court and Special Procedures for Children* (1998) Family Court, Ch 3, [2, 3 and 6]. See particularly 15–6: parental ‘dispute[s] about significant and recommended treatment’ and parental refusal of ‘mechanically assisted life support’.

⁵³ [2004] HCA 20 (29 April 2004).

Family Law Act 1975 (Cth) s 67ZC),⁵⁴ but that case can be distinguished from cases involving parental decisions about their child's medical treatment. Most of the judgments in *B's case* provide specific grounds for such a distinction. The High Court ruled that the welfare jurisdiction of the Family Court did not give the Court a general power to make orders against third parties, simply on the basis that the welfare of a child is in issue. Thus, the Family Court was held not to have jurisdiction where the primary issue was the validity of detention of a child under the *Migration Act 1959* (Cth). That would have extended the Court's welfare jurisdiction beyond issues arising from parental rights and responsibilities and involved an order against a third party, the Minister, not an order binding on the parents. As Kirby J observed, the 'invocation of the jurisdiction of the Family Court [in such a case] seems contrived'.⁵⁵

On the other hand, most of the judgments in *B's case*⁵⁶ specifically acknowledged that the Family Court does have jurisdiction in cases involving the welfare of a child where the issue arises from a determination of the parents' legal obligations towards their child, as in *Secretary Department of Health and Community Services v JWG and SMB* ('*Marion's case*').⁵⁷ These obligations include decisions about medical treatment.⁵⁸ The difference between the circumstances in *B's case* and

⁵⁴ Under s 67ZC, the Family Court has 'jurisdiction to make orders relating to the welfare of children'. Nicholson CJ and O'Ryan J, the majority judges in the Full Court of the Family Court hearing of *B's case*, *B (Infants) and B (Intervener) v Minister for Immigration and Multicultural and Indigenous Affairs* (2003) 30 FamLR 181, 228–9, said that s 67ZC was enacted to give effect to the United Nations Convention on the Rights of the Child, opened for signature 20 Nov 1989, [1991] ATS 4 (entered into force for Australia 16 Jan 1991) and supported by the External Affairs power: noted in the High Court by Gleeson CJ and McHugh J [3–5]; Gummow, Hayne and Heydon JJ [52–62] and Callinan J [181–97]. If that was the case, the Convention would provide the constitutional basis for s 67ZC, independently of the marriage power: *ibid.* Despite judicial reservations in the High Court about the Convention as a source of jurisdiction in *B's case* (see below, n 60–1), it is important to note that the same objection would not apply where parental obligations are the issue, not the actions of a third party. This distinction was reiterated in the High Court: see below.

⁵⁵ *B's case*, [2004] HCA 20 (29 April 2004) [117].

⁵⁶ *Ibid.* Kirby J based his judgment primarily on the interaction of the *Family Law Act* and the *Migration Act*, rather than on the jurisdiction of the Family Court: see especially [177]; he therefore did not consider the issues discussed below. All other judges distinguished between orders arising from parental responsibilities for a child and those alleged to arise from a general 'welfare' jurisdiction.

⁵⁷ *Secretary Department of Health and Community Services v JWG and SMB* ('*Marion's case*') (1992) 175 CLR 218.

⁵⁸ See the joint judgment of Mason CJ, Deane J, Toohey J and Gaudron JJ in *P v P*, (1994) 181 CLR 583, quoted by Callinan J in *B's case*, [2004] HCA 20 (29 April 2004) [212].

those in *Marion's case* is that the latter fall within 'the main object of Part VII of the *Family Law Act*, which [is] ... to require *parents* to act in ways that will advance the best interests of their children'.⁵⁹ That is, the court's jurisdiction does not arise solely under the general welfare provision of the *Family Law Act* (s 67ZC);⁶⁰ it arises from the broader provisions in the Act that '[make] *the parents* responsible for the long-term welfare of [their] child' (emphasis added).⁶¹ In such cases, there is no issue of seeking an order against a third party.

