

SUBMISSION - Joint Select Committee On End of Life Choices

Submitted By: Kevin John Rickson

In summary, I submit and recommend that:

- 1. With appropriate safeguards and oversight, every person should have the right and opportunity to determine their own end of life choices, including voluntary euthanasia, when they are confronted with a “terminal illness” and where death is the reasonable prognosis.**
- 2. The loss of decision making capacity on its own should not preclude a person from determining their own end of life choices, including voluntary euthanasia, in advance of their loss of decision making capacity and having that determination actioned after they have lost decision making capacity.**

Explanatory Note:

For the purposes of this submission and with a view to clarity I have used the term Voluntary Euthanasia which I intend to mean - intentionally ending a life to relieve pain and suffering on a voluntary basis and with the life ending drug being either self-administered or administered by a medical practitioner if circumstances require. I make no recommendation about the appropriateness of further use of that term and leave it to the Joint Select Committee to determine preferred terminology.

My Personal Experience

I have developed a reasonable amount of personal experience in recent years which I feel is relevant to my submission and affords me a practical understanding of the issues involved. Without going into graphic detail that experience is outlined below:

On the 21st February, 2013 my mother-in-law passed away, in a high care facility, as a result of Alzheimer's Disease from which she had suffered for more than ten years. My wife and I had regular and close contact with her during this period of her life and had the unfortunate experience of witnessing her steady deterioration and suffering to the point of sitting at her bedside and watching her waste away and finally die over a period of twelve days.

On the 30th July, 2016, my father-in-law passed away at his home as a result of Lung Cancer with the contributory causes of Cardiac Failure, Renal Failure and Bladder Cancer. My father-in-law was a very independent man who resisted the confines of a care facility and as a consequence my wife and I moved some 400 kilometres from our home to live with him and provide for his palliative care needs on a full-time basis for the last eighteen months of his

life. My father-in-law was also a very brave man and although he was relatively pain free he lived the final year or so of his life with the constant fear of drowning in his own fluids.

On the 8th June, 2017 my wife's aunt, for whom I had been Guardian & Administrator (appointed by the State Administrative Tribunal) for the last seven years of her life, passed away in a high care facility as a result of Alzheimer's Disease from which she had suffered for more than nine years. Whilst we were unable to spend her last days with her we did maintain regular and close contact with her up till a week prior to her death and again had the unfortunate experience of witnessing her deterioration and suffering.

Neither my mother-in-law, father-in-law or aunt had the opportunity to determine their own destiny and I can only trust that this Select Committee and ultimately our representatives in the Parliament have the fortitude to remedy that situation for others in like circumstances.

My Submission

In preparing this submission I do not propose to dwell upon presenting an argument for "the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices", which also incorporate access to voluntary euthanasia.

If there are any of our elected representatives not already aware of and indeed convinced of that need and any who do not recognise and accept the overwhelming support amongst their constituents for voluntary euthanasia then I would suggest a much more serious issue, which is well beyond the terms of reference of this Joint Select Committee, confronts us all.

It is my view that the real challenge for this Joint Select Committee will be the development of a framework for legislation that is both appropriate for and acceptable to most Western Australians.

To that end I recommend that the Joint Select Committee afford particular attention to the final report to the Parliament of Victoria prepared by its Legislative Council Legal and Social Issues Committee and entitled "Inquiry into end of life choices" together with the subsequent "Final Report" of the Ministerial Advisory Panel on Voluntary Assisted Dying addressed to the Victorian Minister for Health.

Both provide well researched information that is contemporary and relevant to the Australian environment and the latter presents a framework for the development of legislation worthy, I suggest, of careful consideration as a suitable foundation upon which to build a practical model for Western Australia.

Notwithstanding, I would submit that there is one serious shortcoming with the Victorian findings and their resultant framework and that is the specific exclusion of every person who has "lost capacity" from access to voluntary euthanasia (assisted dying).

The primary thrust of my submission concerns this shortcoming and my recommendation that the loss of decision making capacity on its own should not preclude a person from determining their own end of life choices, including voluntary euthanasia, in advance of their loss of decision making capacity and having that determination actioned after they have lost decision making capacity.

Given the detailed arguments for the exclusion of persons who have lost decision making capacity outlined in the Victorian reports I have endeavoured to present my views and recommendations on this issue as comments responding to those arguments as quoted below, indented and italicised.

8.5.3 **Criteria and safeguards**

The Committee's recommended framework allows an adult, with capacity, who is at the end of life and has a serious and incurable condition which is causing enduring and unbearable suffering to request assisted dying.

Where the Oregon, Québec and Canadian models include capacity and adulthood as essential criteria, the broader Netherlands model does not. The Committee firmly believes that Victorian values do not support allowing assisted dying to be provided to those who are yet to reach adulthood, nor those who do not have decision making capacity.

It is essential that the patient must be experiencing enduring and unbearable suffering that cannot be relieved in a manner which the patient deems tolerable, as the Québec model requires. This is fundamental to patient-centred care and, while a doctor's advice will be invaluable in assisting patients in their decision, in the shift towards patient-centred medicine the Committee believes it is not for others to decide what is and is not tolerable for a patient.

The Committee notes that its recommended framework includes eligibility criteria and safeguards that will make some people who wish to access assisted dying ineligible, for example those who have lost capacity due to dementia or Alzheimer's disease. The Committee recognises this, but believes the eligibility criteria and safeguards are necessary to guard against potential abuse.

I concur that the necessity for strict eligibility criteria and sound safeguards to guard against potential abuse is paramount but would contend that it is possible to maintain adequate safeguards in a Western Australian model whilst affording access to those who have lost capacity but otherwise would have met the Victorian eligibility criteria. (Please see my further comments.)

Advance care directives

Decision-making capacity and requests for voluntary assisted dying in advance care directives

Feedback to both the Parliamentary Committee and the Panel was that future loss of decision-making capacity is one of people's biggest fears and is something they often want to avoid. People who had witnessed the progression of a loved one's cognitive deterioration considered that people with conditions that cause such deterioration should have the same ability to control the timing and manner of their death as people

with decision-making capacity. It was these circumstances that led some stakeholders to support the option for voluntary assisted dying requests to be made in advance care directives.

In overseas jurisdictions where making a request for voluntary assisted dying in an advance care directive is allowed, how it is handled varies. In Belgium voluntary assisted dying may only be provided through an advance care directive if a person is unconscious. In the Netherlands, legislation does not provide any guidance about the time or circumstance in which an advance care directive for voluntary assisted dying comes into effect.

The Panel considers that there is a fundamental difference between refusing life sustaining medical treatment in an advance care directive and requesting voluntary assisted dying. When refusing medical treatment in an advance care directive, a person identifies medical treatment that would be unacceptable to them, they do not ask to die.

I would submit that in the Western Australian context the above claim is simply not correct.

In Western Australia, we are fortunate to have a very robust and well legislated Advance Health Directive process in accordance with which, for example, I could prepare a legally enforceable advance directive directing that if I was to develop Alzheimer's Disease at some time in the future then, at the point when I could no longer feed myself, I was not to be provided nutrition or hydration in any other way.

The direct consequence of such a directive would be death and I contend that in anyone's terms that directive is asking to die.

The legality of an Advance Health Directive of this nature is well supported at common law and in case law such as *BRIGHTWATER CARE GROUP (INC) -v- ROSSITER* [2009] WASC 229 and *HUNTER AND NEW ENGLAND AREA HEALTH SERVICE V A* [2009] NSWSC 761, copies of which are included herewith as Attachments 1 & 2 for ease of reference.

By contrast, if a person requested voluntary assisted dying in an advance care directive they would need to identify a point at which they would want to die in advance of reaching this point. The Panel is of the view that while a person may appreciate the nature and effect of different medical treatments in advance, and consent to or refuse these, it is not possible for them to accurately identify in advance a point in time at which they would want to die.

I contend that this view is not soundly based and in fact is not supported by the other findings/recommendations advanced in the Ministerial Advisory Panel's report.

Particularly their recommendations in relation to:

1. Assessing decision making capacity which proposes that "a person has decision-making capacity in relation to a decision when they are able to:
 - understand the information relevant to the decision and the effect of the decision;
 - retain that information to the extent necessary to make the decision;
 - use or weigh that information as part of the process of making the decision; and

- communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.
2. "Suffering in the context of voluntary assisted dying" where the recommended eligibility criteria is "is causing suffering that cannot be relieved in a manner the person deems tolerable".

In this day and age most people having decision making capacity are reasonably well educated, intelligent and informed and it would be reasonable to assume that anybody seriously considering the preparation of an advance directive involving voluntary euthanasia would be particularly well informed of the issues involved. To assert otherwise could easily be misunderstood and construed as being demeaning.

From a personal perspective, which I know from experience is shared by many others, if I was to develop Alzheimer's Disease and should the opportunity be available my advance directive will seek voluntary euthanasia at that point in time when I am diagnosed to be at the final stage in the 3 stage Alzheimer's model. I contend that this represents an accurate identification in advance of the point in time at which I would want to die.

The framework recommended for voluntary assisted dying does not provide for universal access to voluntary assisted dying. The person must complete a request and assessment process to demonstrate eligibility and it is not clear how this process would work in an advance care directive.

My recommendation is that the Western Australian framework for Voluntary Euthanasia be developed to incorporate two models. A "Reactive Model" which could be utilised by people who develop a terminal illness and retain their decision-making capacity and a "Proactive Model" for use by people who wish to prepare in advance for a situation where they develop a terminal illness and lose or have lost their decision making capacity.

Both models should be developed to be interactive to the extent that a person may use both if they so choose. (eg A person might develop terminal cancer and commence with and progress the "Reactive Model" then also implement the "Proactive Model" in case they lose their decision making capacity.)

