# THE RIGHT TO DIE

*Limits of the parens patriae jurisdiction*

Justice James D Henry

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# THE RIGHT TO DIE – LIMITS OF THE PARENS PATRIAE JURISDICTION

Justice James D Henry[1]

> "*The boundaries which divide Life from Death are at best shadowy and vague. Who shall say where the one ends, and where the other begins?*"

[1] Edgar Allan Poe posed that question in his short story, *The Premature Burial*, published in 1850. He could not then have envisaged the future advances in medical science's ability to support the life of a patient. That ability nowadays prompts agonising questions amidst family and physicians as to when life should end and death begin.

[2] The modern day answer to Poe's old question lies in a much older source – the parens patriae jurisdiction. In that jurisdiction judges exercise the delegated power of the Crown in the discharge of the Crown's direct responsibility to look after those who cannot look after themselves.[2]

[3] The march of medical science has stretched the parens patriae jurisdiction's initial embrace of the mentally ill and minors to persons deprived of the capacity for conscious decision-making by illness or accident.[3] The condition of such persons leaves them unable to decide for themselves whether they should receive or continue to receive life sustaining medical intervention. Such questions typically arise for determination in hospitals and in two categories.

[4] The first occurs in the context of a medical emergency when the patient will certainly die if lifesaving treatment is not initiated. In such cases the unconscious patient's consent to emergency lifesaving treatment is readily inferred, in the absence of specific knowledge to the contrary. A more agonising equation confronts the patient's physicians and family in the second category of cases. The unconscious patient's life is already being sustained by medical life support. There appears to be little hope of recovery and little point in continuing life support and the patient will likely die if life support is withdrawn.

[5] It is this second category of cases – the life support cases – which is the focus of this paper. They are cases in which interested and potentially opposing parties may, in sometimes urgent circumstances, seek the advice of legal practitioners and the intervention and decision of the court exercising its parens patriae jurisdiction. The object of this paper is

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[1] Justice of the Supreme Court of Queensland and the Far Northern Judge. The author gratefully acknowledges the invaluable research assistance of his associate, Ms Brydie Bilic.

[2] *Secretary, Department of Health and Community Services v JWB and SMB, Marion's Case* (1992) 175 CLR 218, 259.

[3] This is not the sole extension. The jurisdiction's protection has also extended to persons in need of protection in other contexts, not considered herein.

to identify the limits, principles and considerations guiding the court's decision making and thus aid the legal advice to be given in such cases.

[6] Some understanding of the development of the parens patriae jurisdiction will assist understanding of the jurisdiction's guiding principle.

**Development of the parens patriae jurisdiction**

[7] In *The Law Relating to Lunacy* Sir Henry Theobald described the origin of the parens patriae jurisdiction as lost in the mist of antiquity.[4]

[8] The jurisdiction's name is obviously of Roman pedigree. *Parens* is latin for parent. *Patriae* is the genitive singular of *patria*, which is latin for "fatherland", so *patriae* means "of fatherland". Allowing for the advent of nation states, *parens patriae* means the "parent of the State".

[9] In ancient Rome *Parens Patriae* was an honorary title bestowed, for example, upon Julius Caesar and Caesar Augustus.[5] That this latin title was later used to describe the English sovereign is unremarkable. What though of the origin of the jurisdiction bearing that title?

[10] It has been speculated the Roman doctrine of *patria potestas* ("power of a father"), which conferred proprietary powers upon a Roman father over his children, has some connection with the evolution of the parens patriae jurisdiction.[6] Perhaps the Roman laws of *tutela* (tutorship) and *curatela* (curatorship), extensions of the Roman paternal power, informed the thinking underpinning the evolution of the jurisdiction.[7] As against this, "the idea of anyone, let alone the State and its ruler, having an obligation to care for the helpless not of your own family or tribe was profoundly radical" in Rome before the adoption of Christianity as the official religion of the Roman Empire in 380.[8] Hence it has been suggested the benevolent teaching of Christianity and the subsequent rise of the idea of a Christian King was the genesis of such a jurisdiction.[9]

[11] Looking beyond such speculation for credible evidence of a historical source, the investigatory trail back in time reaches a dead end in feudal England. That era spawned differently sourced superintending powers over the mentally incompetent and infants.