The jurisdiction of the Family Court is important in the present discussion and could be challenged.⁶² This is evident from the possible sources of jurisdiction mentioned in the judgments in *B's case* and the way the judges distinguished *B's case* from cases like *Marion's case*. They said that, where there is an issue concerning parents' obligations in relation to their child, the Family Court has jurisdiction under s 67ZC. Despite reservations expressed about s 67ZC (and the Convention⁶³), s 67ZC is a source of jurisdiction per se and a case involving parental responsibility can be distinguished from one involving obligations of third parties when considering s 67ZC as a source of jurisdiction.⁶⁴ The Family Court

⁵⁹ *B's case*, [2004] HCA 20 (29 April 2004) [28] (Gleeson CJ and McHugh J), emphasis added; they also said that, in *Marion's case*, the fact that 'the Act vested ... rights, powers and duties and ... responsibility in the parents' meant that 'a controversy between the parents and the Secretary, as the child's representative, concerning the right of the parents to authorise her sterilisation gave rise to a "matter"', giving the Family Court jurisdiction. That was not the case where an order was sought against a third party, as in *B's case*; there was then no 'matter' giving jurisdiction.

⁶⁰ It may arise from s 67ZC but in combination with other sections of the Act: see below n 67.

⁶¹ *B's case*, [2004] HCA 20 (29 April 2004) [17] (Gleeson CJ and McHugh J).

⁶² In South Australia, parents keen to have treatment continued for their child might object to the jurisdiction of the Family Court, knowing that a State court would be bound by the State Act and that, on a literal interpretation of the Act, they might have a legal right to require treatment to be continued. It is even conceivable that a Right to Life *amicus curiae* might intervene to argue the jurisdictional point if the parents agreed to submit to the jurisdiction of the Family Court.

⁶³ Callinan J, for example, said in *B's case*, [2004] HCA 20 (29 April 2004), that '[t]he strong possibility ... is that the Convention may be aspirational only' [222]; and the Convention 'has not actually been incorporated into the domestic law' [220].

⁶⁴ Gleeson CJ and McHugh J [51] said in *B's case*, [2004] HCA 20 (29 April 2004), that jurisdiction may arise jointly from ss 67ZC, 60B, 61B and 61C: see below n 67. Gummow, Hayne and Heydon JJ [105] said that s 69ZH confines the operation of s 67ZC to the parental responsibilities of the parties to a marriage for a child of the marriage; although the Court may make orders under s 67ZC 'analogous to orders traditionally made by courts exercising the *parens patriae jurisdiction*', these are orders 'binding on a parent' not binding on third parties [74]. Despite Callinan J's reservations, see above n 65, he said [205]: 'the whole thrust of the *Family Act* [sic]

also has jurisdiction under s 67ZC, in combination with ss 60B, 61B and 61C;⁶⁵ under s 68B (the injunction provision which ‘details a range of injunctive relief which may be considered appropriate for the welfare of the child in question’);⁶⁶ and under s 69ZE which confers jurisdiction on the Family Court in matters that are the subject of a reference by a State of power to the Commonwealth.⁶⁷

For these reasons, there is little in *B’s case* to suggest that the Family Court would not have jurisdiction where there is a dispute about medical treatment being withheld or withdrawn from a critically ill child, as a result of parents withholding

so far as children are concerned is to deal with children of marriages *and* the obligations of their parents to them’ (his emphasis); and *Marion’s case* was ‘entirely different’ from *B’s case* [214]. Gleeson CJ and McHugh J said that s 67ZC did not itself ‘confer jurisdiction in respect of a “matter” ... because it does not confer rights or impose duties on anyone’ [13], but, *semble*, it would give rise to a ‘matter’ and could then be a source of jurisdiction if it were to be ‘read down to refer to the parties to a marriage’ (ibid, citing *Marion’s case*, (1992) 175 CLR 218, 257, though the judgments in that case did not support s 67ZC as a source of power: *B’s case*, [2004] HCA 20 (29 April 2004), [14]; see also [22] ‘other provisions of the Act may supply the elements of a “matter”’).