My suggested framework, an outline of which is presented diagrammatically at Attachment 3., proposes the development of a specific "Voluntary Euthanasia Advance Health Directive" (VEAHD) process and pro-forma which should be legislated by amendment of the Guardianship and Administration Act & Regulations.

To provide an additional safeguard I have suggested that the VEAHD should be in the form of an affidavit sworn before a Justice of the Peace.

By contrast, everyone has the right to refuse medical treatment and the obligations of medical practitioners are clear in these circumstances. A person cannot demand treatment in an advance care directive; they may consent to clinically indicated medical treatment or refuse medical treatment.

This is true, however, assuming Western Australia adopted a framework similar to that proposed for Victoria a person will not be able to demand Voluntary Euthanasia at any time

as a Medical Practitioner would be quite entitled to refuse to participate. The person will only be able to request Voluntary Euthanasia.

The situation would be no different under my proposed “Proactive Model”. The person will only be requesting Voluntary Euthanasia via their VEAHD and the Medical Practitioner will be appropriately protected should they choose to participate.

Voluntary assisted dying will not be a clinically indicated treatment that a medical practitioner offers. This means it is not clear who would commence the assessment process, or when they would commence it, if people were allowed to include a request in an advance care directive.

Under my proposed “Proactive Model” it is quite clear that the process must be commenced by the VEAHD maker him/herself. The VEAHD maker will also be ultimately responsible for implementing appropriate arrangements for activating the VEAHD at the stipulated time.

Those arrangements might include discussions with a medical practitioner, family members and/or carers (institutional or otherwise), appointment of an Enduring Guardian, etc. to ensure that existence of the VEAHD is known and understood.

No differently to a current Advance Health Directive a VEAHD could be activated by almost anybody who is aware of its existence but it may only be actioned by a Medical Practitioner who agrees to do so and who has access to the original VEAHD.

The Panel is of the view that excluding people who do not have decision-making capacity from accessing voluntary assisted dying creates a clear and enforceable line. This means access will only be granted to people making voluntary and properly informed decisions to access voluntary assisted dying at the time they may make a request. This removes any doubt or ambiguity about their intention.

Dementia and requests for voluntary assisted dying in advance care directives

Stakeholders, including people in the early stages of dementia, expressed concern that people with dementia would not be able to make requests for voluntary assisted dying in advance care directives so that a lethal dose of medication could be administered when they no longer had decision-making capacity. People who had a ‘lived experience’ of dementia (either a diagnosis of dementia themselves, or as carers), health practitioners who worked in the field, and advocacy groups all commented on the distressing nature of dementia and the impact it can have on the person, their family and friends. These stakeholders also recognised the complexity and challenges that would need to be addressed for legislation to allow people with dementia to request voluntary assisted dying in advance care directives.

The challenge for health and social care delivery is that while dementia is now recognised as a terminal medical condition, people may live for many years with dementia with varying levels of incapacity, and how an individual adjusts to its progression may change over this time. The Panel acknowledges the terminal nature of dementia, that decision-making capacity for someone with dementia may fluctuate, and that cognitive ability will decline over a person’s illness trajectory.

The Panel considered the issue of people with dementia requesting voluntary assisted dying in advance care directives at length in light of the literature, international experience, and feedback from the consultation process. After considerable reflection, the Panel continues to hold the view that balancing principles of respecting individual autonomy and the need to ensure effective safeguards for people without decision making capacity requires that requests for voluntary assisted dying in advance care directives are invalid.

The Panel has made this decision noting that, in other jurisdictions, a significant percentage of people do not take the lethal dose of medication after they have filled the prescription. In Oregon, for example, 30 per cent of people who have the medication prescribed do not take it. The Panel notes that there is no ability to check with a person who does not have decision-making capacity whether they still want to administer the lethal dose of medication and at what point. The timing of this would always be a subjective judgement made by another person. Requiring a person to have decision making capacity to choose to administer or not administer the lethal dose of medication is a fundamental safeguard.

The Panel acknowledges that loss of cognitive capacity may cause distress to people and accepts there may be people who feel the criterion unfairly discriminates against people with dementia. Nevertheless, the existence of decision-making capacity is such a fundamental safeguard to the protection of individual autonomy and the voluntary assisted dying process that it must be included in the eligibility criteria. Voluntary assisted dying must be 'voluntary' – that is, a person must have decision-making capacity to make an autonomous choice – at all stages of the process. Failure to have this safeguard could 'put very vulnerable people at great risk of manipulation and abuse'.

In fact, this stance would only serve to potentially discriminate against the largest group of Western Australians waiting and wishing for the opportunity to make truly fully informed decisions regarding their own end of life choices as is evidenced by the following extracts.

The Australian Bureau of Statistics (ABS) reports that - Dementia, including Alzheimer's disease, remains the second leading cause of death (in Australia) in 2015, with 12,625 deaths. Dementia has increased from 4.9% of all deaths in 2006 to 7.9% in 2015. Cerebrovascular diseases (6.8%), Cancer of the trachea, bronchus and lung (5.3%) and Chronic lower respiratory diseases (5.0%) complete the top five leading causes of death, and in total these causes accounted for more than one-third (37.6%) of all deaths registered in 2015. (see <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2015~Main%20Features~Australia's%20leading%20causes%20of%20death,%202015~3>)

The ABS also reports - “.....that in the 10 years from 2006 to 2015, the number of deaths (in Australia) due to dementia almost doubled, from 6,550 to 12,625. Over the same period, the number of deaths from heart disease decreased from 23,132 to 19,777 and deaths from strokes decreased from 11,479 to 10,869. Dementia is the only one of these three causes for which the death rate is increasing, in part due to the changing population structure, but also because medical treatments are not yet able to prevent or cure this disease.

These factors mean it is highly likely dementia will soon overtake heart disease as Australia's leading cause of death. In fact, a simple mathematical projection based on counts over the

past 10 years indicates dementia deaths will outnumber those from heart disease as soon as 2021.” (see

<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2015~Main%20Features~Dementia:%20Australia's%20future%20leading%20cause%20of%20death%3f~4>)

From a Western Australian perspective Alzheimer's Australia reports that - “There are 33,300 West Australians with dementia. Without a medical breakthrough, this number is projected to increase rapidly and in less than 10 years, will reach 36,500.

Number of people with dementia in WA:

- 2016 - 33,300 people with dementia
- 2020 - 36,500 people with dementia
- 2050 - 69,000 people with dementia”

(see <https://wa.fightdementia.org.au/wa/research-and-publications/dementia-statistics>)

Further to exclude people solely on the basis of lack of decision making capacity will continue to force some to make a lonely and totally unnecessary decision to prematurely end life with often ugly consequences.

I submit that the fundamental safeguard is not decision-making capacity but rather the establishment and maintenance of strict criteria that ensures the individual him/herself is the only person that can ever seek Voluntary Euthanasia.

I would further submit that my proposal provides that fundamental safeguard.

Whilst I acknowledge that I may be a lone voice in promoting access for those who have lost decision-making capacity to Voluntary Euthanasia, should they so choose and albeit in very limited circumstances, my experience tells me that I am far from being alone in holding the views that I have endeavoured to express in this submission.

I urge this Joint Select Committee, whilst being cognisant of practices and developments in other jurisdictions, to recognise, embrace and address the views of the majority of Western Australians in their deliberations by developing a contemporary, compassionate and safe legislative framework which affords equitable access to Voluntary Euthanasia and that also recognises the practical realities of life.

I am happy to expand upon any issues raised in this submission and also to appear before the Joint Select Committee should it be felt that there is a benefit in my doing so.

I appreciate that my submission is of a conceptual nature and in practical terms will require refinement.

Kevin Rickson
26th September, 2017

JURISDICTION : SUPREME COURT OF WESTERN AUSTRALIA
IN CHAMBERS

CITATION : BRIGHTWATER CARE GROUP (INC) -v-
ROSSITER [2009] WASC 229

CORAM : MARTIN CJ

HEARD : 14 AUGUST 2009

DELIVERED : 14 AUGUST 2009

PUBLISHED : 20 AUGUST 2009

FILE NO/S : CIV 2406 of 2009

BETWEEN : BRIGHTWATER CARE GROUP (INC)
Plaintiff

AND

CHRISTIAN ROSSITER
Defendant

ATTORNEY GENERAL OF WESTERN
AUSTRALIA
Intervener

FILE NO/S : CIV 2436 of 2009

BETWEEN : CHRISTIAN ROSSITER
Plaintiff

AND

BRIGHTWATER CARE GROUP (INC)
Defendant

ATTORNEY GENERAL OF WESTERN
AUSTRALIA
Intervener

Catchwords:

Legal obligations of a medical service provider which has assumed responsibility for the care of a patient - Patient is a quadriplegic - Patient is mentally competent - Patient has directed medical service provider to discontinue provision of nutrition and general hydration - Consequence of discontinuing provision of nutrition and general hydration will be that patient dies from starvation - Patient also requests prescription of analgesics for the purposes of sedation and pain relief as he approaches death

Provision of declaratory relief in respect of criminality

Common law - Mental capacity - Principle of autonomy or self-determination - Consent to medical treatment - Informed consent - Right of patient to determine whether or not they will continue to receive medical treatment

Criminal Code (WA) - Duty to provide necessities of life pursuant to s 262 - Interpretation of 'having charge' of another - Surgical and medical treatment within the meaning of s 259 - Amendments pursuant to the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) - General principles relating to palliative care

Legislation:

Acts Amendment (Consent to Medical Treatment) Act 2008 (WA)

Criminal Code (WA)

Guardianship and Administration Act 1990 (WA)

Interpretation Act 1984 (WA)

Result:

Declarations given

Category: A

Representation:

CIV 2406 of 2009

Counsel:

Plaintiff	:	Mr J D Allanson SC & Ms J A Thornton
Defendant	:	Ms L B Black
Intervener	:	Mr R M Mitchell SC

Solicitors:

Plaintiff	:	Allens Arthur Robinson
Defendant	:	Hammond Legal
Intervener	:	State Solicitor for Western Australia

CIV 2436 of 2009

Counsel:

Plaintiff	:	Ms L B Black
Defendant	:	Mr J D Allanson SC & Ms J A Thornton
Intervener	:	Mr R M Mitchell SC

Solicitors:

Plaintiff	:	Hammond Legal
Defendant	:	Allens Arthur Robinson
Intervener	:	State Solicitor for Western Australia

Amicus Curiae : Mr P O'Meara (Right to Life Association)

Case(s) referred to in judgment(s):

Adult Guardian v Langham [2005] QSC 127; (2006) 1 Qd R 1
Airedale National Health Service Trust v Bland [1993] AC 789
Auckland Area Health Board v Attorney General [1993] 1 NZLR 235

Bouvia v Superior Court of Los Angeles County 179 Cal App 3d 1127 (1986)
Commissioner for Corporate Affairs v Sansom [1981] WAR 32
Commonwealth v Sterling Nicholas Duty Free Pty Ltd [1972] HCA 19; (1972)
126 CLR 297
F v R (1983) 33 SASR 189
Hunter and New England Area Health Service v A [2009] NSWSC 761
Imperial Tobacco v Attorney-General [1981] AC 718
Malette v Shulman (1990) 67 DLR (4th) 321
Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam); (2002) 2 FCR (UK)
1
Nancy B v Hotel-Dieu Quebec (1992) 86 DLR (4th) 385
Re BWV; Ex parte Gardner [2003] VSC 173; (2003) 7 VR 487
Re MB (Medical Treatment) [1997] EWCA Civ 1361; (1997) 2 FCR (UK) 541
Re T (Adult: Refusal of Treatment) (1993) Fam 95
Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479
Schloendorff v Society of New York Hospital 211 NY 125 (1914)
Secretary of Department of Health and Community Services v B [1992] HCA
15; (1992) 175 CLR 218

1 **MARTIN CJ:** (This judgment was delivered extemporaneously on
14 August 2009 and has been edited from the transcript.)

2 It is important to emphasise at the outset what this case is not about.
It is not about euthanasia. Nor is it about physicians providing lethal
treatments to patients who wish to die. Nor is it about the right to life or
even the right to death. Nor is the court asked to determine which course
of action is in the best interests of a medical patient.

3 The only issue which arises for determination in this case concerns
the legal obligations under Western Australian law of a medical service
provider which has assumed responsibility for the care of a mentally
competent patient when that patient clearly and unequivocally stipulates
that he does not wish to continue to receive medical services which, if
discontinued, will inevitably lead to his death.

4 I will set out the particular circumstances in which that question
arises in this case, by identifying the findings of fact which I make on the
basis of the largely uncontested evidence which has been produced.

5 Brightwater Care Group (Inc) (Brightwater) operates a facility in
Marangaroo, a suburb of Perth, which provides residential care for people
with disabilities. Mr Christian Rossiter was admitted to Brightwater's
facility on 4 November 2008. Since then, Brightwater has assumed the
responsibility of providing all necessary services to Mr Rossiter, in
conjunction with Mr Rossiter's treating medical practitioner, Dr Richard
Benstead.

6 Mr Rossiter is quadriplegic. Over about 20 years he has suffered
three serious injuries which have combined to cause that condition. In
about 1988 he fell approximately 30 metres from an apartment in Sydney
as a result of which he suffered head and other injuries. He made a
substantial recovery from those injuries with the assistance of
rehabilitation programmes. However, in 2004 he sustained a cervical
spine injury following a collision with a motor vehicle whilst he was
riding a bicycle. During 2008, he suffered two further falls - one whilst
visiting his mother at her nursing home, and the second in the kitchen of
his mother's house in Joondalup on or about 3 March 2008. This last fall
caused his spastic quadriplegia. Following that last fall he was admitted
to the Joondalup Health Campus. He was then transferred to Sir Charles
Gairdner Hospital on 8 March 2008. He was transferred from that
hospital to the Brightwater facility on 4 November 2008, as I have
mentioned. He has remained at that facility since then.

7 As a consequence of his injuries, Mr Rossiter is generally unable to move. The extent of his capacity to move is limited foot movement and the ability to wriggle one finger. He is only able to talk through a tracheotomy. He is totally dependent upon others, generally those employed by Brightwater, for the provision of the necessities of life. The services which he requires include regular turning, cleaning, assistance with bowel movements, physiotherapy, occupational therapy and speech pathology.

8 Mr Rossiter is unable to take nutrition or hydration orally. The nutrition and hydration which he requires in order to survive is provided by way of a percutaneous endoscopic gastrostomy tube (PEG). That is a tube which has been inserted directly into his stomach by way of surgical intervention. Appropriate nutrition and hydration, determined in accordance with medical protocols, is provided to Mr Rossiter by Brightwater staff through the PEG.

9 Mr Rossiter is not terminally ill, nor is he dying. If the services to which I have referred are maintained, he could continue to live for many years. However, he has been advised that there is no prospect that his condition will improve, and in some respects, for example his eyesight, his condition is deteriorating.

10 This clinical description of Mr Rossiter's condition fails to adequately convey the tragedy of his present circumstances. Nor does it recognise the sympathy which any reasonable person would properly have for Mr Rossiter and the predicament in which he finds himself. These matters are, of course, profoundly significant at a human level, but for reasons which I will explain, they are irrelevant to the legal issues which I am required to determine. My lack of reference to these matters in the balance of my reasons should not be construed as any lack of appreciation of the significance of these matters to Mr Rossiter. But my task is to apply the law as dispassionately as I can.

11 Mr Rossiter has clearly and unequivocally indicated to representatives of Brightwater and to Dr Benstead that he wishes to die on many occasions. However, because of the limitations upon his movements to which I have referred, he lacks the physical capacity to bring about his own death. He has therefore directed the staff of Brightwater to discontinue the provision of nutrition and general hydration through the PEG. He has repeated that direction on a number of occasions and maintains, through his evidence and through his counsel, that he requires that service to be discontinued. However, he wishes the

PEG to be maintained and for such hydration as is necessary to dissolve his painkilling medication to be provided. Where in these reasons I refer to the withdrawal of hydration, I mean general hydration, not including the limited hydration which Mr Rossiter wishes to continue to receive.

12 Mr Rossiter is aware that he will die from starvation if nutrition and hydration is no longer administered through the PEG. The evidence of Dr Benstead is that he has described to Mr Rossiter, as best as he can, the physiological consequences which will ensue during the process of starvation. However, in a statement given to his legal advisors, Mr Rossiter asserted that apart from what he had read, he had received no specific advice on the effects of starving to death. He augmented that statement in evidence before me to refer to advice he had received from Dr Colin Eagle who is a friend of his but it is not clear from that evidence that the advice covered all aspects of the physiological consequences of discontinuing the provision of nutrition and hydration. This is a matter to which I will return.

13 Mr Rossiter is assumed to have the mental capacity to give a direction to discontinue the provision of nutrition and hydration unless and until there is evidence which would suggest that he lacks that capacity. There is no such evidence in this case. On the contrary, Dr Benstead deposes that based upon his observations of Mr Rossiter, he has the capacity to comprehend and retain information given to him in relation to his treatment, and has the capacity to weigh up that information and bring other factors and considerations into account in order to arrive at an informed decision.

14 Also in evidence is a report from Ms Rachel Zombor, who is a clinical neuropsychologist. That report is dated 19 February 2009. In that report, Ms Zombor sets out the various observations which she made during her neuropsychological assessment of Mr Rossiter, and the tests which she administered. As a result of those observations, and the results of the tests, she concluded that Mr Rossiter was capable of making reasoned decisions concerning his own health and safety, and in particular was capable of making decisions in respect of his future medical treatment after weighing up alternative options, and was capable of expressing reasons for the decisions which he made in that respect. She also reported that, in her view, Mr Rossiter unequivocally demonstrated that he understood the consequences of withholding the provision of nutrition and hydration through the PEG, and displayed insight into the consequences of that decision.

15 Although Mr Rossiter was previously the subject of a guardianship
order made under the *Guardianship and Administration Act 1990* (WA),
on 10 March 2009, the State Administrative Tribunal revoked that order.

16 This case therefore lacks many of the factors which have
complicated other cases in this area. Mr Rossiter is not a child, nor is he
terminally ill, or dying. He is not in a vegetative state, nor does he lack
the capacity to communicate his wishes. There is therefore no question of
other persons making decisions on his behalf. Rather, this is a case in
which a person with full mental capacity and the ability to communicate
his wishes has directed those who have assumed responsibility for his care
to discontinue the provision of treatment which maintains his existence.
The question I am asked to decide is whether, in those circumstances,
Brightwater is legally obliged to comply with Mr Rossiter's direction or,
alternatively, legally obliged to continue the provision of the services
which will maintain his life.

17 Each of Brightwater (in CIV 2406 of 2009) and Mr Rossiter (in
CIV 2436 of 2009) ask the court to make declarations with respect to their
respective rights and obligations. In the case of Brightwater, their concern
includes the prospect that compliance with Mr Rossiter's directions might
result in criminal prosecution. Declaratory relief is sought to avert that
prospect.

18 The court will only grant declaratory relief in respect of the
criminality of a proposed course of conduct in exceptional circumstances:
Imperial Tobacco v Attorney-General [1981] AC 718, 742. That
approach is taken for a number of sound reasons, including the fact that
whether or not conduct is criminal may depend critically upon a range of
precise facts and circumstances which cannot always be accurately
estimated in advance. Another reason for this approach is that in our
system, the determination of whether particular conduct is criminal or not
is, in serious cases, generally left to a jury, not a Judge.

