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# Withholding and withdrawal of ‘futile’ life-sustaining treatment: Unilateral medical decision-making in Australia and New Zealand

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## ABSTRACT

This article examines the law in Australia and New Zealand that governs the withholding and withdrawal of ‘futile’ life-sustaining treatment. Although doctors have both civil and criminal law duties to treat patients, those general duties do not require the provision of treatment that is deemed to be futile. This is either because futile treatment is not in a patient’s best interests or because stopping such treatment does not breach the criminal law. This means, in the absence of a duty to treat, doctors may unilaterally withdraw or withhold treatment that is futile; consent is not required. The article then examines whether this general position has been altered by statute. It considers a range of suggested possible legislation but concludes it is likely that only Queensland’s adult guardianship legislation imposes a requirement to obtain consent to withhold or withdraw such treatment.

## <DIV>INTRODUCTION

Sometimes disputes can arise where a health care team believes that treatment is ‘futile’ and so should not be provided but the patient or her or his loved ones disagree and want treatment to be given. This can lead to the involvement of the courts or tribunals, and occasionally, details of specific cases spill over into the media. In 2004, a decision made by the director of an intensive care unit to remove life-support from a 75-year-old man resulted in spectacular media coverage, including photos of life-support being turned off and headlines of ‘out of their hands’ and ‘[I]ast moments of a condemned man’.<sup>1</sup> While this case concerned an adult patient who had lost decision-making capacity, conflict can arise in other contexts as well. In that same year in England, Leslie Burke, a 45-year-old man with a degenerative brain condition which affected his physical capabilities (but did not impair his mental capacity), legally challenged the right of his treating team to withhold artificial nutrition and hydration when he approached the end of his life.<sup>2</sup> And in 2003, much publicity surrounded the English case of Charlotte Wyatt, a premature baby whose parents fought a ‘not for resuscitation’ order placed on her by the hospital.<sup>3</sup>

This article undertakes an analysis of the law in Australia and New Zealand that governs the provision of treatment that is regarded as ‘futile’ by the treating doctor. It begins by identifying the source of the legal obligations imposed on doctors to provide potentially life-sustaining treatment to patients under criminal and civil law.

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<sup>1</sup> Jones G, ‘Out of Their Hands’, *Daily Telegraph* (13 November 2004) pp 31-33. This case was the subject of a ruling of the New South Wales Supreme Court in *Messiha v South East Health* [2004] NSWSC 1061.

<sup>2</sup> Although Burke was successful at first instance in *R (Burke) v General Medical Council* [2005] QB 424, that decision was overturned by the Court of Appeal in *R (Burke) v General Medical Council* [2006] QB 273.

<sup>3</sup> There was a series of cases in which Charlotte’s treatment was the subject of judicial proceedings. See eg *Re Wyatt (A Child) (Medical Treatment: Parents’ Consent)* (2004) 84 BMLR 206 and *Re Wyatt (A Child) (Medical Treatment: Continuation of Order)* (2005) 86 BMLR 173.

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The authors then explore the implications that considering the relevant treatment to be 'futile' has on those obligations. The cases to date have concluded that there is no obligation to provide futile treatment either because it is not in the patient's best interests to receive it or because a failure to treat in these circumstances will not breach the relevant criminal law duty. As will be shown, the current law grants doctors a very high degree of autonomy in this area as they have the power to determine that treatment is futile and such an assessment (unless successfully challenged in the courts or tribunals) removes the obligation to treat. This means in Australia (the position is less certain in New Zealand) that there is no obligation at common law to obtain a patient's consent or the consent of her or his loved ones before making this decision. This power is referred to here as one to 'unilaterally withhold or withdraw potentially life-sustaining treatment' as the doctor herself or himself has lawful authority to make this decision. Consent is not required and neither is authorisation from any other source such as a court, tribunal or statute.

The article then considers whether statute has displaced this general position. It closely examines legislation in four Australian jurisdictions (New South Wales, Queensland, South Australia and Western Australia) where the literature or case law have suggested, or at least considered the possibility, that legislative reform has removed in some circumstances the power of doctors to unilaterally withhold or withdraw potentially life-sustaining treatment. The authors ultimately conclude that statute has only altered the general legal position in relation to adults who lack capacity in Queensland.

### **<subdiv>Terminology**

Before turning to this analysis of the law, two issues of terminology are addressed. The first relates to the meaning of 'futile' or 'futility'. Despite repeated attempts to define this term in literature spanning the disciplines of law, medicine, nursing and ethics, the concept remains contested and there is no consensus as to the meaning of the term.<sup>4</sup> Definitions range from 'will not work' to 'will not achieve survival of x, y, or z days or months' to 'not worth doing' (where 'worth' is assessed according to the value ascribed to the quality of life achieved as a result of the treatment).<sup>5</sup> However, for present purposes (ie, explaining what the law is rather than what it should be), it is sufficient to note that the term exists and is used in the literature and the case law, and that a determination of futility has implications for whether or not the law requires that treatment be provided. As has been noted, whether treatment is considered futile or not is a matter for the treating doctors at first instance but this assessment can be challenged before courts and tribunals.

The second terminology issue is that the term "substitute decision-maker" is used as a generic description for one person who is legally authorised to give or refuse consent to medical treatment on behalf of another who is incompetent. Although this is generally a term used for decision-makers for adults, this article considers both adults and children and so the term will include a decision-maker for both.

### **<div>LEGAL DUTIES TO PROVIDE POTENTIALLY LIFE-SUSTAINING TREATMENT**

The starting point for determining whether, as a matter of law, a doctor must provide potentially life-sustaining treatment to a patient is to identify the duties to which he or she is subject. These duties

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<sup>4</sup> See eg Helft PR, Siegler M and Lantos J, 'The Rise and Fall of the Futility Movement' (2000) 343(4) NEJM 293; Kerridge I, Mitchell K and McPhee J, 'Defining Medical Futility in Ethics, Law and Clinical Practice: An Exercise in Futility?' (1997) 4 JLM 235.

<sup>5</sup> For a discussion of the distinction between futile 'not worth doing' and futile 'will not work', see Baylis F, 'Expert Testimony by Persons Trained in Ethical Reasoning: The Case of Andrew Sawatzky' (2000) 28(3) *Journal of Law, Medicine and Ethics* 224.

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may be based in criminal law or civil law.<sup>6</sup> This article does not seek to describe these duties in particular depth, as their existence and source are not controversial.<sup>7</sup>

### <subdiv>Criminal law

The criminal law gives rise to duties to provide potentially life-sustaining treatment in certain circumstances.<sup>8</sup> At common law in Australia, a person who voluntarily assumes responsibility for another who is unable to care for themselves due to mental or physical incapacity, has a duty to provide that other with the necessities of life.<sup>9</sup> This common law duty operates in the Australian Capital Territory, New South Wales, South Australia and Victoria. An equivalent duty is imposed in the jurisdictions of the Northern Territory, Queensland, Tasmania and Western Australia that are governed by Criminal Codes.<sup>10</sup> Further, at both common law and in the Code jurisdictions, a similar duty arises in relation to the provision of the necessities of life to children.<sup>11</sup> The general duty to provide the necessities of life in New Zealand is contained in the *Crimes Act 1961* (NZ).<sup>12</sup>

This duty to provide the necessities of life has been identified as the principal source of potential criminal responsibility for those involved in decisions to withhold or withdraw potentially life-sustaining treatment.<sup>13</sup> There are two main components to this duty. First, the duty extends to the 'necessaries of life'. Secondly, the duty to provide the necessities of life arises only if a doctor has the care or charge of a person, and that person is unable to care for themselves.<sup>14</sup> Each component is considered in turn.

First, 'necessaries of life'. If the medical treatment is not a 'necessary of life', the duty imposed by the criminal law does not arise. The plain meaning of the term is clear: a necessary of life is treatment that is required to keep a person alive. In most instances, this would be a straightforward assessment.

The case of *Brightwater Care Group v Rossiter* (2009) 40 WAR 84; [2009] WASC 229 is illustrative. Rossiter was a man with quadriplegia who was being kept alive by the delivery of artificial nutrition and hydration through a tube into his stomach. He was not in the terminal phase of an illness and, provided the treatment was given, he would have continued to live. He decided that he no longer wished to receive such medical treatment and asked the facility that was providing him with care to withdraw the artificial nutrition and hydration. The lawfulness of the proposed withdrawal was considered by the Western Australian Supreme Court. In declaring that, in the circumstances of the

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<sup>6</sup> The dual sources of duty were recognised by Lord Browne-Wilkinson in the landmark House of Lords decision of *Airedale NHS Trust v Bland* [1993] AC 789 at 881-885.