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4 H Theobald *The Law Relating to Lunacy* (1924) p 1.

5 As is illustrated in this paper's cover sheet image of a Roman coin bearing an image of Julius Caesar and the title *Parens Patriae*. The awarding of the title, including to Marcus Tullius Cicero, is explained in A E Zurek, 'All the King's Horses and All the King's Men' (2006) 27 *Journal of Public Law and Policy* 357, 377-378.

6 A E Zurek, 'All the King's Horses and All the King's Men' (2006) 27 *Journal of Public Law and Policy* 357, 378.

7 The influence of those roles on the modern law of guardianship is usefully explained in CP Sherman *Debt of the Modern Law of Guardianship to Roman Law* 12 Mich L Rev 124 1913-1914

8 Justice F Kunc and K Heath *'Dented and Rusty Like a Suit of Armour? Reflections on the Origins of the Parens Patriae Jurisdiction'* (Paper presented at a Francis Forbes Society Legal History Tutorial, 15 October 2014).

9 Justice F Kunc and K Heath *'Dented and Rusty Like a Suit of Armour? Reflections on the Origins of the Parens Patriae Jurisdiction'* (Paper presented at a Francis Forbes Society Legal History Tutorial, 15 October 2014).

[12] Firstly, as to the mentally incompetent, they were described at common law as "idiots" or "lunatics". "Idiots" were persons said to have been born without glimmer of reason, whereas "lunatics" were persons who, subsequent to their birth, became temporarily or permanently deprived of their reason or *non compos mentis*.[10] The distinction held some financial significance, as explained in Halsbury's *The Laws of England*:

> "In the case of idiots, the King had the custody of their lands (except copyholds) and chattels … without waste, and subject to finding them necessaries, and to the duty of restoring the property to the heirs. In the case of lunatics, the Crown acted merely as trustee, being bound to sustain the lunatic and his family and restore the residue to the lunatic on his return to reason, taking nothing for his own use,"

An entitlement to benefit from use of an idiot's property without duty to account does not suggest a jurisdictional origin of particularly Christian benevolence.

[13] In *The Law Relating to Lunacy* Sir Henry Theobald suggested the Crown's *parens patriae* jurisdiction over the mentally incompetent originated during the reign of Edward I (1272-1307). He wrote:

> "[T]he most probable theory is that either by general assent or by some statute, now lost, the care of persons of unsound mind was by Edw. I taken from the feudal Lords, who would naturally take possession of the land of a tenant unable to perform his feudal duties."[11]

[14] The existence of the power was recognised in the *de Prerogativa Regis* (of the King's prerogative)[12], an instrument of mysterious status, which likely came into existence during the ensuing reign of Edward II (1307-1327).[13] It was a power delegated to the jurisdiction of the Chancellor and then the Court of Chancery.

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10 Earl of Halsbury *The Laws of England* 1909 Vol VI, p 475 [736] fn (g).

11 H Theobald *The Law Relating to Lunacy* (1924) p 1.

12 J Chitty *A Treatise on the Law of the Prerogatives of the Crown,* Butterworth & Son 1820 pp 157-159.

13 "The status of *Prerogativa Regis* is something of a mystery. It is presented as a list of the king's rights, for there are no words of promulgation in it, ordaining or commanding that these rules be kept. This, together with its somewhat anecdotal later sections, led Maitland to conclude that it is not in fact a statute, but a treatise written by a member of the legal profession. Scholars remain unsure of the origin of the document, and its subsequent history is as mysterious as its text. It is included in the *Statutes of the Realm*, but there it is included with the statutes of uncertain date. It is also in the early printed editions of the statutes, where it was assigned by tradition to 17 Edward II. It seems clear that it belongs to the reigns of either Edward I or Edward II, for the text refers to "King Henry, father of King Edward". Maitland suggests that it belongs to the early years of Edward I, but a year book case from the reign of Edward III refers to it as being made in the time of King Edward the father of the present king, while Staunford, in the mid-16th century, argued that it must date from the reign of Edward II, since otherwise the text would have referred to King Henry our father, rather than King Henry father of King Edward. … *Prerogativa Regis* is usually called a statute, but in the period from which it dates, the two most common tests of authenticity for a statute were that it should be dated and sealed. *Prerogativa Regis* meets neither of these criteria. This need not necessarily pose a problem, for the definition of statutes in the 13th and 14th centuries was far from sophisticated. In this period statutes were a relatively novel means of achieving legal change. Plucknett … argues that in the early years of the common law, legislation was hardly a distinct function of king or parliament, but simply one way of changing the common law and that "change was easy and might be effected in very informal ways." Thus in the reign of Edward I and for some time after it, statutes did not differ in their nature from other forms of legal instruction, such as the king's instructions to judge on Eyre, and might simply be the king's expression of his role as law maker." – per M McGlynn *The King and the Law: Prerogativa Regis in Early Tudor England* 1998 Centre for Medieval Studies, University of Toronto (National Library of Canada) pp 37-38 (citations omitted).