19 But the cases recognise that in exceptional circumstances,
declarations may be made in respect of conduct that could be the subject
of criminal charges: ***Commissioner for Corporate Affairs v Sansom***
[1981] WAR 32, 36. Those cases also establish that in this respect there
is a vital distinction between making a declaration with respect to the
lawfulness of conduct which is proposed but has not occurred, and
making a declaration as to whether or not conduct which has occurred
constitutes a criminal offence. Declarations in respect of proposed future
conduct add to the practical utility of this jurisdiction, but a declaration in

respect of conduct which has occurred has little practical utility and would usurp the jurisdiction and role of the criminal courts, and for those reasons, will not be made: *Commonwealth v Sterling Nicholas Duty Free Pty Ltd* [1972] HCA 19; (1972) 126 CLR 297, 305.

20 The exceptional nature of the jurisdiction I am exercising imports two significant constraints. They are:

1. I should only answer questions directly and explicitly raised by the facts of this particular case, and refrain from making any observations with respect to any other hypothetical scenarios; and
2. I should only grant declaratory relief if I am satisfied that I have received all the evidence which is relevant to the issues to be determined, and all the facts necessary to determine the issues which arise have been established to an appropriate level of satisfaction.

21 If I conclude that Brightwater is legally obliged to comply with Mr Rossiter's direction, there is a subsidiary question which I am also asked to determine. That is because Mr Rossiter wishes Dr Benstead to prescribe analgesics for the purposes of sedation and pain relief as he approaches death by starvation. Dr Benstead is concerned that he might face criminal prosecution in the event that he prescribes medication for those purposes and, to that end, Brightwater also seeks declaratory relief on that issue. For reasons which I will give, that subsidiary issue seems to me to raise more complex questions than the primary question I am asked to decide.

The position at common law

22 Leaving to one side the statutory provisions relevant to these issues in Western Australia, the answer to the primary question posed in this case at common law is clear and unambiguous. That answer comes about as a consequence of a number of well-established principles.

23 The first is that a person of full age is assumed to be capable of having the mental capacity to consent to, or refuse, medical treatment: *Re MB (Medical Treatment)* [1997] EWCA Civ 1361; (1997) 2 FCR (UK) 541 (per Lady Justice Butler-Sloss); *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); (2002) 2 FCR (UK) 1 [10] (per Dame Butler-Sloss); and *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [23] (per McDougall J). That presumption applies in this case, but in any event, there is direct medical evidence which establishes

to my satisfaction that Mr Rossiter has the mental capacity necessary to make an informed decision in respect of the future provision of treatment, and if provided with the necessary information, could do so with a full appreciation of the consequences of that decision.

- 24 Another principle well established at common law is the principle which has been described in the cases as the right of autonomy or self-determination. Lord Hoffmann has described this right as being related to respect for the individual human being and in particular for his or her right to choose how he or she should live his or her life: *Airedale National Health Service Trust v Bland* [1993] AC 789, 826. Included within the right of autonomy or self-determination is the right, described as long ago as 1914 in the United States by Justice Cardozo, as the right of 'every human being of adult years and sound mind ... to determine what shall be done with his own body: *Schloendorff v Society of New York Hospital* 211 NY 125 (1914), 129.
- 25 That right has been recognised in Australia and referred to with approval by the High Court: *F v R* (1983) 33 SASR 189, 192 - 193 (per King CJ); *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479, 487. That right also underpins the established legal requirement that the informed consent of the patient is required before any medical treatment can be undertaken lawfully. That principle has been affirmed by the High Court on a number of occasions: *Secretary of Department of Health and Community Services v B* [1992] HCA 15; (1992) 175 CLR 218 (*Marion's case*), 233 and *Rogers v Whitaker*, 489. Also see the English case of *Airedale NHS v Bland*, 857.
- 26 The corollary of that requirement is that an individual of full capacity is not obliged to give consent to medical treatment, nor is a medical practitioner or other service provider under any obligation to provide such treatment without consent, even if the failure to treat will result in the loss of the patient's life. That principle has been established by decisions in each of the major common law jurisdictions, including the United States (*Bouvia v Superior Court of Los Angeles County* 179 Cal App 3d 1127 (1986), 1137 and 1139 - 1141); Canada (*Nancy B v Hotel-Dieu Quebec* (1992) 86 DLR (4th) 385; *Malette v Shulman* (1990) 67 DLR (4th) 321, 328); the United Kingdom (*Airedale NHS Trust v Bland*, 857 (Lord Keith) and 864 (Lord Goff); *Ms B v An NHS Hospital Trust* [16] - [21]); New Zealand (*Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, 245) and Australia (*Hunter and New England Area Health Service v A*, [9] - [15]).

- 27 The principle is applied without regard to the reasons for the patient's choice, and irrespective of whether the reasons are rational, irrational, unknown or even non-existent: *Re T (Adult: Refusal of Treatment)* (1993) Fam 95, 113 (cited with approval in *Ms B v An NHS Hospital Trust* [18] and *Hunter and New England Health Service v A* [15]).
- 28 However, the conflict in the evidence on the extent to which Mr Rossiter has been informed of the precise aspects and effects of the physiological deterioration which will occur during the process of starvation raises a question on the extent to which the decision to refuse to consent to treatment must be an informed decision. In *Hunter and New England Area Health Service v A*, McDougall J (at [28] - [30]) rejected the notion that a refusal to consent had to be informed to be effective in the context of an advance directive given by a person who, at the time of the court hearing, lacked the capacity to receive further information or make any further decision.
- 29 The circumstances of this case are quite different. Mr Rossiter has the capacity to receive and consider information he is given, and to make informed decisions after weighing that information. Also relevant is the fact that Brightwater have assumed responsibility for providing nutrition and hydration through the PEG for quite some time now, so the question is whether there should be a change in that regime.
- 30 As I have mentioned, it is clearly established that medical service providers have a legal duty to inform patients of all aspects and risks associated with any medical procedure before seeking their consent to that procedure. With respect to McDougall J, in the circumstances of this case, where it is perfectly feasible to ensure that Mr Rossiter is given full information as to the consequences of any decision to discontinue treatment before he makes that decision, I can see no reason why his medical service providers should not be under a similar obligation. This view is consistent with the views expressed in the English and Canadian cases to which I have referred, where emphasis is placed on the need for an informed decision to discontinue life support: *Airedale NHS Trust v Bland*, 864, and *Nancy B v Hotel-Dieu de Quebec*. There will obviously be cases in which it is not possible to obtain such a decision, but this is not one of them, and I will refrain from proffering any view as to what should be required in such cases. At the moment, on the evidence before me there is some doubt as to whether Mr Rossiter has been given the information that he would need to be fully informed on these issues.

31 Another corollary of the principles to which I have referred is that a medical practitioner or service provider who provides treatment contrary to the wishes of a mentally competent patient breaks the law by committing a trespass against the person of that patient: *Marion's case*, 264 and 309 - 310.

32 It follows that, at common law, the answers to the questions posed by this case are clear and straightforward. They are to the effect that Mr Rossiter has the right to determine whether or not he will continue to receive the services and treatment provided by Brightwater and, at common law, Brightwater would be acting unlawfully by continuing to provide treatment contrary to Mr Rossiter's wishes. In the particular circumstances of this case, in my view, Brightwater has a duty to ensure that Mr Rossiter is offered full information on the precise consequences of any decision to discontinue the provision of nutrition and hydration prior to him making that decision.

The Western Australian statutory provisions

33 The question then becomes whether this clear position at common law is altered by any relevant statutory provisions in force in Western Australia. The provisions to which the parties have pointed are those to be found within the *Criminal Code* (WA). Prominent amongst them is s 262, which provides:

Duty to provide necessities of life

It is the duty of every person having charge of another who is unable by reason of age, sickness, mental impairment, detention, or any other cause, to withdraw himself from such charge, and who is unable to provide himself with the necessities of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessities of life; and he is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.

34 However, that section must be read in conjunction with s 259 of the *Criminal Code* which makes specific provision in relation to surgical and medical treatment:

Surgical and medical treatment

- (1) A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) -

- (a) to another person for that other person's benefit; or
- (b) to an unborn child for the preservation of the mother's life,

if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

- (2) A person is not criminally responsible for not administering or ceasing to administer, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) if not administering or ceasing to administer the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

35 There is no doubt that the nutrition and hydration provided to Mr Rossiter through the PEG is 'surgical or medical treatment' within the meaning of s 259. The PEG was inserted by surgical means, and the precise mix of nutrition and hydration is supplied in accordance with medical principles and protocols. This conclusion is consistent with views expressed in other jurisdictions: *Re BWV; Ex parte Gardner* [2003] VSC 173; (2003) 7 VR 487 [74] - [79]; *Adult Guardian v Langham* [2005] QSC 127; (2006) 1 Qd R 1 [32].

36 It is of considerable significance to the resolution of the issues in this case that s 259 was amended by the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA). Indeed, subsection (2) of s 259 only came into operation on 27 June 2009. I will explain the significance of that amendment a little later.

37 There are other provisions of the *Criminal Code* which could come into operation if s 260 is construed as imposing upon Brightwater a legal duty to continue to provide Mr Rossiter with the necessities of life even though he has directed them not to. For example, if s 262 has the effect of imposing such a duty on Brightwater, it may be arguable that breach of that duty would lead to the conclusion that Brightwater had caused the death of Mr Rossiter within the meaning of s 270 or s 273 of the *Criminal Code*, with the consequence that the homicide provisions of the *Criminal Code* (including s 268 and s 277) might apply. Further, s 304 might also apply. That section provides that if a person omits to do any act that it is the person's duty to do, as a result of which the life, health or safety of any person is likely to be endangered, that person is guilty of a crime.