<sup>7</sup> Although not imposing a duty to treat, the current authors also note that non-treatment decisions resulting in death may be the subject of coronial investigation: see eg *Inquest into the Death of June Woo* (unrep, Queensland Coroner's Court, 1 June 2009) and *Inquest into the Death of Paulo Melo* [2008] NTMC 80.

<sup>8</sup> In addition to the duties discussed below, there may also be other duties under the criminal law that apply in this context. For a discussion of where death is caused through a negligent omission, see Bronitt S and McSherry B, *Principles of Criminal Law* (3rd ed, Lawbook Co, Pyrmont, 2010) pp 537-542 and 544-546.

<sup>9</sup> *R v Taktak* (1988) 14 NSWLR 226.

<sup>10</sup> Northern Territory: *Criminal Code* (NT), s 149; Queensland: *Criminal Code* (Qld), s 285; Tasmania: *Criminal Code* (Tas), s 144; and Western Australia: *Criminal Code* (WA), s 262.

<sup>11</sup> In relation to common law jurisdictions, see *R v Russell* [1933] VLR 59 and *R v Clarke* [1959] VR 645. In the Code jurisdictions, the duty applies to children who are under 16 years: Northern Territory: *Criminal Code* (NT), s 149; Queensland: *Criminal Code* (Qld), s 286(1)(a); Tasmania: *Criminal Code* (Tas), s 145; and Western Australia: *Criminal Code* (WA), s 263.

<sup>12</sup> *Crimes Act 1961* (NZ), s 151. In relation to a child under 16 years, see *Crimes Act 1961* (NZ), s 152. For a wider discussion of duties to provide life-sustaining treatment in New Zealand, see Skegg PGD, 'Omissions to Prolong Life' in Skegg PGD and Paterson R (eds), *Medical Law in New Zealand* (Thomson Brookers, 2006) pp 533, 537-543.

<sup>13</sup> See eg *Brightwater Care Group v Rossiter* (2009) 40 WAR 84; [2009] WASC 229; *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235; *Re RWG* [2000] QGAAT 2 at [55]-[63]; *Re HG* [2006] QGAAT 26 at [101]-[107]; *Re SAJ* [2007] QGAAT 62 at [54].

<sup>14</sup> This aspect of the duty is discussed in more detail in White B, Willmott L and Allen J, 'Withholding and Withdrawing Life-sustaining Treatment: Criminal Responsibility for Established Medical Practice?' (2010) 17 JLM 849.

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case, it would be lawful to withdraw the treatment,<sup>15</sup> Martin CJ engaged with the duty under the *Criminal Code* to provide the necessities of life. In the course of his consideration of that provision, his Honour assumed that artificial nutrition and hydration was a necessary of life. This approach is not surprising as Rossiter would have continued to live for an extended period if he received it. Courts have encountered more difficulty with the term in a case where a person is in the terminal phase of their illness, and the medical opinion is that treatment would be ‘futile’ in that it would simply delay an inevitable death. The implication of a futility assessment on the criminal law duty that is imposed on doctors is explored in the next section of this article.

Secondly, ‘care and charge of a person’. The meaning of the term ‘having charge of another’ as it appears in the *Criminal Code* of Western Australia was also considered by Martin CJ in *Brightwater*. If the care facility was regarded as ‘having charge of’ Rossiter, on a plain reading of the provision, it would be *obliged* to provide the artificial nutrition and hydration as it is a necessary of life. His Honour, however, concluded that the facility was did not ‘have charge’ of Rossiter. One ground for this conclusion was that Rossiter was competent and, because he therefore had the capacity to decide on his own treatment, the facility could not be regarded as having charge of him (at [39]-[40]). The other reason given by the court as to why the Code duty may not arise was that, given Rossiter’s capacity, there would be ‘nothing preventing him from finding another service provider, and discharging himself from Brightwater and into the care of that other provider’ (at [41]).<sup>16</sup>

In the context of cases being considered in this article, however, it is likely that this second requirement would be met; most cases involve incompetent individuals.

### <subdiv>Civil law

So far as the civil law is concerned, in Australia at least, a doctor is required by the general law of negligence to use reasonable care and skill when making treatment decisions in relation to her or his patient.<sup>17</sup> What a doctor must do in a particular case to discharge the duty of care will depend on all of the circumstances. Where medical treatment is needed to keep a patient alive, reasonable care will often require that treatment be provided. Thus, withholding or withdrawing potentially life-sustaining treatment can give rise to a breach of this civil duty if doing so falls short of exercising reasonable care and skill.<sup>18</sup>

In New Zealand, the existence of its accident compensation scheme means that it is the *Code of Health and Disability Services Consumers’ Rights* which is the principal means of imposing this civil law obligation of reasonable care and skill on doctors.<sup>19</sup> Paterson notes that the Code itself does not create a legal duty to provide ‘services’; its remit is to regulate the quality of care and not to create a right of access to care.<sup>20</sup> Nevertheless, where a patient is regarded as already receiving health services, the Code would operate. An example is where the decision in question is whether to withdraw treatment already being provided. Any duty to provide treatment must also be considered in light of cl 3 of the Code which deals with how ‘providers’ can comply with Code rights. That clause states that a provider will not breach the Code if he or she has taken reasonable steps in the circumstances, and those circumstances are specifically defined to include the provider’s resource constraints.

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<sup>15</sup> In his formal orders, his Honour declared that before the treatment could be lawfully stopped, a medical practitioner was required to advise Rossiter of the consequences that would flow from the cessation of the administration of nutrition and hydration: *Brightwater Care Group v Rossiter* (2009) 40 WAR 84; [2009] WASC 229 at [58].

<sup>16</sup> Martin CJ did not come to a final conclusion on this point as he did not have evidence of Rossiter’s financial capacity to find an alternative service provider.

<sup>17</sup> *Rogers v Whitaker* (1992) 175 CLR 479 (although note the various civil liability legislation which has altered the common law).

<sup>18</sup> Cf *Hunter Area Health Service v Marchlewski* (2000) 51 NSWLR 268 which considered the duty of care owed to the parents of an infant who was ultimately the subject of a non-treatment decision.

<sup>19</sup> *Code of Health and Disability Services Consumers’ Rights*, Right 4. See Manning J, ‘The Required Standard of Care for Treatment’ in Skegg and Paterson, n 12, pp 61-66.

<sup>20</sup> Paterson R and Skegg PGD, ‘The Code of Patients’ Rights’ in Skegg and Paterson, n 12, pp 23, 37.

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Another possible civil law source of duties to provide treatment at the end of life is human rights law, although this branch of law has not yet been influential in this area in Australasia.<sup>21</sup> Section 8 of the *New Zealand Bill of Rights Act 1990* (NZ) dealing with the right not to be deprived of life and s 11 conferring the right to refuse medical treatment have been only briefly considered in this context.<sup>22</sup> In Australia, only two jurisdictions have human rights legislation – the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2004* (ACT) – and only the latter has been mentioned in passing in this area.<sup>23</sup>

### <DIV>IMPLICATIONS OF ‘FUTILITY’ ON LEGAL DUTIES TO PROVIDE TREATMENT

The preceding section identified the nature and source of the duties that are owed by a doctor to a patient to provide potentially life-sustaining medical treatment. Failure to discharge these duties appropriately may result in criminal or civil sanction. The extent to which these obligations on doctors to provide treatment change if the treatment is assessed as being ‘futile’ are now considered.

There are only a few cases in Australia and New Zealand where a decision to withhold or withdraw treatment has been litigated, and where the issue of futile treatment has been raised. The courts have been consistent in concluding that there is no duty to provide treatment that is futile. These cases have been resolved in one of two ways: determining that treatment is not in the patient’s best interests, or deciding that not treating does not breach the criminal law. These two groups of cases are considered below.

