HEALTH SERVICES AND THE RIGHT TO LIVE: WHEN CAN I DEMAND LIFE SAVING MEDICAL TREATMENT?

By Cameron Stewart*

The Court of Appeal of New Zealand has found that a health care authority can refuse to provide life-sustaining treatment to a person when there has been a decision not to treat, based on a clinical assessment of the patient's best interests.[1] This finding is not earth-shattering on its face.[2] What is alarming in this finding is that the decision not to treat the patient was found to be in the patient's best interests, contrary to the expressed wishes of the patient and his family members.

Rau Williams was a patient suffering from diabetes, end stage renal disease and brain damage. Despite his disabilities Mr Williams was semi-competent and had expressed his desire to live. The only available treatments for Mr Williams were a kidney transplant or to spend the rest of his life on a dialysis machine. Without such treatment Mr Williams would die.

After assessing Mr Williams' suitability for acceptance in a dialysis treatment program, the local health authority, Northland Health Limited ("Northland"), decided that Mr Williams was not a suitable candidate for treatment.

Mr Shortland *(Shortland)*, Mr Williams' representative, initiated judicial review proceedings claiming that the decision was a breach of duty and that the decision not to treat Mr Williams was illegal. The Court of Appeal unanimously held that the decision was not illegal and that judicial review would not be granted.

Mr Williams died the next day.

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1 *Shortland v Northland Health Limited* (NZ Court of Appeal, No 230/97, 10 November 1997, Richardson P, Keith and Tipping JJ) (hereafter *Shortland*).

2 Doctors have for some time been recognized as having the power to withhold treatment from patients in vegetative states when treatment is no longer in their best interests: *Airedale NHS Trust v Bland* [1993] AC 789.

The issues

The application for judicial review was based on two grounds:

(1) The refusal to treat was in breach of the standards of good medical practice which required the treating physicians to consult with an ethical review body as well as with the relatives of the patient; and

(2) the decision not to treat was a breach of the New Zealand *Bill of Rights Act* 1990, which provides that:

"No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice."[3]

Good medical practice

The requirement for "good medical practice" in end of life decisions had been laid down by Thomas J in the case of *Auckland Area Health Board v Attorney-General*[4].

In that case a declaration was sought as to the lawfulness of a decision to remove life support from a suffer of "locked-in" syndrome (where the patient's brain was functioning but effectively unable to communicate with the rest of the body). Thomas J found that life support could be withdrawn without any criminal liability as the decision had been made in accordance with "good medical practice."

Thomas J found it impossible to give a strict legal definition of "good medical practice". However his Honour found that it included the following factors ("the Thomas J criteria"):

(1) a decision made in good faith as the decision was made in the best interests of the patient;

(2) conformity with the prevailing standards of medicine which command general approval within the medical profession;[5]

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3 *Bill of Rights Act* 1990 (NZ), section 8.

4 [1993] 1 NZLR 235.

5 Reminiscent of the negligence principle in *Bolam v Friern Hospital Management* [1957] 1 WLR 582. This principle does not apply to the law of negligence in Australia: *Rogers v Whitaker* (1992) 175 CLR 479.

(3) consultation with the appropriate medical specialists and the medical profession's recognised ethical bodies; and

(4) the fully informed consent of the patient's family.

Shortland argued that Northland's decision had failed to satisfy requirements 2 to 4 of the Thomas J criteria. The Court of Appeal dismissed these allegations and found that:

(1) there was no tenable basis for an allegation that Northland or its doctors had failed in their clinical responsibilities. The treatment decision was said to be an example of clinical and professional judgment, *par excellence*.[6] The evidence overwhelmingly supported the view that the decision was made according to good medical practice.

(2) There was no fixed requirement in the present case that an ethical review board be consulted. The Thomas J criteria could not be regarded as mandatory as the decision was largely clinical and not "ethical". Seemingly this distinct was based on the fact that the decision was said to have been made on a clinical basis without resource allocation dimensions.

(3) The requirement of the fully informed consent of the patient's family should not be applied irrespective of the circumstances of the case. To require such consent would give family members a power to require treatment to be given or continued irrespective of the clinical judgment of the doctors involved.[7] Such a proposition could not be countenanced. It was proper to expect that there be reasonable consultation with available family members and that the doctors should then make their decision according to what is best for the patient within available resources.[8]

Accordingly the application for judicial review based on failure to comply with "good medical practice" failed.