⁶⁵ See Gleeson CJ and McHugh J (para 51): ‘The parents of a child may seek an order under s 67ZC ... the right to seek that order arises from various provisions in Part VII, but particularly from ss 60B, 61B and 61C’; Gummow, Hayne and Heydon JJ [95], citing s 69C(2): proceedings may be instituted by, inter alia, a parent and ‘any other person concerned with the care, welfare or development of a child.’ That is, the issue arose from the parent’s guardianship of their child, not a ‘general discretionary welfare power over any or all children’: Callinan J [215]. Gleeson CJ and McHugh J said that the Family Court could make an order under s 67ZC that is ‘binding on a parent ... [but not] binding on third parties’: [52].

⁶⁶ Gummow, Hayne and Heydon JJ [94]; they note that this jurisdiction, like that of s 67ZC, is limited to ‘the parental responsibilities of the parties to a marriage for a child of the marriage’ [105]. Kirby J did not mention s 68B; the other judges mentioned it only to say that it did not confer jurisdiction in circumstances such as those in *B’s case*, [2004] HCA 20 (29 April 2004).

⁶⁷ Gummow, Hayne and Heydon JJ noted that s 69ZE did not apply to the applications in *B’s case*, [2004] HCA 20 (29 April 2004), since South Australia had referred power only for ‘matters of maintenance, custody, guardianship and access’ [74] – matters of ‘a narrower genus than those relating to the welfare of a child’ [104]; this would not exclude review of parental decisions about a child’s medical treatment, which fall within a parent’s guardianship responsibilities; see also [79–80]. Callinan J emphasised that the states referred powers concerning “[p]arenting” and its obligations’ [205]; ‘parental obligations owed to children’ [206]. Because South Australia referred ‘guardianship’ power to the Commonwealth, the Family Court of Australia has jurisdiction to rule on medical treatment for ex nuptial children in South Australia, not only for children of the marriage (under the ‘marriage’ power in the Federal Constitution).

consent.⁶⁸ If a hospital applied for judicial directions,⁶⁹ then that would seem to involve the obligations of parents towards their child and an order ‘binding on the parents’ within the principle in *B’s case* and to give rise to a ‘matter’. The form of the order⁷⁰ would not be an order against a third party (the hospital or the doctors);⁷¹ it would be a declaration as to the lawfulness of particular treatment in relation to the best interests of the child,⁷² which would then be binding on the parents. It is true that such an order would be different from those the Family Court has, to date, been called upon to make. Its role has been to authorise medical procedures that save children’s lives (such as authorising life sustaining treatment that parents have refused on religious or other grounds); or to enhance the child’s ongoing life (such as sterilisation, as in *Marion’s case*; or ‘sex change’ therapy⁷³). The Court has not been asked to approve the withdrawal or withholding of life-sustaining treatment, especially in the face of parental objection. (The same would seem to be true of state child protection jurisdiction, such as that of the South Australian Youth Court, which I will not discuss more fully.⁷⁴) However, the broad issue of what is in a child’s best interests seems to be common in both circumstances.

B State Protective Jurisdiction

The State Supreme Court would have jurisdiction to hear an application for directions concerning medical treatment for an incompetent patient⁷⁵ (both children

⁶⁸ [2004] HCA 20 (29 April 2004).

⁶⁹ The *Family Law Act 1975* (Cth) s 69C(2)(d) enables proceedings to be instituted by ‘any ... person concerned with the care, welfare or development of the child’.

⁷⁰ See the form of the Declarations below n 74 and text, below n 84.

⁷¹ I have argued earlier that a court would not order health professionals to provide treatment against medical judgment.

⁷² Cf the Declaration made in *Re Marion (No 2)* (1992)17 Fam LR 336 at 355: ‘The performance of a hysterectomy without the preservation of the ovaries is in the best interest of the long-term welfare of the child...’.

⁷³ *Re Alex: Hormonal Treatment For Gender Identity Dysphoria* [2004] Fam CA 297.

⁷⁴ W Keough discusses this jurisdiction in relation to children: ‘Authority to treat: A comparative look at the jurisdiction, practice and procedure of the Supreme Court of Victoria, Children’s Court of Victoria and Family Court of Australia in medical matters’ (2003) 10 *Journal of Law and Medicine* 442.