#### <subdiv>Futile treatment is not in the patient’s best interests

There have been a small number of cases in Australia and New Zealand, decided on the basis of ‘best interests’, where family members have gone to court seeking to prevent doctors from withholding or withdrawing treatment from their loved ones.<sup>24</sup> In such cases, the family is, in effect, challenging the doctor’s assessment of futility. To date, these cases have all arisen in relation to patients who were not competent, and so it has been the *parens patriae* jurisdiction (or the equivalent statutory welfare jurisdiction for children) which has been invoked. This jurisdiction is an ancient authority and responsibility to act to protect the best interests of those who lack capacity (both incompetent adults and children) and cannot protect themselves.<sup>25</sup>

The case of *Messiha v South East Health* [2004] NSWSC 1061 is illustrative of how this kind of conflict will be resolved by courts in their *parens patriae* jurisdiction. The patient was a 75-year-old man who suffered a cardiac arrest which resulted in his brain being deprived of oxygen for at least 25

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<sup>21</sup> This can be contrasted with the United Kingdom where human rights law has been the subject of greater consideration in cases of this type: see eg *R (Burke) v General Medical Council* [2006] QB 273 where both the High Court at first instance ([2005] QB 424) and the Court of Appeal grappled with, among other things, whether the guidance issued by the General Medical Council entitled *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making*, was incompatible with the *Convention for the Protection of Human Rights and Fundamental Freedoms*, namely Art 2 (Everyone’s right to life shall be protected by law), Art 3 (No one shall be subjected to torture or to inhuman or degrading treatment or punishment) and Art 8 (Everyone has the right to respect for his private and family life). Burke, a competent man suffering from a degenerative brain condition, was concerned that the guidance unlawfully permitted artificial nutrition and hydration to be withheld from him against his will when he reached the final stages of his illness.

<sup>22</sup> See *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 at 444-445 and *Auckland Healthcare Services Ltd v L* [1998] NZFLR 998 at [14]-[16] in relation to s 8; and *Re G* [1997] 2 NZLR 201 at 210 in relation to s 11.

<sup>23</sup> *Australian Capital Territory v JT* (2009) 4 ACTLR 68 at [31] and [63]. Note Faunce’s critique of the lack of consideration of human rights in this area: Faunce T, ‘Re Herrington: Aboriginality and the Quality of Human Rights Jurisprudence in End-of-life Decisions by the Australian Judiciary’ in “Medical Law Reporter” (2007) 15 JLM 201.

<sup>24</sup> *Slaveski v Austin Health* [2010] VSC 493; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197; [2007] NTSC 71; *Re Herrington* [2007] VSC 151; *Messiha v South East Health* [2004] NSWSC 1061; *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549; *Auckland Healthcare Services Ltd v L* [1998] NZFLR 998. There have also been cases in which the treating team (sometimes with the agreement of the patient’s substitute decision-maker that withholding or withdrawal of treatment would be the best course of action) have gone to court for reassurance against liability or for authorisation drawing on assessments of the patient’s best interests: *Application of Justice Health*; *Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432; *Re G* [1997] 2 NZLR 201; *Re Baby D (No 2)* [2011] FamCA 176.

<sup>25</sup> For a discussion of this jurisdiction in New Zealand see eg *Hawthorne v Cox* [2008] 1 NZLR 409 and in Australia see eg *Secretary, Department of Health and Community Services v JWB and SMB (NT) (Marion’s Case)* (1992) 175 CLR 218.

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minutes. He was unconscious and apparently in a deep coma when admitted to the hospital's intensive care unit. He was receiving artificial ventilation, hydration and nutrition but the health care team believed that stopping potentially life-sustaining treatment would be in the patient's best interests. The family disagreed and sought an injunction to compel the health care team to continue treatment. The family was unsuccessful, the court being persuaded by the unanimous medical evidence from three doctors that continued treatment could not be justified on medical grounds. Howie J concluded that it was not in the patient's best interests to continue the treatment.

Although legal challenges to a doctor's assessment of futility have generally not succeeded, a determination of what is in the patient's best interests (which can involve a consideration of futility) is seen as ultimately resting with the court. In *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 (*Northridge*), the New South Wales Supreme Court held that the doctors had wrongly withheld (although then later restarted) treatment that was described as 'ordinary reasonable and appropriate' (at [24]). In that case, a man suffered brain damage following a cardiac arrest that was caused by a heroin overdose. He was unconscious when admitted to hospital and, six days after admission, his treating doctor decided to stop antibiotics and artificial nutrition. A 'not for resuscitation order' was also made. Such decisions were taken in the absence of consultation with the patient's sister who then successfully challenged the actions of the treating team. O'Keefe J ordered (at [125]) that 'necessary and appropriate medical treatment directed towards the preserving of [the patient's] life and the promoting of his good health and welfare' be provided to the patient and that 'no Not for Resuscitation Order be made without prior leave of the court'.

In all of the cases in this category other than *Northridge*, the courts applying the best interests approach either endorsed or did not interfere with the non-treatment proposed by the treating doctors.<sup>26</sup> Of note for this article is that a number of the cases also made specific reference to the fact that treatment for the patient was futile as part of determining that it was not in the patient's best interests and so need not be provided.<sup>27</sup>

### **<subdiv>Stopping futile treatment does not breach the criminal law**

As noted above, the main duty on doctors to provide potentially life-sustaining treatment is the duty under the criminal law to provide the necessities of life. In the context of potentially futile treatment, there have been three cases in New Zealand<sup>28</sup> which have considered this duty and concluded that it would not be breached in appropriate cases either because the treatment is not a 'necessary of life' or because there is a lawful excuse not to provide treatment.<sup>29</sup>

### **<group>Treatment that is not a 'necessary of life'**

The meaning of the phrase 'necessary of life' was considered by the New Zealand High Court in *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235, a case concerning a 59-year-old man with severe Guillain-Barré syndrome (a degenerative neurological condition). He was totally

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<sup>26</sup> *Application of Justice Health; Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432; *Re Baby D (No 2)* [2011] FamCA 176; *Slaveski v Austin Health* [2010] VSC 493; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197; [2007] NTSC 71; *Re Herrington* [2007] VSC 151; *Messiha v South East Health* [2004] NSWSC 1061; *Auckland Healthcare Services Ltd v L* [1998] NZFLR 998; *Re G* [1997] 2 NZLR 201.

<sup>27</sup> *Application of Justice Health; Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432 at [2]; *Re Baby D (No 2)* [2011] FamCA 176 at [149]; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197 at [27]; *Re Herrington* [2007] VSC 151 at [24]; *Messiha v South East Health* [2004] NSWSC 1061 at [26] and [28]; *Auckland Healthcare Services Ltd v L* [1998] NZFLR 998 at [18].

<sup>28</sup> *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235; *Shortland v Northland Health Ltd* [1998] 1 NZLR 433; and *Re C; Hutt District Health Board v B* [2011] NZFLR 873. The last case is not discussed further as it did not advance the jurisprudence on the issue of unilateral withholding and withdrawal and acknowledged the other two decisions listed as being 'the leading authorities'. There are Australian authorities that have considered whether withholding or withdrawing treatment could breach relevant criminal law duties but they have arisen in relation to refusals of treatment by competent adults rather than in the futility context: *Brightwater Care Group v Rossiter* (2009) 40 WAR 84; [2009] WASC 229; *H Ltd v J* (2010) 107 SASR 352.

<sup>29</sup> For a discussion of other ways in which the duty to provide the necessities of life might be found not to apply in this context, see White, Willmott and Allen, n 14.

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dependent upon artificial ventilatory support, completely paralysed, and unable to communicate. His condition was characterised as 'a "locked in" and "locked out" state' (at 240). The doctors, with the support of the patient's wife, believed that stopping ventilatory support would be the most appropriate course of action. However, they feared liability under the *Crimes Act 1961* (NZ) and so sought a declaration that the withdrawal of ventilatory support in the circumstances of the case would not be unlawful.

Thomas J considered whether the ventilatory support could be regarded as a 'necessary of life'. He concluded that treatment was a necessary of life if 'required to prevent, cure, or alleviate a disease that endangers the health or life of the patient' (at 249) and it was not a necessary of life if 'the patient is surviving only by virtue of the mechanical means which induces heartbeat and breathing and is beyond recovery' (at 249-250). As there was no prospect of the patient's health improving, Thomas J found that the artificial ventilation in this case was not a necessary of life.<sup>30</sup> On this authority, where treatment is regarded as futile, it would not be a necessary of life and so the relevant duty would not arise.