38 I digress to observe that if s 262 of the *Criminal Code* is to be construed as imposing a legal duty to provide medical treatment against

the wishes of a mentally competent patient, it would represent a drastic alteration of the common law position. That is because it would require a medical service provider who is under a common law duty to not provide services against the wishes of a patient, to provide services against the patient's wishes or face criminal prosecution for not doing so. Given the strength of the principle of self-determination to which I have referred, it seems inherently unlikely that the Parliament intended such a drastic change when enacting s 262 in its current form, and I would only conclude that it was Parliament's intention to make such a drastic change if compelled to that conclusion by the clear and unequivocal language of the section. It seems to me that there is no such clear and unequivocal language in that section and that therefore the first answer to the proposition that s 262 might apply to the circumstances of this case is that the section should not be read as extending to the imposition of duties which would be unlawful at common law.

39 I have not been able to find any previous cases dealing with the scope and application of s 262, or any similar statutory provision, in circumstances such as these. On a superficial reading of s 262, it might be thought to apply to this case and to impose a duty on Brightwater to provide Mr Rossiter with the necessities of life, irrespective of Mr Rossiter's wishes. That is because the section appears to apply in circumstances where a person has charge of another who is by reason of sickness unable to withdraw himself from such charge and who is unable to provide himself with the necessities of life. However, upon a more considered reading, it is clear that the section is aimed at a wide variety of circumstances in which, by reason of age, sickness, mental impairment, detention or any other cause, a person lacks the capacity to control or direct their own destiny and to provide themselves with the necessities of life. Put another way, it seems to me that in s 262 the reference to a person 'having charge of another' is a reference to a person who, by reason of one or more of the various disabilities identified in the section, lacks the capacity to direct or control their own destiny and is therefore dependent upon the person 'having charge' of them.

40 Mr Rossiter lacks the physical capacity to control his own destiny, but enjoys the mental capacity to make informed and insightful decisions in respect of his future treatment. In that latter respect he is not relevantly within 'the charge' of Brightwater. Rather, Brightwater is, in that respect, consistent with the well-established common law position to which I have referred, subject to Mr Rossiter's direction.

41 There is another reason why, in my view, s 262 might have no application to the circumstances of this case. Mr Rossiter has the capacity to give directions as to his future care, and it seems may have the financial capacity to implement those directions. There would be nothing preventing him from finding another service provider, and discharging himself from Brightwater and into the care of that other provider. If that were the case, he would not therefore be a person who is 'unable to withdraw himself' from the charge of Brightwater, but I lack the evidence to arrive at any final conclusion on this aspect of the possible application of s 262.

42 I therefore conclude that s 262 of the *Criminal Code* does not impose upon Brightwater a duty to provide the necessities of life to Mr Rossiter against his wishes.

43 Even if I am wrong in that view, in my opinion, s 259 of the *Criminal Code* provides Brightwater with a good defence to any claim that it would contravene the *Criminal Code* by discontinuing treatment in accordance with Mr Rossiter's informed decision to that effect.

44 Subsection (2) of that section specifically provides that a person is not criminally responsible for not administering medical treatment (including palliative care) if that course is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. Plainly, the phrase 'all the circumstances of the case' is quite broad enough to include the informed decision of a mentally competent patient. Having regard to the common law principle of self-determination to which I have referred, it is clearly 'reasonable' to act in accordance with the informed decision of a mentally competent patient who refuses to consent to medical treatment.

45 That proposition is strongly reinforced by the other provisions of the *Acts Amendment (Consent to Medical Treatment) Act* which caused subsection (2) to be introduced into the *Criminal Code*, which were all aimed at providing measures sometimes described as 'living wills' whereby persons are given the legal capacity to give directions as to the course of medical treatment which is to be followed after they lose mental or physical capacity. Many of those provisions have not yet been proclaimed, but they provide clear guidance to the intention of the legislature when enacting subsection (2) of s 259. It would be utterly inconsistent with the philosophy of that legislation to construe subsection (2) of s 259 in any way other than as reflecting the right of a patient to give directions in respect of their medical treatment, and the legal

obligation of medical service providers to not provide services contrary to those directions.

46 If and to the extent that it is said there is any ambiguity in the terminology used in subsection (2) of s 259, it is appropriate and legitimate to have regard to the Parliamentary Debates at the time of its enactment (see the *Interpretation Act 1984* (WA), s 19).

47 In the Second Reading Speech given in support of the Bill, the Hon Mr Jim McGinty MLA said:

The principle of personal autonomy is central to the bill. The bill establishes a simple, flexible scheme whereby persons can ensure that, in the event that they become mentally incompetent and require medical treatment for any condition, including a terminal illness, their consent, or otherwise, to specified treatment can be made clear in an advance health directive and or alternatively treatment decisions can be made by an enduring guardian chosen by them. ... The bill, however, will not change the position at common law whereby a health professional is under no obligation to provide treatment that is not clinically indicated. In other words, although a patient, or someone on the patient's behalf, will be entitled to refuse lawful treatment, there will still be no legal entitlement by a patient to demand treatment.

48 It is therefore clear that the entire thrust of the legislation which resulted in the introduction of subsection (2) of s 259 was aimed at giving force and effect to the common law principle of autonomy and self-determination to which I have referred. It would be utterly inconsistent with that legislative objective to construe s 259 as detracting from that common law position. Plainly, it was intended to give effect to it. This reinforces my view that s 259(2) of the *Criminal Code* provides Brightwater with a complete defence if they discontinue providing nutrition and hydration services at Mr Rossiter's request.

49 I therefore conclude that the statutory provisions to which I have referred do not in any way alter the clear position established pursuant to the common law principles which I have enunciated. It follows that it seems to me to be absolutely clear that after he has been provided with full information with respect to the consequences of any decision he might make, Mr Rossiter has the right to determine and direct the extent of the continuing treatment in the sense that treatment cannot and should not be administered against his wishes. If, after the provision of full advice, he repeats his direction to Brightwater that they discontinue the provision of nutrition and hydration to him, Brightwater is under a legal obligation to comply with that direction.

50 In the course of submissions, reference has been made to the possible application of subsection (1) of s 259 of the *Criminal Code*, and in particular, to the proposition that this subsection might provide Brightwater with a defence to any claim or charge brought as a consequence of the provision of medical treatment to Mr Rossiter against his wishes in the past. It would be entirely inappropriate for me to express any view on that issue. As I have mentioned, while declarations are sometimes given in respect of the criminality of proposed future conduct, declarations are not generally made in respect of the criminality of conduct which has taken place. To do so would entirely usurp the criminal process and the possible role of a jury. In any event, the expression of a view on that subject would depend upon findings of fact with respect to the precise circumstances in which medical treatment has been provided in the past, and I do not have adequate evidence before me to enable me to make those findings.

51 This brings me to the more difficult question of the provision of palliative care to Mr Rossiter following his withdrawal of consent to the provision of nutrition and hydration. That issue squarely raises the prospective application of subsection (1) of s 259, and in particular, that portion of the subsection which refers to the provision of palliative care.

52 There are a number of general principles which can be confidently stated in relation to this issue. The first is that the legal rights and obligations relating to the provision of palliative care are unaffected by the circumstance that the occasion for the provision of that care comes about as a consequence of Mr Rossiter's withdrawal of consent to the continuing provision of other medical treatment, namely, the provision of nutrition and hydration. Put another way, Dr Benstead's rights and obligations with respect to the provision of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of nutrition and hydration are no different to the obligations which attend the treatment of any other patient who may be approaching death. Even more specifically, in my view there is no reason why s 259(1) would not apply to the provision of palliative care to Mr Rossiter, even though the occasion for the provision of that palliative care comes about as a consequence of Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

53 The second general principle that may be stated is that if and to the extent that palliative care is administered with the informed consent of the patient, and does not have the effect of causing or hastening the death of that patient, no question of breach of legal obligation arises.

54 The third general principle which can be stated is that it is unlawful for any person, including any health professional, to administer medication for the purpose of causing or hastening the death of another person.

55 It will be seen that these general principles cover the ends of a spectrum of possible facts and circumstances. Within that spectrum is the circumstance in which medication which might be administered for the purpose of relieving pain or easing discomfort might have the incidental effect of hastening death. Section 259(1) might well provide a defence to any criminal charge brought in such a circumstance. Whether or not it does will, of course, depend upon all the particular facts and circumstances of that case, including the condition of the patient and the palliative care provided. Within the range of possible facts and circumstances, the application of the provisions of subsection (1) of s 259 will depend critically upon the particular facts and circumstances of the individual case. I have insufficient evidence before me to make any findings with respect to the particular facts and circumstances that might apply to the administration of palliative care to Mr Rossiter if and when he directs Brightwater to discontinue the provision of nutrition and hydration. Accordingly, I should not grant any declaratory relief in relation to those issues, other than to declare that any person providing palliative care to Mr Rossiter on the terms specified in s 259(1) would not be criminally responsible for providing that care notwithstanding that the occasion for its provision arises from Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

56 However, I would hope that the general principles I have enunciated would provide sufficient guidance to Dr Benstead and enable him to provide appropriate palliative care to Mr Rossiter if and when the occasion arises.

57 Finally, I would observe that although the evidence establishes that Mr Rossiter has on a number of occasions in the past directed Brightwater to cease the provision of nutrition and hydration, the question of whether or when he repeats such an instruction after this ruling and after the issue of the extent of the information given to him has been put beyond doubt, is entirely a matter for him. I would also observe that any such direction would not be irrevocable, and while he retains his capacities, could be revoked by him at any time. It follows that the precise terms of any declaratory relief granted in order to give effect to these reasons should take account of those contingencies.