⁷⁵ See, for example, *Supreme Court Act 1935* (SA) s 17(1) (general jurisdiction). The powers of the Supreme Court of South Australia have not been removed by the *Family Law Act 1975* (Cth) (amendments in 1987). The *Commonwealth Powers (Family Law) Act 1986* (SA) s 3(1)(b) refers to the Commonwealth state powers concerning ‘the custody and guardianship of, and access to, children’; however, there is a reservation of the jurisdiction of State courts under certain Acts listed in the Schedule to the Act ‘to make orders ... in respect of ... the custody, guardianship, care or control of children’: s 3(2)(c)(ii). Two of these Acts deal with child welfare, including the *Children’s Protection and Young Offenders Act 1979* (SA) (now the *Children’s Protection Act 1993* (SA)). The *Family Law (Child Protection*

and adults) and the Supreme Court would provide an appropriate avenue, given the implications of the criminal law (which is principally a state matter) if treatment is wrongfully withheld.⁷⁶ Other cases concerning disputes about the withholding of treatment have been heard in State Supreme Courts⁷⁷ and their jurisdiction is not limited to patients who are children. A state court can also make a child a ward of the court, as in the English case of *D*⁷⁸, which the Family Court cannot do.⁷⁹

The cases in which Supreme Courts have exercised jurisdiction in circumstances regarding ‘end of life’ treatment have arisen from applications to continue treatment, rather than to withhold or withdraw it. In *Northridge*, for example, O’Keefe J said that the New South Wales Supreme Court has *parens patriae* jurisdiction to ‘prevent the withdrawal of such treatment, support and sustenance [namely, ordinary reasonable and appropriate treatment] where the withdrawal may put in jeopardy the life, good health or welfare of such unconscious individual’.⁸⁰ However, he also said that the

usual relief sought in England in respect of patients from whom artificial feeding, hydration and treatment are sought to be withdrawn, is by way of declaration that: “the responsible medical practitioners ... may lawfully discontinue all life sustaining treatment and medical support measures,

Convention) Regulations 2003 (Cth) reg 22 confers jurisdiction on a ‘State Court’ in matters arising under the Convention; for South Australia, the Youth Court is a ‘State Court’: *Family Law (Child Protection Convention) Regulations 2003* (Cth) Reg 3(1) Sched 2; *Children’s Protection Act 1993* (SA).

⁷⁶ Injury or death resulting from an omission to provide treatment when there is a duty to do so is no less a ground for criminal liability than an act that causes harm.

⁷⁷ For example, *Northridge v Central Sydney Area Heath Service*, [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O’Keefe J, (29 December 2000); also Vincent J heard an application in the Supreme Court of Victoria concerning treatment allegedly being withheld from a baby in hospital: *Re F; F v F* (Unreported, Supreme Court of Victoria, Vincent J, 2 July 1986). I have not discussed this case because it was heard well before the more recent English cases; there was no evidence given; and there was no legal argument; see L Skene, above n 12, [11.14].

⁷⁸ *A National Health Service Trust v D* [2000] 2 FLR 677 (High Court of Justice: Family Division).

⁷⁹ *Marion’s case* (1992) 175 CLR 218, 256 (Mason CJ, Dawson, Toohey and Gaudron JJ).

⁸⁰ *Northridge v Central Sydney Area Heath Service*, [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O’Keefe J, (29 December 2000), [15–24], (quoting from para 24), citing *Marion’s case*, (1992) 175 CLR 218; *Northridge* concerned an adult patient but the principle would seem the same for a child: see [18]: reference to a ‘frail baby’, citing *Marion’s case* at 266.

(including ventilation, nutrition and hydration by artificial means) designed to keep (the patient) alive in (his or her) existing permanent vegetative state”⁸¹

It would seem from these comments that O’Keefe J believed that the Supreme Court could make such a declaration, or alternatively, the Court’s failure to exercise its power to prevent the withdrawal of treatment would, in effect, be an authority to withdraw it.