#### **<group>A lawful excuse**

In *Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235 (*Auckland*), Thomas J also considered the meaning of 'lawful excuse'. Section 151 of the *Crimes Act 1961* (NZ), which imposes the duty to provide the necessities of life, is expressly subject to the justification of a lawful excuse. His Honour concluded that even if the artificial ventilation was a necessary of life, it could be withdrawn because there was a lawful excuse for doing so, namely 'good medical practice' (at 250-253). His Honour stated (at 250) that there is a lawful excuse for not providing the necessities of life 'where there is no medical justification for continuing that form of medical assistance'.

The lawful excuse of good medical practice was considered further in the New Zealand Court of Appeal decision of *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (*Shortland*),<sup>31</sup> which involved a disagreement between a patient's family members and his treating team. The patient was a 63-year-old man with a long history of type II diabetes, end-stage chronic renal failure, and dementia. He was not accepted into the renal dialysis program, and his family challenged that decision.

The Court of Appeal held that not providing the treatment the family sought was not a breach of Northland Health's duty to provide necessities of life because it was done in accordance with 'good medical practice'. Regard was had to the way in which 'good medical practice' was defined in *Auckland* which the court summarised as follows (at 442):

<blockquote>

- (1) a decision in good faith that withdrawal of the life-support system was in the best interests of the patient;
- (2) conformity with prevailing medical standards and with practices, procedures and traditions commanding general approval within the medical profession; (3) consultation with appropriate medical specialists and the medical profession's recognised ethical body; (4) the fully-informed consent of the patient's family.

</blockquote>

The court considered that these criteria may not necessarily be applicable to situations different from *Auckland* although it noted that the first two criteria were clearly satisfied in this case. In relation to the final criterion, the court explicitly rejected as a general proposition the need to obtain the fully informed consent of the patient's family (at 443):

<blockquote>

The appropriate course is to expect, where circumstances permit, that there will be reasonable consultation with the patient and such members of the family as are available. Indeed the patient's wishes about who else should be consulted, if the patient is able to rationally express those wishes, should ordinarily be respected.

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<sup>30</sup> Note the critique of this approach by Skegg PGD, 'Omissions to Provide Life-prolonging Treatment' (1994) 8 *Otago Law Review* 205.

<sup>31</sup> For a critique of this case on another ground, namely the failure of the Court of Appeal to engage with whether a decision could be challenged based on the allocation of scarce resources between patients in addition to clinical factors, see Manning J and Paterson R, "'Prioritization": Rationing Health Care in New Zealand' (2005) 33 *Journal of Law, Medicine and Ethics* 681.

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Those responsible for the patient's care should bear in mind the views expressed but ultimately they must decide what in clinical terms and within the resources available is best for their patient.

</blockquote>

Although deciding that family consent was not required in this case, the court did, however, recognise in dicta that 'the criterion may have been appropriate in the context of the proposed removal of a life-support system' (at 443).

Putting aside for the moment the uncertainty as to what the term means, if it is accepted that it is 'good medical practice' not to provide futile treatment, then in New Zealand at least, there would be a lawful excuse for that decision and it would not give rise to criminal responsibility.

The position is less clear in Australia as this argument has not been judicially tested although undoubtedly it could be advanced. So far as the Code States are concerned, whether such an argument would succeed would depend on the terms of the relevant Code or other statutory provision.<sup>32</sup> It is suggested that without such legislative authority, recognising a lawful excuse based on what the medical profession regards as 'good medical practice' sits awkwardly with the law that governs the interpretation of a Code.<sup>33</sup>

#### <group>**A relevant Australian case**

Before leaving the discussion of cases dealing with declarations as to whether the criminal law has been breached, it is worth noting briefly the case of *Australian Capital Territory v JT* (2009) 4 ACTLR 68. This case dealt with a request from the Australian Capital Territory, on behalf of doctors treating a mentally ill man who lacked capacity, for a declaration that not administering artificial nutrition and hydration to that man except for the purposes of palliative care would be lawful. The case does not engage with the relevant criminal law framework but rather seems to address the question of lawfulness at a more global level, informed by a review of various cases involving withholding and withdrawing potentially life-sustaining treatment. What is significant for present purposes, though, is the role that futility played in the decision. Higgins CJ stated that if the treatment were futile, then it would not be necessary to provide the treatment. However, in this case, the treatment was not futile as it would avert death in the 'short to medium term' and so the court declined to provide the declaration on the basis that not treating 'might well be unlawful' (at [66]).

#### <subdiv>**Some concluding observations**

Having considered the duties on doctors to provide treatment at the end of life and the small body of Australian and New Zealand case law that is relevant to the context of futility, four general conclusions about the law in these countries can be reached – with the caveat, however, that the variation across the Australian jurisdictions and in New Zealand means that these conclusions can only be expressed as generalisations.

The first conclusion is that there is no general duty on doctors to provide treatment that they consider to be futile. The above discussion reveals the ways in which the cases have reached this conclusion: there is no duty to provide futile treatment as it would not be in a patient's best interests, or that not treating in this context would not be in breach of the duty to provide the necessities of life. Some of the cases specifically consider the issue of futile treatment in reaching this conclusion.<sup>34</sup> Although the

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<sup>32</sup> An example of such a provision is s 259 of the *Criminal Code* (WA), which provides that a person does not incur criminal responsibility for not providing treatment if that course of action is reasonable having regard to the patient's state at the time and to all the circumstances of the case. As discussed below, this section could be relied upon by the courts to excuse an apparent breach of duty to provide treatment where that treatment is futile.

<sup>33</sup> See *Bank of England v Vagliano Bros* [1891] AC 107; *R v Martyr* [1962] Qd R 398; *Ward v The Queen* [1972] WAR 36; *Stuart v The Queen* (1974) 134 CLR 426 at 437 (Gibbs J); *Mellifont v Attorney-General* (Qld) (1991) 173 CLR 289 at 309 (Mason CJ, Deane, Dawson, Gaudron and McHugh JJ).

<sup>34</sup> See eg *Application of Justice Health; Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432 at [2]; *Re Herrington* [2007] VSC 151 at [24]; *Messiha v South East Health* [2004] NSWSC 1061 at [26] and [28]; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197; [2007] NTSC 71 at [27]; *Slaveski v Austin Health* [2010] VSC 493 at [43]; *Re C; Hutt District Health Board v B* [2011] NZFLR 873 at [19]; *Auckland Healthcare Services Ltd v L* [1998] NZFLR 998 at [18].

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relevant cases to date in Australia and New Zealand have involved only incompetent patients,<sup>35</sup> the English case of *R (Burke) v General Medical Council* [2006] QB 273 suggests a similar approach will be taken in relation to patients who are competent. The English Court of Appeal concluded that applying the ‘best interests’ test was not helpful in the context of competent adults but nevertheless concluded that patients could not demand treatment if the doctors formed the view that it was ‘not clinically indicated’ (at 301-302).<sup>36</sup>

The second conclusion, which flows from the first, is that, in Australia at least, doctors do not need consent from the patient or a substitute decision-maker, or other authorisation from the courts or elsewhere, to withhold or withdraw treatment they consider to be futile. In other words, withholding or withdrawal of treatment can be done *unilaterally* by the treating doctor. Indeed, at least as a matter of law, they may do this despite the objections of others who are requesting treatment. There is no duty to provide futile treatment so authorisation not to treat is not required. This is underlined by the fact that the courts’ response in a number of the cases considered above was to decline to intervene as requested by the family and so the treating doctor’s decision remained undisturbed.<sup>37</sup> This makes clear the doctor’s power as no other authorisation is provided or required by the court. As Brereton J stated in *Application of Justice Health; Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432 at [6] and [8]:

<blockquote>

No patient has a right to insist on being given any particular treatment. The patient’s right is that the medical practitioner use reasonable professional care in the interests of the patient’s health and wellbeing. A patient is not entitled to insist on being prescribed particular drugs or receiving particular treatment but to that treatment, which the medical practitioner, using reasonable care, judges is best for the patient in the circumstances ...

[I]t would not in the present circumstances be necessary for the medical practitioners to resort to the Court for any declaration of the type sought.