I make declarations as follows:

- (1) If after Mr Rossiter has been given advice by an appropriately qualified medical practitioner as to the consequences which would flow from the cessation of the administration of nutrition and hydration, other than hydration associated with the provision of medication, Mr Rossiter requests that Brightwater cease administering such nutrition and hydration, then Brightwater may not lawfully continue administering nutrition and hydration unless Mr Rossiter revokes that direction, and Brightwater would not be criminally responsible for any consequences to the life or health of Mr Rossiter caused by ceasing to administer such nutrition and hydration to him.
- (2) Any person providing palliative care to Mr Rossiter on the terms specified in s 259(1) of the *Criminal Code* would not be criminally responsible for providing that care notwithstanding that the occasion for its provision arises from Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

Reported 74 NSWLR 88
Decision :



New South Wales Supreme Court

CITATION :	Hunter and New England Area Health Service v A [2009] NSWSC 761
HEARING DATE(S) :	15 July 2009
JUDGMENT DATE :	6 August 2009
JURISDICTION :	Equity Division
JUDGMENT OF :	McDougall J at 1
DECISION :	See paragraph [61] of the judgment.

CATCHWORDS :	MEDICINE - medical practitioners - refusal of medical treatment - unconscious patient - advance care directive stating patient's desire to refuse certain treatments - whether directive was a valid indication of patient's desire - capacity - whether patient had capacity to decide to refuse treatment when directive made - patient's right of self-determination even where withdrawal of treatment would have life threatening consequences. - PRACTICE - approach to be taken by medical practitioners - application to court - desirable where uncertainty exists regarding capacity or intention of unconscious patient.
LEGISLATION CITED :	Guardianship Act 1987
CATEGORY :	Principal judgment
CASES CITED :	Airedale NHS Trust v Bland [1993] AC 789 F v R (1983) 33 SASR 189 F v West Berkshire Health Authority (Mental Health Act Commission Intervening) [1990] 2 AC 1 In re AC 573 A 2d 1235 (1990) Malette v Shulman 67 DLR (4th) 321 (1990) Re Bridges [2001] 1 Qd R 574 Re MB [1997] 2 FCR 514 Rogers v Whitaker (1992) 175 CLR 479 Schloendorff v Society of New York Hospital (1914) 211 NY 125
PARTIES :	Hunter and New England Area Health Service (Plaintiff) A by his tutor T (Defendant)
FILE NUMBER(S) :	SC 3683/09
COUNSEL :	G M Gregg (Plaintiff)

SOLICITORS :

Director, Legal & Legislation and General Counsel
NSW Health (Plaintiff)

**IN THE SUPREME COURT
OF NEW SOUTH WALES
EQUITY DIVISION**

McDOUGALL J

6 August 2009

**3683/08 HUNTER NEW ENGLAND AREA HEALTH SERVICE v A by his
tutor T**

JUDGMENT

1 HIS HONOUR: When these proceedings were heard, the defendant (Mr A) was a patient in a hospital conducted by the plaintiff (the Service). He had been admitted to the emergency department of the hospital on 1 July 2009, suffering from septic shock and respiratory failure and showing a decreased level of consciousness. He was transferred to the Intensive Care Unit the following day. Although all appropriate treatment had been given to Mr A, his condition deteriorated and he developed renal failure. By 14 July 2009, Mr A was being kept alive by mechanical ventilation and kidney dialysis.

2 On 14 July 2009, the Service became aware that a document apparently prepared by Mr A a year earlier, on 19 August 2008, indicated that he would refuse dialysis. In those circumstances, the Service commenced these proceedings seeking (by its amended summons filed on 15 July 2009) declarations to the effect that the document to which I have referred was a valid “Advance Care Directive” given by Mr A, and that it would be justified in complying with his wishes as expressed in that directive.

3 I made the declarations as sought, and said that I would give my reasons for doing so at a later date. These are my reasons.

What this case does and does not involve

4 This case is concerned, at the level of principle, with the right of a capable adult to refuse medical treatment; and, at the particular level, with the question of whether the advance care directive prepared by Mr A was a valid exercise of that right. It is not concerned with any such notion as “the right to die”. That is so even if (as it appears is the case) the likely consequence of giving effect to Mr A’s wishes, as expressed in the advance care directive, is that he will die.

Right to choose: the principles

The relevant interests

5 The common law recognises two relevant but in some cases conflicting interests:

(1) a competent adult’s right of autonomy or self-determination: the right to control his or her own body; and

(2) the interest of the State in protecting and preserving the lives and health of its citizens.

6 In *Schloendorff v Society of New York Hospital* (1914) 211 NY 125, Cardozo J said at 129 that “[e]very human being of adult years and sound mind had has a right to determine what shall be done with his own body”.

7 In a somewhat different context, King CJ in *F v R* (1983) 33 SASR 189 at 193 identified “the paramount consideration that a person is entitled to make his own decisions about his life”. His Honour’s statement was cited with approval by Mason CJ, Brennan, Dawson, Toohey and McHugh JJ in *Rogers v Whitaker* (1992) 175 CLR 479 at 487.

8 Cardozo J’s statement has been cited and applied in many cases. Thus, in *Malette v Shulman* 67 DLR (4th) 321 (1990), Robins JA, speaking with the concurrence of Catzman and Carthy JJA, said at 328 that “[a] competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. ... it is the patient who has the final say on whether to undergo the treatment”.

The conflict

9 The competing interests, and the possibility of conflict, were recognised by Lord Donaldson of Lynton MR in *Re T* [1993] Fam 95 at 112. His Lordship pointed out that there may be (and was in the case before the Court) a conflict between a competent adult patient’s right of self-determination and the interest of society in the preservation of life. His Lordship recognised that, at least when other factors did not tip the balance one way or the other, the individual patient’s right was paramount. Nonetheless, his Lordship said, if there were doubt as to the individual’s expression of preference, “that doubt falls to be resolved in favour of the preservation of life”.

10 Butler-Sloss LJ, who agreed with the general propositions of law stated by the Master of the Rolls, said at 116 that “[a] man or woman of full age and sound understanding may choose to reject medical advice and medical or surgical treatment either partially or in its entirety. A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered”. Her Ladyship expressly agreed with the reasoning of the Court of Appeal of Ontario in *Malette*. (The Master of the Rolls had referred to *Malette*, without any apparent disapproval, at 114.)

11 The third member of the Court, Staughton LJ, expressed himself in similar terms. He said at 120-121 that “[a]n adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment. Thus far the law is clear.”

12 *Malette* concerned what it is convenient to call an advance care directive. Ms Malette was a Jehovah’s Witness. She carried with her a card stating her adherence to that faith, and stating in no uncertain terms that, whilst understanding the implications of her decision, she did not wish blood or blood products to be administered to her under any circumstances. The Court of Appeal held that the defendant, Dr Shulman, who had express notice of the terms of that card, was not entitled to disregard it.

13 *Re T* was a different case. The plaintiff, Ms T, gave what the trial judge found was an oral directive refusing blood transfusion after she had been admitted to hospital, and when (on the medical evidence) her life was in danger if she were not transfused. She had been a Jehovah’s Witness, but there was some reason to doubt the continuing strength of her adherence to the tenets of that creed. The questions to be decided by the Court of Appeal were whether that oral directive was an expression of Ms T’s free will, and whether it applied to the situation at hand. The Court answered both questions in the negative.

14 In *Malette*, Robins JA pointed out at 328 that the recognition of the freedom of competent adults to make choices about their medical care necessarily encompassed recognition of the right “to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others”. It follows that a medical practitioner confronted with a clear choice made by a competent adult on the basis of social, religious or moral values must respect that choice, even though the practitioner does not share the values underpinning it.

15 Indeed, even a decision lacking any apparent justification must be respected. See Lord Donaldson in *Re T* at 113: “the patient’s right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent”. However, the lack of any discernible basis for a decision to refuse treatment may be something to take into account in assessing the competence or validity of the decision.

16 Recognition of the right to reject medical treatment does not depreciate the value of life. As Robins JA said in *Malette* at 334, “[i]ndividual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life”. His Lordship’s analysis – with which, respectfully, I agree – raises a question as to the extent of the tension between the individual and state interests that I identified at [5] above. Clearly, Lord Donaldson thought that there was such a tension (*Re T* at 112: see at [9] above). Were it necessary to resolve the tension, I would conclude, with Robins JA in *Malette*, that a proper understanding of society’s interest in the preservation of life cannot be considered without taking into account the constituents, or attributes, of life. In a free and democratic society those attributes include the right of autonomy or self-determination. Thus, one would think, the concept of “life” that is the subject of the State’s interest is a concept that has annexed to it that right (no doubt, among others). But, it being unnecessary to resolve that issue for the purpose of these reasons, I will say no more.

Supremacy of the individual’s right

17 It is in general clear that, whenever there is a conflict between a capable adult’s exercise of the right of self-determination and the State’s interest in preserving life, the right of the individual must prevail. (I note, but leave to one side, because it does not arise in this case, the situation where the State takes drastic action to deal with a widespread and dangerous threat to the health of its citizens at large.) In *Airedale NHS Trust v Bland* [1993] AC 789, Lord Keith of Kinkel said at 859 that the State’s interest is not absolute, and does not compel treatment of a patient contrary to the patient’s express wishes. In the same case, Lord Goff said at 864 that:

“it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so. ... [t]o this extent, the principle of the sanctity of human life must yield to the principle of self-determination... “.

18 Lord Mustill expressed himself to similar effect at 894.

19 There may be an exception to the principle that a capable adult’s right of self-determination is paramount. Lord Donaldson in *Re T* at 102 noted, as a “possible qualification” to the paramountcy of that right, “a case in which the choice may lead to the death of a viable foetus”.