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[6] n1 at 16.

[7] Id at 17.

[8] Id at 18.

Bill of Rights

Section 8 of the Bill of Rights was said to enshrine the principle of the sanctity of life. It was said to be a restatement of Article 6 of the *International Covenant on Civil and Political Rights*, which states that no-one shall be arbitrarily deprived of life.

The Court of Appeal found that there were no attempt to deprive Mr Williams of life as there was no legal duty to provide Mr Williams with the "necessaries of life", as stipulated in the *Crimes Act*.[9] Put simply, as the treatment decision had been made according to the standards of good medical practice Northland had a lawful excuse for not treating and could not be said to be "depriving" Mr Williams of life.

Causes for concern?

The judgment raises a number of issues which impact on a patient's right to life.

Primarily, the judgment illustrates the courts' general unwillingness to be involved in any area which impacts on the clinical decision making powers of doctors. While the courts are rightly reluctant to interfere with the proper sphere of medical competence, there is a danger that, as medical decisions continue to become "bureaucratized", decisions whether to provide treatment maybe taken outside the strictly clinical sphere. Given this trend it is dangerous to presume that, just because the decision is a treatment decision, irrelevant or illegal considerations have been taken into account. The decision in *Shortland* still leaves open the question of whether judicial review would be available in such a case.

Secondly, the judges were careful in the present case to distinguish it from circumstances where treatment was refused on the basis of lack of resources. This possibly hints at more willingness on the part of the court to grant judical review in those circumstances. However, in England the courts have generally refused to review medical decisions that were based solely on considerations of scarce resources.[10]

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9 *Crimes Act* 1961 (NZ), s 151.

10 *Re J(A Minor)(medical treatment)* [1992] 4 All ER 614; *R v Secretary of State for Social Services; ex parte Hincks* (1980) 1 BLMR 93; *R v Secretary for State for Social Services; ex parte Walker* (1987) 3 BLMR 32; *R v Cambridge Health Authority; ex parte B.*

In these cases the clear message is that the only avenues for reviewing a decision not to treat are bias, illegality and *Wednesbury* unreasonableness.[11]

The present case shows that if the usual health industry standards for assessing treatment are maintained there will be no avenue of review based on bias or illegality, even when the refusal to treat costs the patient his or her life.

That leaves the dying patient with the sole remedy of judicial review on Wednesbury grounds. The Court of Appeal did not examine *Wednesbury* principles in Mr Williams' case. Other cases which have pointed to the availability of the remedy have consistently failed to articulate how the *Wednesbury* test might apply in a decision concerning whether or not to treat.[12]

Finally, the comments of the Court concerning the role of the family in such decisions are disturbing. I have argued elsewhere[13] that, in cases where patients are unable to make decisions for themselves, the family members' view on the best interests of the patient should be of primary importance in the doctor's clinical assessment of whether to continue treatment. While there was no finding of illegality or bias in the present case, the Court's statement that the wishes of the family are ultimately irrelevant leaves open the scope for abuse and infringement of basic human rights. Doctors should be joint decision-makers with the family in these circumstances and in cases where there is disagreement, the arguments should be heard and determined either by the court or by an administrative body, such as the Guardianship Board.

Ultimately, the decision is a blow to those who would like to see greater protection for incompetent or semi-competent patients. Giving the medical profession (and ultimately the medical bureaucracy) sole power to make these decisions does not improve the standard of decision making. Nor does it make it any easier for family members to understand why their loved one should die while others are allowed to live.

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[11] *Associated Provincial Picture House v Wednesbury Corporation* [1948] 1 KB 223 (hereafter *Wednesbury*) where it was said that there was a ground for judicial review if a decision was so unreasonable that no reasonable person could have come to it.

[12] See cases above, n 10. Also see R v *North Derbyshire Health Authority; ex parte Fisher* [1997] Med LR 327, where a health authority was found to have both acted illegally and irrationally in deciding not to provide a drug for multiple sclerosis in contravention of a National Health Service policy.

[13] C Stewart, "Who Decides When I Can Die?" (1997) 4 *JLM* 386.