</blockquote>

The position in New Zealand, particularly so far as it depends on treatment not breaching the duty to provide the necessities of life, is a little more complicated in light of the discussion above about the role of consent in good medical practice. That is, there is some authority for the proposition that consent from a family member may be required if the medical treatment is already being provided to the patient. However, the Court of Appeal in *Shortland* concluded that the approach outlined in *Auckland* which referred to the ‘fully-informed consent of the patient’s family’ is not of general application. While reasonable consultation may be appropriate, the court made clear that good medical practice would not necessarily require consent. Nevertheless, some level of uncertainty remains.<sup>38</sup>

A third conclusion implicit in the discussion to date but nevertheless worth noting is that the determination of futility is in the first instance made by doctors.<sup>39</sup> They are the decision-makers as to when their duty to treat ends as they are responsible for determining when treatment is futile.

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<sup>35</sup> Note, however, that in *Shortland v Northland Health Ltd* [1998] 1 NZLR 433, no judicial findings were made about the capacity of the adult who was denied access to a kidney transplant as well as dialysis, as that was not necessary for a determination of the matter. However, there was evidence that the adult suffered from moderate dementia to the extent that he was unable to cooperate with active therapy required for dialysis.

<sup>36</sup> Note, however, that the English Court of Appeal was at pains to emphasise throughout the judgment that continued artificial nutrition and hydration where requested by a competent adult (the situation of Burke in this case) would always be clinically indicated and so must be provided: *R (Burke) v General Medical Council* [2006] QB 273 at 297, 299, 301.

<sup>37</sup> *Re Herrington* [2007] VSC 151 at [25]; *Messiha v South East Health* [2004] NSWSC 1061 at [28]; *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197; [2007] NTSC 71 at [29]; *Slaveski v Austin Health* [2010] VSC 493 at [51]-[53].

<sup>38</sup> Skegg PGD, ‘Omissions to Prolong Life’ in Skegg and Paterson, n 12, pp 533, 552-554.

<sup>39</sup> See eg *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 at 554 (which was cited with approval in *Messiha v South East Health* [2004] NSWSC 1061 at [3] and [25]); *Melo v Superintendent of Royal Darwin Hospital* (2007) 21

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The final conclusion is that while this determination as to futility is capable of being challenged before a court or tribunal, there is no obligation on the part of the treating doctor to facilitate the resolution of a dispute in this way. The onus rests on the family or other party objecting to the treatment being withheld or withdrawn.

Before leaving this analysis of the law in relation to futile treatment, some recent commentary on this area of law that is relevant to the focus on unilateral withholding or withdrawing of life-sustaining treatment is noted.<sup>40</sup> Of significance for this article is a comparison that is made between the common law and the Queensland guardianship legislation. The latter regime, as will be seen below, generally requires that consent be obtained by a doctor to withhold or withdraw life-sustaining treatment even where it is regarded by the treating doctor as futile. The quotation that is relevant for present purposes states:<sup>41</sup>

<blockquote>

These cases show that the common law encourages the seeking of consent (or *consensus*) from substitute decision-makers, because it is strong evidence of a robust assessment of the patient's best interests. It is also clear from these cases that ... [the requirement to obtain consent under Queensland's guardianship law] is not as major a departure from the common law as it may first appear. The Queensland law merely formalises the common law requirement for consultation by making it a requirement to seek consent.

</blockquote>

The current authors take a different view and consider there are differences that are legally significant between the common law and the approach illustrated by Queensland's guardianship legislation where consent is generally required. The most important statement for present purposes is the last sentence of the above quote which states first, that the common law imposes a requirement for consultation, and secondly, that consultation can be seen at some level as being analogous to consent.

Dealing first with the second claim, there is a *legally* significant difference between the concepts of consultation and consent, although it is acknowledged that this difference may only become *practically* significant in cases where there are disputes. Underpinning this legal difference is who holds decision-making power in the clinical setting (assuming here that legal review processes are not engaged). To suggest that consent 'merely formalises' consultation does not take sufficient account of the issue of who is actually able to make the decision. Consultation generally entails a right to be heard but no more. Where a doctor is only subject to a duty to consult, he or she retains unilateral power, in the first instance, to withhold or withdraw life-sustaining treatment that the doctor deems to be futile. By contrast, the need to obtain consent means a doctor does not have unilateral decision-making authority.

Turning to the second issue identified above, the authors also consider there is a threshold issue which is that the Australian common law does not impose a requirement on doctors to consult with a substitute decision-maker or patient in making a futility assessment.<sup>42</sup> While such consultation is prudent from a legal perspective before seeking to make a determination about futility (in addition to being ethically and practically required),<sup>43</sup> drawing on the analysis of the legal position above, the case law in Australia does not impose a legal duty to consult with a patient or substitute decision-maker as a precondition to making a decision about life-sustaining treatment.

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NTLR 197; [2007] NTSC 71 at [26]; *Application of Justice Health; Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432 at [6]; *Slaveski v Austin Health* [2010] VSC 493 at [35].

<sup>40</sup> Stewart C, 'A Defence of the Requirement to Seek Consent to Withhold and Withdraw Futile Treatments' (2012) 196 MJA 406.

<sup>41</sup> Stewart, n 39 at 406 (emphasis in original).

<sup>42</sup> The position in New Zealand is perhaps less clear with *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 making references to it being appropriate to expect that consultation would occur 'where circumstances permit': see above.

<sup>43</sup> For example, in terms of the practical aspects of decision-making, assessments of a patient's best interests would be difficult to undertake without discussions with that patient or her or his substitute decision-maker.

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## <div>NEW SOUTH WALES, QUEENSLAND, SOUTH AUSTRALIA AND WESTERN AUSTRALIA: A STATUTORY OBLIGATION TO OBTAIN CONSENT?

Having established that the duties imposed on doctors to provide treatment in Australia and probably New Zealand permit them to unilaterally withhold or withdraw what they consider to be futile treatment, the authors now consider where the literature or case law has suggested that legislative reform might have altered this general position. Guardianship or medical consent legislation in Queensland, South Australia and Western Australia, as well as the *Crimes (Administration of Sentences) Act 1999* (NSW) in New South Wales are examined. From this review, it is concluded that the preferable interpretation of the legislation in New South Wales, South Australia and Western Australia is that the common law is not altered regarding the ability of a doctor to unilaterally withhold or withdraw treatment that he or she considers to be futile. Queensland legislation, on the other hand, expressly alters the common law by requiring that consent from a substitute decision-maker (or some other authorisation) be obtained before a doctor can withhold or withdraw futile treatment from an adult who lacks capacity.

### <subdiv>New South Wales Crimes (Administration of Sentences) Act 1999

In *Application of Justice Health; Re a Patient* (2011) 80 NSWLR 354; [2011] NSWSC 432, the New South Wales Supreme Court was asked to consider whether the *Crimes (Administration of Sentences) Act 1999* (NSW) required that a prisoner who had end-stage lung cancer and lacked decision-making capacity be provided with cardiopulmonary resuscitation in circumstances where unanimous medical opinion was that doing so would be futile. Section 72A of that Act required that prisoners be provided with medical treatment that is 'necessary for the preservation of the[ir] health'. Brereton J concluded (at [14]) that this provision did not require that the prisoner be given cardiopulmonary resuscitation:

<blockquote>

In my view, treatment that is futile is not treatment that is necessary for the preservation of health. The mere fact that the treatment might prolong life, by hours or days, without quality, does not make it treatment that is necessary for the preservation of health. Although life and health are closely associated, there is a distinction between treatment necessary for the preservation of health, and treatment that might achieve the mere prolongation of life.

</blockquote>

His Honour noted that the provision was not intended to create more stringent medical standards for prisoners than for the general community (at [12]) which, he had previously observed, did not involve any obligation on doctors to provide treatment they considered to be futile (at [6], [8]). As such, it appears that the *Crimes (Administration of Sentences) Act 1999* (NSW) does not interfere with the law described earlier that permits unilateral decision-making by doctors in this area. It should be noted, however, that his Honour commented that his decision was reached without the benefit of a contradictor, and this fact has implications for the case's authority (at [13]).