State guardianship tribunals and boards also exercise jurisdiction in respect of incompetent people. Some, like the Victorian Civil and Administrative Tribunal (Guardianship List) (VCAT) are limited to dealing with adults. Others, like the South Australian Guardianship Board, appear to have jurisdiction over children as well.⁸² Guardianship bodies may have a role in overseeing the withdrawal or withholding of particular types of treatment but generally cannot authorise that directly. The leading Victorian case of this kind, *BWV*, was commenced in VCAT;⁸³ and a recent application by the Monash Medical Centre to withdraw dialysis from an elderly, demented woman against her family’s wishes was also commenced in VCAT, though it did not proceed.⁸⁴ In both cases, the application was not for approval to withdraw treatment but to appoint a guardian who could then make that decision. However, VCAT would presumably not appoint a guardian if it did not consider the case appropriate for withdrawal of treatment.

IV CONCLUSION

Although the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(2) appears on a literal reading, to prevent doctors withholding or withdrawing treatment if patients or their representatives object, the sub-section could be

⁸¹ *Northridge v Central Sydney Area Health Service*, [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O’Keefe J, (29 December 2000) [110]; see also [111], referring to *Practice Note* (1996) 4 All ER 766.

⁸² The current Presidents of the Guardianship Board and two past Presidents have expressed reservations about the Board’s jurisdiction over children as it seems contrary to the *Guardianship of Infants Act 1940* (SA) and the *Family Law Act 1975* (Cth) in taking guardianship away from the parents and giving it to someone else: John Harley, Public Advocate, SA, personal communication (e-mail), 26 May 2004. However, the Board’s website states that it has jurisdiction over children: Office of the Public Advocate, *Prescribed Medical Treatment* (2005), <http://www.opa.sa.gov.au/fact_sheets/public%20advocate%20sheet%2010.pdf>, at 16 July 2004.

⁸³ *BWV* [2003] VCAT 121, Gardner; re *RWV* [2003] VSC 173.

⁸⁴ Tom Noble, ‘Family and Hospital Clash Over a Woman’s “Best Interests”’, *The Age*, Melbourne, 22 Dec 2003. According to this report, the hospital applied to VCAT for a guardian to be appointed and VCAT asked the Office of the Public Advocate to investigate.

interpreted as conferring statutory immunity in cases where there has been no objection to the proposed treatment and inapplicable where there is such an objection. The section, under this interpretation, would not mean that patients have a right to demand other treatment. Recognising such a right would be inconsistent with the rest of the Act and contrary to long accepted principles of medical ethics and the common law.

Health care providers commonly continue basic treatment for a short time to assist relatives to adjust to the patient's death and to say goodbye.⁸⁵ After that, the decision to withhold or withdraw further treatment is up to them. Health care providers face little risk if appropriate precautions are taken in making the decision to withdraw treatment. The decision should be based on unanimous, carefully considered and fully documented medical opinion, reached after full consultation with the family and backed by the clinical ethics committee of the hospital, that continuing treatment is not in the patient's best interests. Nevertheless, if there is a dispute about life-sustaining treatment being withheld or withdrawn it would be wise for health care providers to consider applying for a declaration in the form commonly used in such cases.⁸⁶ If the patient is a child, the application could be made to the Family Court and it could override the State Act. If the patient is an adult, the application must be made to the Supreme Court of South Australia or the Guardianship Board and, if they took a literal view of s 17(2), they would have no power to intervene. If they did not take that view, they might make a declaration concerning the treatment that is appropriate in that case. Relevant issues for a court or tribunal in making a declaration are illustrated by the New South Wales case of *Northridge*.⁸⁷ For convenience, these matters are listed in the Appendix as a guide for hospitals and professional carers in approaching a court or tribunal for judicial directions. They would place great weight on the views of the family but those views would not be determinative.

There remains a significant problem with the South Australian legislation. Section 17(2) may not be interpreted in the way that I have advocated; some lawyers will say that the meaning is clear and must be applied whatever the consequences. Although the Family Court might possibly have jurisdiction and could override the State Act for a patient who is a child, that is not the case with adult patients. The legislation must therefore be amended as a matter of urgency to make it clear that

⁸⁵ This is not only therapeutically appropriate but, in relation to children, delay is acknowledged in the guidelines as good practice: see *A Question of Right Treatment*, above n 54, 59–60 'Primary Dispute Resolution'.

⁸⁶ See text: above n 84.