20 Brown P was faced with precisely that situation in *Re S* [1993] Fam 123. In that case, his Lordship said at 124, the medical evidence was “emphatic” that a particular operation was necessary to save the mother’s life, and the life of her unborn child. He said that the child could not be born alive if the operation were not carried out. In those circumstances, Brown P declared that the operation and any necessary consequential treatment could lawfully be performed despite the mother’s refusal of consent.

21 That situation has been recognised in the American courts, including by the Court of Appeals of the District of Columbia in *In re AC* 573 A 2d 1235 (1990). Terry J, for the majority, noted at 1246 that there were “rare cases in which a patient’s right to decide her own course of treatment has been judicially overridden”. That was usually done “to vindicate the state’s interest in protecting third parties, even if in fetal state”. His Honour cited a number of authorities. In that case, Belson J dissented in part. The point of his Honour’s dissent was to emphasise, more than he thought the majority judgment had done, the State’s interest in protecting the interests of a viable unborn child (see at 1254-1255).

22 Since the question does not arise in this case, it is neither desirable nor necessary that I should explore it further.

Capacity

23 There is a presumption of capacity, whereby an adult “is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted”(see Butler-Sloss LJ in *Re MB* [1997] 2 FCR 514 at 553).

24 In this context, it is necessary to bear in mind that there is no sharp dichotomy between capacity on the one hand and want of capacity on the other. There is a scale, running from capacity at one end through reduced capacity to lack of capacity at the other. In assessing whether a person has capacity to make a decision, the sufficiency of the capacity must take into account the importance of the decision (as Lord Donaldson pointed out in *Re T* at 113). The capacity required to make a contract to buy a cup of coffee may be present where the capacity to decide to give away one’s fortune is not.

25 As Butler-Sloss LJ said in *Re MB* at 553 – 554, in deciding whether a person has capacity to make a particular decision, the ultimate question is whether that person suffers from some impairment or disturbance of mental functioning so as to render him or her incapable of making the decision. That will occur if the person:

(1) is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or

(2) is unable to use and weigh the information as part of the process of making the decision.

Vitiating of consent

26 An apparent consent (or refusal of consent) may be ineffective for a number of reasons. First, the individual concerned may not have been competent in law to give or refuse that consent. Secondly, even if the individual were competent in law, the decision may have been obtained by undue influence (as, the Court of Appeal found, had happened in *Re T*) or some other vitiating means. Thirdly, the apparent consent or refusal may not extend to the particular situation (which was the basis on which the primary judge in *Re T* rested his decision; and the Court of Appeal agreed with this aspect of his reasoning). This was indeed one of the arguments advanced for Dr Shulman in *Malette*. Fourthly (and to some extent this overlaps with the previous category) the terms of the consent or refusal may be ambiguous or uncertain.

27 I referred in the second category to undue influence or other vitiating factors. It has been suggested that a refusal of medical treatment will be vitiated if it is based on incorrect information or an incorrect assumption. Thus, in *Re T*, Ms T was told that there would be effective alternatives to blood transfusion, and that it was unlikely that it would be necessary to transfuse her; whereas in fact the likelihood of transfusion was high (Ms T was to undergo a caesarean section) and there were no adequate alternatives to transfusion.

28 Another factor that has been suggested to vitiate refusal of treatment is the absence of, or failure to provide, adequate information. I do not accept the proposition that, in general, a competent adult's clearly expressed advance refusal of specified medical procedures or treatment should be held to be ineffective simply because, at the time of statement of the refusal, the person was not given adequate information as to the benefits of the procedure or treatment (should the circumstances making its administration desirable arise) and the dangers consequent upon refusal. As I have said, a valid refusal may be based upon religious, social or moral grounds, or indeed upon no apparent rational grounds; and is entitled to respect (assuming of course that it is given freely, by a competent adult) regardless. But more fundamentally, the concept of informed refusal seems to me to involve some degree of confusion.

29 There is no doubt that an apparent consent to medical treatment may be vitiated if, there being an adequate opportunity explanation of the treatment and its benefits and dangers, no proper explanation is given. See, for example, *Rogers v Whitaker* (1992) 175 CLR 479 at 489, where Mason CJ, Brennan, Dawson Toohey and McHugh JJ said (omitting citations) that "all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice... it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that

matter, of the medical profession”.

30 In circumstances where it is practicable for a medical practitioner to obtain consent to treatment, then, for the consent to be valid, it must be based on full information, including as to risks and benefits. But the question with which I am concerned is whether an advance refusal of consent to certain specified forms of medical treatment equally needs to be supported by the provision of all adequate information. The reason for obtaining consent to treatment is to justify in law what would otherwise be a battery (I leave aside the emergency situation where consent cannot be obtained). A consent that is based on misleading information is clearly of no value; and a consent based on insufficient information is not much better. But once it is accepted that religious, social or moral convictions may be of themselves an adequate basis for a decision to refuse consent to medical treatment, it is clear that there is no reason that a decision made on the basis of such values must have taken into account the risks that may follow if a medical practitioner respects and acts upon that decision. This is so a fortiori where there is no discernible rational basis for the decision. No question arises of justifying what would otherwise be unlawful, and factors to be taken into account in determining whether something is or is not unlawful do not have application by analogy.

The emergency principle

31 Where it is not practicable for a medical practitioner to obtain consent for treatment, and where the patient’s life is in danger if appropriate treatment is not given, then treatment may be administered without consent. This is justified by what is sometimes referred to as the “emergency principle” or “principle of necessity”.

32 Lord Donaldson referred to the “the classic emergency situation with an unconscious patient” in *Re T* at 103. His Lordship said that, in such a situation, “the practitioner can lawfully treat the patient in accordance with his clinical judgment of what is in the patient’s best interests”. Staughton LJ referred to “the principle of necessity” in the same case at 121. His Lordship referred to the speech of Lord Goff of Chieveley in *F v West Berkshire Health Authority (Mental Health Act Commission Intervening)* [1990] 2 AC 1 at 25 – 26. Lord Goff said that, for the principle of necessity to apply, two conditions must be met:

- (1) There must be “a necessity to act when it is not practicable to communicate with the assisted person”; and
- (2) “the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person”.

33 I would add to his Lordship’s first condition the words “or some other person authorised to give consent on behalf of the assisted person”.

34 However, Lord Goff pointed out, the principle of necessity does not apply

where, among other things, the proposed action “is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish”. It follows that the principle of necessity cannot be relied upon to justify a particular form of medical treatment where the patient has given an advance care directive specifying that he or she does not wish to be so treated, and where there is no reasonable basis for doubting the validity and applicability of that directive.

Approach to be taken

35 What approach should the courts take in assessing what is said to be an advance refusal of medical care? This question cannot be answered in the abstract. In some cases – and, at least to the Court of Appeal, *Re T* seems to have been such a case – the circumstances will be such that careful analysis is required.

36 It is proper, and not inconsistent with an individual’s right of self-determination, that if there is any real doubt as to the sufficiency of an advance refusal of medical treatment, the court should undertake a careful analysis. But the analysis should start by respecting the proposition that a competent individual’s right to self-determination prevails over the State’s interest in the preservation of life even though the individual’s exercise of that right may result in his or her death. An over-careful scrutiny of the material may well have the effect of undermining or even negating the exercise of that right.

37 It is necessary to bear in mind that not all those who execute advance care directives are legally trained. Their words should not be scrutinized with the care given to a particularly obscure legislative expression of the will of Parliament. On the other hand, particularly bearing in mind the likely consequences of upholding an apparent exercise of the right of self-determination, the court must feel a sense of actual persuasion that the individual acted freely and voluntarily, and intended his or her decision to apply to the situation at hand. As Robins JA pointed out in *Malette* at 337, if a medical practitioner is to act on doubts as to the validity of an advance refusal of medical treatment, those doubts must be rationally founded. The same applies to a court asked to determine the validity of an advance refusal of medical treatment. It cannot be correct to recognise, on the one hand, an individual’s right of self determination; but, on the other, effectively to undermine or take away that right by over-nice or merely speculative analysis.

The Guardianship Act 1987

38 As will be seen, Mr A had executed an instrument in writing appointing two people, his tutor in these proceedings Mr T and a Mr L, to be his guardians jointly and severally. The appointment was expressed to be enduring (see s 6D of the *Guardianship Act 1987*). By that appointment, Mr A authorised each of his enduring guardians, among other things, to decide what health care he should receive and to consent to the carrying out on him of medical or dental treatment.

39 By s 6A of the *Guardianship Act*, an appointment under Pt 2 (which is the part of the Act under which Mr A appointed Messrs T and L) has effect during such period of time as the appointor is a person in need of a guardian. By s 3(1) a “person in need of a guardian” is “a person who, because of a disability, is totally or partially incapable of managing his or her person”. It is not necessary to set out, or to consider, the statutory concept of “disability” (see s 3(2) of the *Guardianship Act*); nor is it necessary to consider the relationship between the statutory concepts of a person having a disability (s 3(2)) and a person incapable of giving consent (s 33(2)). That is because, if the appointment of Messrs T and L as enduring guardians had effect (which it would if Mr A were a person who had a disability), the mechanism for obtaining consent from Mr T or Mr L has not been invoked (see s 40). I do however note that, for the purposes of Pt 5 (see, for example, s 37, and in particular subs (3)(b)), a person is taken to object to the carrying out of medical treatment if, among other things, that person has previously indicated, in similar circumstances, that he or she did not then want the treatment to be carried out, and has not subsequently indicated to the contrary (s 33(3)(b)). Thus, to some extent and for some purposes, the *Guardianship Act* may give recognition to advance care directives.