### <subdiv>Queensland guardianship legislation

The position is different under the guardianship legislation in Queensland<sup>44</sup> where a health provider is generally required to obtain consent from a substitute decision-maker to withhold or withdraw a potentially life-sustaining measure from an adult who lacks capacity, even if the treatment is regarded as futile. This conclusion flows from the following interpretation of that legislative framework.<sup>45</sup>

Section 79 of the *Guardianship and Administration Act 2000* (Qld) makes it an offence for a health provider to carry out 'health care' for an adult with impaired capacity unless the appropriate consent (or some other authorisation) is obtained. 'Health care' is defined to include withholding and withdrawal of a life-sustaining measure 'if the commencement or continuation of the measure ...

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<sup>44</sup> *Powers of Attorney Act 1998* (Qld) and *Guardianship and Administration Act 2000* (Qld).

<sup>45</sup> For more detail on the Queensland legislation in this field, see White B and Willmott L, *Rethinking Life-sustaining Measures: Questions for Queensland* (QUT Printing Services, Brisbane, 2005) pp 69-72, <http://eprints.qut.edu.au/7093/> viewed 7 July 2012; Willmott L, White B and Then SN, 'Withholding and Withdrawing Life-sustaining Medical Treatment' in White B, McDonald F and Willmott L (eds), *Health Law in Australia* (Thomson Reuters, Sydney, 2010) at [13.240].

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would be inconsistent with good medical practice' (emphasis added).<sup>46</sup> This means that a potentially life-sustaining measure that is considered futile would fall within that definition.

Accordingly, unless some other authorisation is available,<sup>47</sup> consent must be obtained from either the adult's advance health directive or, more commonly, from a substitute decision-maker to withhold or withdraw a futile potentially life-sustaining measure.<sup>48</sup> This means that doctors do not have unilateral power to make decisions not to provide such treatment they regard as futile, and indeed, a substitute decision-maker can insist on that treatment being given.<sup>49</sup> In 2009, the Queensland State Coroner considered the above interpretation of the *Guardianship and Administration Act*, and concluded that 'the patient or a person authorised under the GAA must consent to the withholding of life-sustaining measures'.<sup>50</sup>

While the above represents the starting point for decisions about withholding or withdrawing futile treatment, the legislation does contain mechanisms for challenging the decision of a substitute decision-maker who refuses to consent to the withholding or withdrawal of treatment. In an appropriate case, a decision to withhold or withdraw may be made by the Adult Guardian,<sup>51</sup> the Queensland Civil and Administrative Tribunal<sup>52</sup> or the Supreme Court.<sup>53</sup>

### <subdiv>South Australian medical consent legislation

The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) deals with a range of matters related to consent to medical treatment, including children's competence to consent, the appointment of medical agents and the making of anticipatory directions about medical treatment. It also deals with the care of people who are dying. Section 17(1) creates protection for health professionals who provide palliative care that may incidentally hasten death<sup>54</sup> while s 17(2) is designed to protect health professionals when they consider the most effective form of care is *not* to provide treatment that prolongs the patient's life. A possible interpretation of the latter section is that it grants a patient or

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<sup>46</sup> *Guardianship and Administration Act 2000* (Qld), Sch 2, s 5(2). See also the definition of 'life-sustaining measures': Sch 2, s 5A.

<sup>47</sup> For example, authorisation for a decision to withhold or withdraw a life-sustaining measure exists where the decision must be taken immediately: *Guardianship and Administration Act 2000* (Qld), s 63A. Note, however, that this authorisation is subject to the health provider not knowing that the adult has objected to the treatment being withheld or withdrawn: s 63A(2). This operates as a limit on unilateral decision-making by doctors in the emergency context. Authorisation also does not extend to a decision to withhold or withdraw artificial nutrition and hydration: s 63A(4).

<sup>48</sup> The criteria to be applied by a substitute decision-maker in making such a decision are the general principles and the health care principle set out in the *Guardianship and Administration Act 2000* (Qld). For a discussion of how these principles apply to decisions to withhold or withdraw life-sustaining measures, see Willmott L, White B, Parker M and Cartwright C, 'The Legal Role of Medical Professionals in Decisions to Withhold or Withdraw Life-sustaining Treatment: Part 2 (Queensland)' (2011) 18 JLM 523.

<sup>49</sup> Willmott, White and Then, n 45 at [13.240]. The authors also note that this interpretation is consistent with s 66B of the *Guardianship and Administration Act 2000* (Qld) which requires the adult's health provider to certify in the adult's medical records as to the various things enabling the measure to be withheld or withdrawn. The provision presumes that in a non-urgent situation, a measure can be withdrawn only pursuant to a direction in an advance health directive, or because the substitute decision-maker provided consent.

<sup>50</sup> *Inquest into the Death of June Woo* (unrep, Queensland Coroner's Court, 1 June 2009) p 23.

<sup>51</sup> Pursuant to s 43 of the *Guardianship and Administration Act 2000* (Qld), the adult guardian is empowered to make a decision about a health matter if the substitute decision-maker refuses to make a decision or makes a decision that the adult guardian believes is contrary to the health care principle. The 'health care principle' is set out in Sch 1 of the legislation and requires the person making the decision to exercise power in a particular way including in a way that is least restrictive of the adult's rights and in the adult's best interests.

<sup>52</sup> Pursuant to ss 81(1)(f) and 115 of the *Guardianship and Administration Act 2000* (Qld), the tribunal can consent to the withholding or withdrawal of a life-sustaining measure if an application is brought before it.

<sup>53</sup> The *parens patriae* jurisdiction of the Supreme Court of Queensland is retained by s 240 of the *Guardianship and Administration Act 2000* (Qld) under which the court could authorise the withholding or withdrawal of treatment. It is not an offence for a health provider to withhold or withdraw treatment on the basis of such authority: s 79(1)(c).

<sup>54</sup> The equivalent common law defence is the doctrine of double effect. For a consideration of the common law and statutory equivalents, see White B and Willmott L, 'The Doctrine of Double Effect' in White, McDonald and Willmott, n 45, Ch 14.

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substitute decision-maker power to require medical treatment, even if it is futile. The relevant parts of s 17 state (emphasis added):

<blockquote>

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

(3) For the purposes of the law of the State –

...

(b) the non-application or discontinuance of life sustaining measures in accordance with subsection (2) does not constitute an intervening cause<sup>1</sup> of death.

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

</blockquote>

Skene discusses what she describes as a 'literal interpretation' of s 17(2) and notes that it would lead to the following result:

<blockquote>

[I]f there is an express direction from a patient or from the patient's representative (a parent or guardian), then the medical practitioner and other staff must use life sustaining measures in treating the patient.<sup>55</sup>

</blockquote>

On this interpretation, if there is a direction to give potentially life-sustaining measures, any decision to withhold or withdraw that treatment would fall outside the authorisation provided by s 17(2). This means that the deeming of the non-treatment to not be 'an intervening cause of death' pursuant to s 17(3)(b) would not be triggered. The argument continues that if the patient or the patient's substitute decision-maker is demanding treatment, the doctor would be in breach of the statutory obligation imposed by s 17(2) if he or she did not provide it.

The current authors consider that the provision is very unlikely to be interpreted by a court in this way. Instead, they agree with an alternative interpretation outlined by Skene, namely that s 17(2) creates protection for doctors and other health professionals in the circumstances to which it applies, but that it does not regulate other circumstances. In other words, where the conditions of the section are met, there is statutory immunity for a doctor or health professional who does not provide treatment. But if the section does not apply, then it does not affect the liability or duties of doctors or others.<sup>56</sup> In adopting this view, it is conceded that it is not obvious why the words 'in the absence of an express direction by the patient or the patient's representative to the contrary' appear in s 17(2). The parliamentary debates do not address this issue and so do not shed light on the rationale for including these words.<sup>57</sup> One possible explanation is that the objective was to state the circumstances in which Parliament would grant doctors and others absolute immunity. But Parliament was not prepared to extend automatic legislative protection to a situation where there was disagreement about whether treatment should be provided or not.

Of significance for Skene, in advancing this interpretation, was viewing this provision in the context of the Act as a whole and, in particular, having regard to the stated objects of the legislation.<sup>58</sup> One of the purposes of enacting the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) was 'to allow for the provision of palliative care, in accordance with proper standards, to people who are

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<sup>55</sup> Skene L, 'Withholding and Withdrawing Treatment in South Australia When Patients, Parents or Guardians Insist That Treatment Must Be Continued' (2003) 24 *Adelaide Law Review* 161 at 163. See also Stewart, n 40.

<sup>56</sup> Skene, n 55 at 164.