⁸⁷ *Northridge v Central Sydney Area Health Service*, [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O'Keefe J, (29 December 2000)).

the ultimate decision about the withdrawal or withholding of medical treatment rests with a court or guardianship body, as it does in all other jurisdictions.⁸⁸

APPENDIX

Independent Expert's Medical Report

The matters that have been considered by courts in cases involving withholding or withdrawal of treatment⁸⁹ indicate the issues that should be covered in supporting material. The independent⁹⁰ medical expert's report⁹¹ should set out the following matters⁹² (though the last two could be provided in a separate report by treatment staff):

- The expert's qualifications and expertise, including the basis of his or her 'independence' from the case in question.
- Whether the expert has examined the patient (a personal examination is obviously highly desirable but may not always be possible).
- Whether the expert has had full access to the patient's clinical records and what he or she has found in them.
- The patient's condition – noting in detail the expert's own physical findings that support his or her opinion.
- The patient's prognosis – again based on physical observations that are set out in the report.

⁸⁸ Section 17(2) could be amended by deleting the words 'in the absence of an express direction by the patient or the patient's representative to the contrary'; but that would be politically contentious. An amendment adding a paragraph to s 17(2) in the following form may be more achievable as it would make South Australian law similar to that in other jurisdictions by allowing judicial review: 's 17(2)(b): If the patient or representative has given an express direction to the contrary, the Supreme Court of South Australia (or the Youth Court) may make a declaration on whether it is in the patient's best interests to continue life sustaining measures or to provide only palliative care'.

⁸⁹ See *Re Marion* (No 2) (1992) 17 Fam LR 336.

⁹⁰ The 'expert' should be independent of the treating 'team' but need not be someone outside the hospital. It may be difficult or indeed impossible to gain an expert from outside a specialist hospital given the geography of Australia. Note that in *Northridge v Central Sydney Area Heath Service*, [2000] NSWSC 1241 (Unreported, NSW Supreme Court, O'Keefe J, (29 December 2000), [109], O'Keefe J referred to the English guidelines and said that 'there should be at least two independent reports ... from ... doctors ... [who] must undertake their own assessments ...'.

⁹¹ In the case of a patient who is a child, the report would generally be by affidavit, except in urgent cases: *Family Law Rules 2004* (Cth) R 4.09(3).

⁹² Cf matters listed in *Family Court Rules 2004* (Cth) R 4.09(2).

- Whether the patient appears to be in the terminal phase of the particular condition so that he or she may be said to be in a 'moribund state' or in a 'persistent vegetative state'.⁹³
- Whether the expert's assessment of the patient's condition has been determined according to, and if so which, professional guidelines.⁹⁴
- The expert's opinion on the treatment that should or should not be offered to a patient in such circumstances, and the reasons for that view. For example, the administration of oxygen, antibiotics, suction to clear passages, and physiotherapy may be appropriate if the patient develops an infection because they may assist the patient's comfort. However, endotracheal intubation and long-term ventilation may not be appropriate because those procedures impose a burden on the patient that is not warranted in view of the prognosis, the burden arising from the ongoing distress and discomfort from the treatment. Such invasive procedures would merely prolong the terminal phase of the illness with no likely gain in the patient's quality of life.
- Whether the patient's family have been consulted and their response, including the period during which they have been involved in decision making (if the expert's knowledge of this is based on the patient's clinical records or another source, then that should be stated).
- Whether there has been any ethical review of the patient's case by anyone outside the treatment team; and, if so, who has undertaken that review and what recommendation has been made. If anyone has put arguments as an advocate for the child, that should be noted. The source of the expert's information on these matters should be stated.

POST SCRIPT

After this paper was submitted for publication, the English High Court delivered judgment in *R (Burke) v The General Medical Council* [2004] EWHC 1879 (judgment 30 July 2004). The judge, Munby J, before his appointment to the Bench, was described in an Editorial in the *British Medical Journal* as 'the QC

⁹³ Note that these are not the same. A patient with a massive heart attack, with secondary organ failure and no hope of survival is in a 'moribund state' and the diagnosis may be made clinically over a much shorter time-frame than persistent vegetative state (PVS), which should be reserved for patients meeting the NHMRC guidelines; NHMRC, *Post-coma Unresponsiveness (Vegetative state): A Clinical Framework for Diagnosis* (2003), <<http://www.nhmrc.gov.au/publications/synopses/hpr23syn.htm>> at 20 August 2004. Also, PVS is really only applicable to cerebral dysfunction, whereas a patient may be 'moribund' from a number of different scenarios: Dr Mark Finnis, intensive care specialist, Adelaide, personal communication (e-mail), 28 June 2004.