Summary of principles

40 There does not appear to be a great body of authority in Australia dealing with the relevant principles. (The decision of Ambrose J in *Re Bridges* [2001] 1 Qd R 574 focused on relevant Queensland legislation, and on its application on the facts of that case.) Accordingly, to assist those faced with emergency care decisions, I summarise my understanding of the relevant principles (whilst acknowledging that what I say will not apply in every conceivable circumstance):

(1) except in the case of an emergency where it is not practicable to obtain consent (see at (5) below), it is at common law a battery to administer medical treatment to a person without the person’s consent. There may be a qualification if the treatment is necessary to save the life of a viable unborn child.

(2) Consent may be express or, in some cases, implied; and whether a person consents to medical treatment is a question of fact in each case.

(3) Consent to medical treatment may be given:
by the person concerned, if that person is a capable adult;
by the person’s guardian (under an instrument of appointment of enduring guardian, if in effect; or by a guardian

appointed by the Guardianship Tribunal or a court);
by the spouse of the person, if the relationship between the person and the spouse is close and continuing and the spouse is not under guardianship; by a person who has the care of the person; or
by a close friend or relative of the person.

(4) At common law, next of kin cannot give consent on behalf of the person. However, if they fall into one or other of the categories just listed (and of course they would fall into at least the last) they may do so under the *Guardianship Act*.

(5) Emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person's consent if the person's condition is such that it is not possible to obtain his or her consent, and it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out.

(6) A person may make an "advance care directive": a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive. Again, there may be a qualification if the treatment is necessary to save the life of a viable unborn child.

(7) There is a presumption that an adult is capable of deciding whether to consent to or to refuse medical treatment. However, the presumption is rebuttable. In considering the question of capacity, it is necessary to take into account both the importance of the decision and the ability of the individual to receive, retain and process information given to him or her that bears on the decision.

(8) If there is genuine and reasonable doubt as to the validity of an advance care directive, or as to whether it applies in the situation at hand, a hospital or medical practitioner should apply promptly to the court for its aid. The hospital or medical practitioner is justified in acting in

accordance with the court's determination as to the validity and operation of the advance care directive.

(9) Where there is genuine and reasonable doubt as to the validity or operation of an advance care directive, and the hospital or medical practitioner applies promptly to the court for relief, the hospital or practitioner is justified, by the emergency principle, in administering the treatment in question until the court gives its decision.

(10) It is not necessary, for there to be a valid advance care directive, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment. Nor does it matter that the person's decision is based on religious, social or moral grounds rather than upon (for example) some balancing of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by any discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misrepresentation, by a capable adult.

(11) What appears to be a valid consent given by a capable adult may be ineffective if it does not represent the independent exercise of persons volition: if, by some means, the person's will has been overborne or the decision is the result of undue influence, or of some other vitiating circumstance.

41 I have spoken above in terms of medical treatment, and hospitals and medical practitioners. However, the principles apply more broadly: to all those (including ambulance officers and paramedics) who administer medical treatment. They extend further to other forms of treatment (for example, dental treatment) where, without consent, the treatment would constitute a battery.

Mr A appoints enduring guardians

42 On 5 July 2009, Mr A attended a solicitor, Mr N. Mr N had had a number of clients who were Jehovah's Witnesses. He said that, when he was instructed to prepare appointments of enduring guardians for Jehovah's Witnesses, it was his practice to explain to them the risks attending refusal of blood transfusion. In this case, the form of appointment expressly stated:

I REQUIRE THAT EACH OF MY ENDURING
GUARDIANS EXERCISE HIS OR HER
FUNCTIONS SUBJECT TO THE FOLLOWING
DIRECTIONS:

As one of Jehovah's Witnesses **I DIRECT** my
guardian to refuse consent for a

TRANSFUSION of whole blood, red cells, white cells, platelets, or blood plasma to be given to me under any circumstances even if health-care providers believe that such are necessary to preserve my life or even it any of my family, my relatives, or my friends, disagrees with my considered and non-negotiable decision. **I ALSO DIRECT** my guardian to refuse any pre-donation and storage of my blood for later infusion under any circumstances.

43 However, Mr N said, he did not explain the risk of refusing dialysis, because in his understanding, it was unclear whether, according to the beliefs held by Jehovah's Witnesses, there was any biblical proscription of this form of treatment.

44 Mr N said further that he knew that congregations of Jehovah's Witnesses had a practice making available to members documents described as "Worksheet 1" and "Worksheet 2", by which those members could indicate their attitude to various forms of medical treatment specified in the worksheets. However, Mr N did not give those worksheets to Mr A.

The worksheets

45 There were in evidence two documents – Worksheet 1 and Worksheet 2 – completed with the full name and then address of Mr A, and dated 19 August 2008. Mr T identified those documents as having been completed by Mr A. By Worksheet 1, Mr A indicated that he would refuse five specified forms of medical treatment, but that he would accept one other. It is not necessary to go to the details.

46 Worksheet 2 concerned, on its face:

"Procedures involving the medical use of your own blood"

47 It stated that:

"[t]he methods of applying each of these medical procedures vary from physician to physician. You should have your physician explain exactly what is involved in any proposed procedure to ensure that it is in harmony with Bible principles and with your own conscientious decisions."

48 There then followed three columns. The first was headed "Name of Treatment". The second was headed "What It Accomplishes". The third was headed "Choices You Need to Make". Under the heading of the third column appear words which, so far as they are legible, read: "(you might want to speak to your physician before authorising or refusing any of these procedures)". Under the first column, some eight different treatments were

specified, including, as the fourth, “Dialysis”. The explanation given to this treatment was:

“Functions as an organ. In haemodialysis, blood circulates through a machine that filters and cleans it before returning it to the patient”.

49 Under the third column, three alternative choices were specified:

I accept

I might accept *

I refuse

50 For “Dialysis”, Mr A ticked the third of those choices (as, to the extent that it is relevant, he did for all but one of the other procedures).

51 Mr T, who was a member of the same congregation as Mr A, and who may be inferred to be a friend of Mr A, said that Worksheet 2 reflected Mr A’s wishes. It is apparent that, in Mr T’s view, this was so not only at the time the document was prepared but also at all material times thereafter.

52 Mr T said further that, in his opinion, Mr A was perfectly capable of making up his own mind both as at 19 August 2008 and at the time he was admitted to the hospital.

53 Considering the evidence as a whole, I am satisfied that Worksheet 2 did represent Mr A’s considered views. Mr T said that Mr A “was a simple man with an uncomplicated way of living however he was adamant about the things he didn’t want”. On the basis of Mr T’s evidence and Worksheet 2, I am satisfied that dialysis was indeed one of the things that Mr A “didn’t want”.

Application of the principles to the facts

54 I conclude that Worksheet 2 represents a considered decision made by Mr A, and that when Mr A made that decision (and, to the extent that it may be relevant, when he was admitted to hospital), Mr A was in law capable of making the decision to refuse dialysis.

55 I do not know whether the decision to refuse dialysis was based on some religious principle, although there is a basis in the evidence for inferring that it was. But, regardless, it is a considered decision made by a person of legal capacity.

56 Returning to the principles, I consider that Worksheet 2 in general, and the advance refusal of dialysis in particular, represent Mr A’s prospective exercise of his right of self-determination: his right to decide what should be done to his own body. There is nothing in the evidence to suggest that his expression of intent was vitiated in any way. On the contrary, it seems to me to be clear that it was his own voluntary decision.

57 Thus, in my view, the intention expressed in Worksheet 2 was one to which the hospital was required to give effect. To put the matter negatively: I think that Worksheet 2 meant that the hospital could not be taken to have

been authorised, by the emergency principle or otherwise, to administer dialysis to Mr A.

58 That is not a criticism of the hospital. The worksheets that were provided to it were not signed by Mr A, although on Mr T's evidence they had been completed by Mr A in his own handwriting. Further, there is perhaps some tension between the appointment of enduring guardians – which, as I have said, explicitly prohibits only blood transfusion – and the form of the worksheets. In my view, in circumstances where Mr A was unable to give instructions (because he was unable to communicate), the hospital acted rightly in taking steps to preserve his life whilst seeking the Court's decision. In this regard, I respectfully agree with what Lord Donaldson MR said in *Re T* at 115:

“If in a potentially life threatening situation or one in which irreparable damage to the patient's health is to be anticipated, doctors or hospital authorities are faced with a refusal by an adult patient to accept essential treatment and they have real doubts as to the validity at that refusal, they should in the public interest, not to mention that of their patient, at once seek a declaration from the courts as to whether the proposed treatment would or would not be lawful.”

59 At 116, his Lordship, in a summary of his view as to the legal principles applicable, said that “[i]n cases of doubt as to the effect of a purported refusal of treatment, where failure to treat threatens the patient's life or threatens irreparable damage to his health, doctors and health authorities should not hesitate to apply to the courts for assistance”.

60 On the basis of the medical evidence, I accept that the result of withdrawal of dialysis will be to hasten Mr A's death. That is a consequence of the decision that he made, as signified in Worksheet 2. What my orders did was recognise his right to make that decision. As I said towards the outset of these reasons, it is no recognition of a “right to die”.

Conclusion

61 For those reasons, the hospital was entitled to the declarations sought.

62 It is appropriate, before I conclude these reasons, to acknowledge (as I did when I made the declarations sought) the assistance that the Court received. I refer not only to the efforts of Mr Gregg of counsel and his instructing solicitor Ms Richards (who between them, in a short time, were able to amass a helpful body of authorities and other material, and to put before the Court the evidence that I have summarised), but also Mr T and Mr N. Both those gentleman responded, on very short notice, to questions from Ms Richards. They were able to give her information which she put before the Court in an affidavit sworn by her on information and belief. That

affidavit provided much of the foundation for the factual findings that I have made.

63 Finally, I acknowledge the responsible attitude taken by the hospital, and in particular by the treating doctor, Dr D. Dr D swore an affidavit that was read in the proceedings, and which is the other major basis for the factual findings that I have made.

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- Voluntary Euthanasia Process -

(REACTIVE)

(PROACTIVE)