<sup>57</sup> Skene, n 55 at 164-166.

<sup>58</sup> Skene, n 55 at 164-166.

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dying and to protect them from medical treatment that is intrusive, burdensome and futile'.<sup>59</sup> Interpreting s 17(2) as permitting patients and their substitute decision-makers to demand futile treatment would be inconsistent with that objective. Looking at the Act as a whole, Skene identifies that s 8, which permits the appointment of an agent, is expressed in terms of consent and refusal of treatment rather than requiring that treatment be given.<sup>60</sup> It is noted that an agent appointed under a medical power of attorney is a patient's 'representative' as referred to in s 17(2).<sup>61</sup>

To this, the current authors would add reference to s 7 dealing with anticipatory grants or refusals of consent. This provision permits a person to make a 'direction' (the wording used in s 17(2)) but such a direction only has the effect that a person is 'taken to have consented to medical treatment ... and to have refused medical treatment'. It seems clear from the wording adopted in s 7 that it is not contemplating that a direction would include the power to *require* treatment to be provided. It is also noted that this is the nature of the power granted to enduring guardians appointed by an adult under the *Guardianship and Administration Act 1993* (SA). An enduring guardian who, like an agent above, may be a patient's 'representative',<sup>62</sup> has power to provide consent or refuse consent, but is not given power to require that treatment be provided.<sup>63</sup>

Skene also notes that the 'literal interpretation' is a marked departure from the common law. While Parliament may have chosen to do this, one would expect a clearer indication of this intention, and there is nothing in the parliamentary debates that reveals such an intention.<sup>64</sup>

The current authors agree and also note the absurd consequences that could follow if s 17(2) were regarded as a source of a duty to provide treatment. Section 17 deals only with '[t]he care of people who are dying' and s 17(2) is expressly limited in application to where a patient is inevitably dying: in a terminal phase of a terminal illness. The 'literal interpretation' described above permits dying patients or their substitute decision-makers to demand treatment. But s 17 does not purport to regulate patients who are *not* dying and this would be governed by the general principles outlined earlier in this article. As will be recalled, the general position is that a demand for treatment that doctors do not wish to provide is not effective. This would lead to the absurd result that the law in South Australia protects the right of patients who are inevitably dying to demand treatment but would permit doctors to unilaterally decide not to treat patients who are healthier and more likely to benefit from that treatment.

Finally, the authors also dispute whether the approach described as a 'literal interpretation' is in fact how the provision would be literally read. On its face, s 17(2) does no more than state that no duty to provide treatment will arise in certain circumstances. It offers protection to doctors and other health professionals who then have statutory immunity from liability. There is nothing on the face of s 17(2) that seeks to *create* a duty. So the assertion then that a duty must necessarily arise in the circumstances that fall outside those protected by the provision is flawed. The creation of an immunity (or relief from a duty) does not then implicitly create a duty which operates in all circumstances where that immunity does not apply.

As a result, although the position is not beyond doubt, it is considered that the South Australian legislation does not alter the common law position which allows doctors to unilaterally withhold and withdraw treatment that they consider to be futile.

### **<subdiv>Western Australian guardianship legislation**

It has been suggested that amendments by the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) to the *Guardianship and Administration Act 1990* (WA) impose a duty on a doctor, as in

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<sup>59</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 3(c).

<sup>60</sup> Skene, n 55 at 167, fn 13.

<sup>61</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 4 (definition of representative).

<sup>62</sup> *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 4 (definition of representative). The definition includes a person acting under 'some other lawful authority'.

<sup>63</sup> *Guardianship and Administration Act 1993* (SA), s 25(5)(b).

<sup>64</sup> Skene, n 55 at 167.

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Queensland, to obtain consent before withholding or withdrawing life-sustaining treatment from an adult who lacks capacity.<sup>65</sup> It appears that the most significant provision for this argument is s 110ZJ of the *Guardianship and Administration Act*. It states the order of priority in which ‘treatment decisions’ can be made in relation to a patient who cannot make her or his own decisions.

To illustrate, s 110ZJ(2) provides that if there is an advance health directive containing a relevant treatment decision, then ‘whether or not the treatment is provided to the patient *must be decided* in accordance with the treatment decision’ (emphasis added). The suggestion is that the words emphasised mean that the direction in an advance health directive, if it deals with the treatment in question, determines what decision is made. The provision continues with a hierarchy of substitute decision-makers – enduring guardians, guardians and then persons responsible – and again states that whether or not treatment is provided *must be decided* by the relevant decision-maker.<sup>66</sup> This interpretation of the provision means that a doctor would not be able to unilaterally withhold or withdraw futile treatment because they are not the relevant decision-maker.

It could also be suggested that support for this position is found in s 110ZL of the *Guardianship and Administration Act*. That section states that where a health professional does not provide or continue treatment in accordance with a treatment decision contained in an advance health directive or by a substitute decision-maker, he or she is taken for all purposes to have acted in accordance with a valid treatment decision.

While on its face, s 110ZJ appears to grant sole decision-making power (even for futile treatment) to a patient (through an advance health directive) or a substitute decision-maker, the authors consider that the operation of this section needs to be viewed in the context of the Act as a whole. Three arguments support the conclusion that this provision does not alter the common law position and does not permit a patient through an advance health directive, or a substitute decision-maker, to demand futile treatment. The first is that s 110ZJ is couched in terms of a ‘treatment decision’: either there is a treatment decision in an advance health directive or the relevant substitute decision-maker is authorised to make a treatment decision.<sup>67</sup> ‘Treatment decision’ is defined in s 3(1) in the following terms:

<blockquote>

‘treatment decision’, in relation to a person, means a decision to consent or refuse consent to the commencement or continuation of any treatment of the person.

</blockquote>

A treatment decision may only be either consenting to treatment or refusing consent to treatment. Requesting or demanding treatment is not a treatment decision as it is defined. Accordingly, the scope of s 110ZJ extends only to treatment that is being offered. Granting powers to consent or refuse consent to treatment implies that treatment has been offered by someone in a position to provide it, namely a health professional. Such an interpretation is also consistent with the wording of s 110ZJ(1). That provision states that this section applies where a patient cannot make decisions ‘in respect of any treatment proposed to be provided to the patient’.<sup>68</sup> So while, eg, a substitute decision-maker can make a decision about whether or not treatment is provided under this provision, that can only occur in relation to treatment that is offered.

Secondly, s 110ZJ is limited, at least so far as substitute decision-makers are concerned, to where a substitute decision-maker ‘is *authorised* to make a treatment decision’ (emphasis added).<sup>69</sup> The terms

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<sup>65</sup> Stewart, n 40 at 406.

<sup>66</sup> *Guardianship and Administration Act 1990* (WA), s 110ZJ(3)-(5).

<sup>67</sup> There is no specific reference to the term ‘treatment decision’ in s 110ZJ(5) of the *Guardianship and Administration Act 1990* (WA) which deals with ‘persons responsible’, but this is the scope of the provision (see heading to the provision) and s 110ZD makes clear that the powers of the ‘person responsible’ relate to treatment decisions.

<sup>68</sup> This phrase is also used in s 110ZD of the *Guardianship and Administration Act 1990* (WA) dealing with when a person responsible may make decisions for a patient.

<sup>69</sup> See s 110ZJ(3)(b)(i) and s 110ZJ(4)(b)(i) of the *Guardianship and Administration Act 1990* (WA) for enduring guardians and guardians respectively. In relation to persons responsible, their authorisation stems from s 110ZD.

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of the Act as a whole make clear that the scope of a substitute decision-maker's authority does not extend to demanding treatment considered to be futile. In relation to enduring guardians and guardians, they are granted all of the powers given to a person who has a parenting order under the *Family Court Act 1997* (WA).<sup>70</sup> This does not include the power to demand futile treatment, so these substitute decision-makers are not authorised to make such a decision. In relation to a 'person responsible', her or his treatment decision has effect 'as if the treatment decision had been made by the patient'.<sup>71</sup> Because a competent adult cannot demand futile treatment, a person responsible will not have this power either. A similar argument can also be made in relation to advance health directives: a treatment decision operates 'as if the treatment decision had been made by the maker at that time'.<sup>72</sup> Because the scope of the power granted to a substitute decision-maker or by an advance health directive is limited in these ways, s 110ZJ does not extend to decisions to demand futile treatment.