⁹⁴ For example, NHMRC guidelines, above n 96.

regularly briefed by the Official Solicitor to represent patients' interests',⁹⁵ appearing in cases like *Bland*. Munby J's judgment in *Burke* was reserved, detailed and fully reasoned but, in my view, conservative⁹⁶ and of limited application in circumstances such as those described in this paper; especially in Australia (*Burke* is also on appeal).

In brief, Munby J recognised that a 44 year old patient with 'a congenital degenerative brain condition' was legally entitled to be given 'artificial feeding and hydration' even if his doctors did not consider that treatment appropriate towards the end of his life. Munby J acknowledged the role of courts in overseeing patients' interests (as O'Keefe J did in *Northridge*) and, in terms similar to some of the judgments discussed in this paper, he said:

Doctors can properly claim expertise on medical matters; but they can claim no special expertise on the many non-medical matters which go to form the basis of any decision as to what is in a patient's best interests. Medical opinion, however eminent, can never be determinative of what is in a patient's best interests.⁹⁷ ... The evaluation of a patient's best interests involves a welfare appraisal in the widest sense, taking into account, where appropriate, a wide range of ethical, social, moral, emotional and welfare considerations.⁹⁸

Again, as in other judgments discussed in this paper, Munby J said that hospitals have a duty to provide the care that is in a patient's best interests and that, if a patient is incompetent, a court may rule on what those interests are.⁹⁹ A court can make a declaration that 'a refusal either to provide such treatment or to transfer the patient to the care of those willing to provide it is unlawful'.¹⁰⁰ Again, this is little different from *Northridge*. However, Munby J also envisaged that, although

the court will not grant a mandatory order requiring an individual doctor to treat a patient ... [there is] no reason why in principle it should not ... grant declaratory relief against him. ... [The court could then] by appropriate orders ensure that a patient who ought to be treated is, if need be, transferred to the care of doctors who are willing to do so.¹⁰¹

⁹⁵ *BMJ* 1996; 313:1280 (23 Nov).

⁹⁶ I believe the judgment is theoretically questionable, especially in eliding a right not to be given unwanted treatment with a right to have treatment provided against medical advice. Munby J says that both rights are both part of a patient's right to autonomy; I disagree: L Skene, 'Disputes About the Withdrawal of Treatment: The Role of the Courts' (2004) *Journal of Law, Medicine and Ethics* (in press).

⁹⁷ *Burke* [213](e).

⁹⁸ *Ibid* [213](d).

⁹⁹ *Ibid* [90].

¹⁰⁰ *Ibid* [193].

¹⁰¹ *Ibid* [91], [92], [193].

In effect, this might allow the court to order that treatment must be provided against medical advice.

There are several reasons why I consider that this aspect of Munby J's judgment will not be applied in cases involving critically ill infants in Australia. First, he emphasised that Mr Burke was likely to remain cognitively aware until shortly before death, even if he could no longer communicate. Secondly, Munby J emphasised that he was considering artificial feeding and hydration, 'which is relatively simple and straight-forward and a routine staple of day-to-day medical practice in hospitals up and down the land, ... [not] treatment with significant cost implications'.¹⁰² Thirdly, the judgment was based largely on the *Human Rights Act* 1998 (UK). And finally, the transfer of a patient to another hospital may be more readily achieved in the UK than in countries where hospitals and the bodies that administer them may not be public bodies subject to judicial review.

Burke is now on appeal, expected to be heard in May 2005. There have also been a number of recent cases involving disputes about treatment for critically ill infants, such as Charlotte Wyatt.¹⁰³

¹⁰² Ibid [27]–[29].

¹⁰³ *Re Wyatt (a child) (medical treatment: parents' consent)* [2004] EWHC 2247; M Brazier, 'Letting Charlotte Die' (2004) 30 (6) *Journal of Medical Ethics* 519.