Thirdly, as a general point of statutory interpretation, it would be surprising for such a fundamental alteration to the common law to be made in such an indirect way. If the legislature meant to make such a change, it would have done so expressly. Section 110ZJ does not expressly require doctors to obtain consent to the withholding or withdrawal of futile treatment.

For these reasons, while s 110ZJ on its own does appear to grant ultimate decision-making power to a patient through an advance health directive and a substitute decision-maker, it does so only in relation to a certain class of decisions. Where treatment is considered to be futile and is not being offered, it falls outside s 110ZJ because it would not be a 'treatment decision' governed by the provision. Nor does the *Guardianship and Administration Act* confer authority on a substitute decision-maker or a person through their advance health directive to make such a decision.

While the current authors consider that the true interpretation of the legislation is clear when looked at in this way, should there be any residual uncertainty, they would have regard to the parliamentary debates of the amending Bill when it was introduced. In the Bill's second reading speech in the Legislative Assembly, the Hon Jim McGinty (who was then Minister for Health) stated:<sup>73</sup>

<blockquote>

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.

</blockquote>

To further bolster this view, it is noted finally that there is an argument that aspects of the amending legislation could potentially be relied upon by health professionals to avoid criminal responsibility for not providing treatment they regard as futile. One provision inserted by the amending Act was s 259(2) of the *Criminal Code* (WA), which states:

<blockquote>

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

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<sup>70</sup> Section 45(1) of the *Guardianship and Administration Act 1990* (WA) (guardians); and this includes the power to make treatment decisions (s 45(2)(d)). Enduring guardians are given the same powers as guardians subject to any limits in the instrument itself (s 110G).

<sup>71</sup> Section 110ZD(9) of the *Guardianship and Administration Act 1990* (WA).

<sup>72</sup> Section 110S(2)(b) of the *Guardianship and Administration Act 1990* (WA).

<sup>73</sup> Western Australia, Legislative Assembly, *Parliamentary Debates* (21 June 2006) p 4062 (Jim McGinty). Note that the Bill was at that time called the *Acts Amendment (Advance Health Care Planning) Bill 2006* (WA) but was changed to its current title shortly before it was transmitted to the Legislative Council. In the Bill's second reading speech in the Legislative Council, the Hon Sue Ellery confirmed the position already expressed: 'The bill ... clarifies and expands the protection from criminal and civil liability given to health professionals. 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.' See Western Australia, Legislative Council, *Parliamentary Debates* (6 December 2006) p 9244b (Sue Ellery).

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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.

</blockquote>

This provision protects health professionals and others from criminal responsibility for not providing treatment if their conduct meets the criteria set out above. Of note is that the provision is not restricted in operation, like the guardianship legislation previously considered, to situations involving adults who lack capacity but rather applies to withholding and withdrawing treatment generally. The argument would be that if treatment is futile, then a decision not to provide it would be reasonable having regard to the patient's state and the other circumstances of the case.<sup>74</sup>

As a result of the above analysis, the authors consider that the position in Western Australia is unaltered by the amendments to the *Criminal Code* (WA) or the *Guardianship and Administration Act*, so doctors may continue to unilaterally withhold and withdraw futile treatment. Indeed, the addition of s 259(2) of the *Criminal Code* (WA) may provide greater protection to doctors making such decisions.

## <DIV>CONCLUSION

The notion of 'futile treatment' gives rise to a range of challenging questions. Should doctors be able to make decisions that treatment is futile and need not be provided, or should such decisions be entrusted to a patient (or her or his family if the patient is incompetent)? What criteria should a decision-maker employ in her or his deliberations? How should disputes that arise as to whether treatment should be provided be resolved? These are questions that a legal system must address and there are different models for how this can be done.<sup>75</sup>

But an important part of deliberations about whether reform is needed is first to establish a benchmark of the current legal position in the relevant jurisdictions. How does the law in Australia and New Zealand currently answer the questions set out above? Addressing this threshold issue has been the objective of this article. The authors concluded that the general legal position is that doctors are able to determine unilaterally when treatment is futile and so need not be provided. This is either because futile treatment is not in a person's best interests or because not providing such treatment does not breach the criminal law. It is noted, though, that the position in New Zealand appears less certain given conflicting judicial statements about the need for family consent, at least in cases involving withdrawal of existing treatment.

The authors also examined whether legislation altered this general position and concluded that generally it did not. Most of the legislation considered does not remove a doctor's unilateral decision-making power in relation to futility, although there is perhaps some uncertainty in South Australia. The exception was the guardianship legislation in Queensland where consent (or some other authorisation) is required to withhold or withdraw futile treatment from adults who lack capacity.

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<sup>74</sup> It could be argued that assessments of reasonableness should have regard to whether there is consent of a patient or substitute decision-maker to not treat. Consent was considered relevant in *Brightwater Care Group v Rossiter* (2009) 40 WAR 84; [2009] WASC 229 but that was in the context of a refusal of treatment which was otherwise supported by the common law, rather than a request for treatment. Given the current legal position that consent is not required to stop treating and current notions of what is regarded as good medical practice in Australia and New Zealand, obtaining consent *not* to treat is not likely to be required as part of acting reasonably.

<sup>75</sup> The two models considered in this article were the common law position and that under Queensland's guardianship legislation. Another model which has attracted a great deal of scrutiny is that established by the *Texas Advance Directives Act 1999* (Texas). See *Texas Health & Safety Code Ann* §§ 166.001-305 (Vernon 2007); and eg Fine R and Mayo T, 'Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives' (2003) 138 *Annals of Internal Medicine* 743. Yet another model is that established by the Ontario *Health Care Consent Act 1996* (Ont) SO 1996, c2, Sch A. Pursuant to s 2 of this Act, doctors must have consent to treatment and treatment includes a 'plan of treatment' and plans of treatment include 'the withholding or withdrawal of treatment in light of the person's current health condition'. The issue of doctors' authority to withhold or withdraw treatment without the consent or against the wishes of a patient or patient's substitute decision-maker under this Act is currently the subject of litigation (*Rasouli v Sunnybrook Health Sciences Centre* 2011 ONCA 482 leave to appeal to the Supreme Court of Canada granted 22 December 2011, matter heard 10 December 2012, decision pending).

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The broad position, then, is that unilateral decision-making power is generally accorded to doctors to determine that treatment is futile, which then relieves them of the obligation to provide that treatment. Questions can and should be asked as to whether this is the best legal model. Because of the significance of these decisions, it is important that careful consideration be given to determining the appropriate decision-maker and the criteria they should apply. It is proposed that the analysis undertaken in this article be a departure point for deliberations about the law governing futile treatment in Australia and New Zealand.

### <DIV>POSTSCRIPT

Section 17(2) of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) will be amended and replaced by Schedule 1, section 11 of the *Advance Care Directives Act 2013* (SA). The latter Act received assent on 18 April 2013 but has not yet commenced operation. Reports suggest that the Act will not become law until the relevant policy and educational programs to support the wider advance care planning reforms are in place.

Of significance for this article is that the purpose of the relevant amendment is to address the potential confusion identified above in South Australia from subsection 17(2) of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). The Explanation of Clauses states in relation to the amendment:<sup>76</sup>

This clause substitutes section 17(2) of the principal Act to clarify some confusion about the ability of a patient's representative to demand the continuation of treatment to a dying patient in circumstances where to do so is futile. New subsection (2) makes it clear that medical practitioners and those under their supervision are under no duty to use or continue treatment in such circumstances, regardless of the whether the patient's representative has requested them to do so. However, the medical practitioner etc must withdraw life sustaining measures if directed to do so by the patient's representative.

Upon commencement of the reforms, new section 17(2) will read:<sup>77</sup>

- (2) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision—
  - (a) is under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state (whether or not the patient or the patient's representative has requested that such measures be used or continued); and
  - (b) must, if the patient or the patient's representative so directs, withdraw life sustaining measures from the patient.

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<sup>76</sup> South Australia, House of Assembly, *Parliamentary Debates* (17 October 2012) p 3242 (JD Hill).

<sup>77</sup> See also other relevant amendments relating to demands for treatment in the *Advance Care Directives Act 2013* (SA): section 6 (Health practitioner cannot be compelled to provide particular health care) and Schedule 1, s 4 inserting s 4B in the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (Consent not required for withdrawal etc of medical treatment).