[15] Secondly, as to as to the sovereign's power over infants, it evolved out of the way in which heirs were treated by the feudal land holding systems of socage tenure and military tenure. Heirs to socage tenure were placed under the wardship of their nearest relation who, by the late 13th century, could not take profits and had a duty to account to the heir.[14] In harsh contrast, where tenants held land by military service, one of the incidents of that service "entitled the lord to wardship of both the person and property of a male heir under the age of 21 or a female heir under the age of 14 upon the death of a knight service tenant".[15] This entitled the lord, or the Crown in the case of a tenant holding of the King, to the rents and profits of the land during the heir's minority and to arrange and profit from the heir's marriage, without obligation to account.[16] To evade this harsh arrangement, the device of the use was regularly adopted, thus avoiding interests descending directly to an heir. It was countered by the *Statute of Uses* in 1535 and then, to enforce the King's revived feudal entitlement, the Court of Wards was established in 1540.[17] That court is said to have been "established with the express purpose of increasing revenue from sales of wardships".[18] It and military tenures were eventually abolished by the *Tenures Abolition Act 1660*. Socage tenure survived and its more benevolent approach to wardship was kept alive by the Court of Chancery, which justified its power of care over infants as an aspect of its *parens patriae* jurisdiction.[19] Whether the assumption of that power gave sufficient consideration to the connection to property as the historical source of power over wards has been doubted.[20]

[16] In his article *The Origins of the Doctrine of Parens Patriae* Lawrence Custer suggests the inclusion of infants within the parens patriae jurisdiction's protection of idiots and lunatics may have flowed from a printer's error in Lord Coke's reporting of *Beverley's Case* in 1610 and again in 1658.[21] The error substituted the word "infant" in place of the word "idiot" in the report's reference to an explanation by Anthony Fitzherbert's treatise, *Natura Brevium*, on the nature of the King's protective duty towards idiots.

[17] In 1696 in *Falkland v Bertie*[22] Lord Summers, while citing no authority, included the care of infants with idiots and lunatics as traditionally within Chancery's jurisdiction. Then, in 1722, *Beverley's Case* and *Falkland v Bertie* were cited along with Fitzherbert's *Natura Brevium* in 1722 in *Eyre v Shaftsbury*[23] where it was explained that:

> "[E]very loyal subject is taken to be within the King's protection, for which reason it is, that idiots and lunatics, who are uncapable to take care of themselves, are provided for by the King as *pater patriae*, and there is the same reason to extend this care to infants."[24]

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14 J Seymour, 'Parens Patriae and Wardship Powers: Their nature and origins' (1994) 14 *Oxford J. Legal Stud.* 159, 164.

15 LB Custer, 'The Origins of the Doctrine of Parens Patriae' (1978) 27 *Emory LJ* 195, 199.

16 LB Custer, 'The Origins of the Doctrine of Parens Patriae' (1978) 27 *Emory LJ* 195, 199.

17 J Seymour, 'Parens Patriae and Wardship Powers: Their nature and origins' (1994) 14 *Oxford J. Legal Stud.* 159.

18 LB Custer, 'The Origins of the Doctrine of Parens Patriae' (1978) 27 *Emory LJ* 195, 199.

19 *E (Mrs) v Eve* [1986] 2 SCR 388, 4081.

20 *Wellesley v Beaufort (The Duke of)* (1827) 2 Russ. 1, 38 ER 236, 243.

21 LB Custer, 'The Origins of the Doctrine of Parens Patriae' (1978) 27 *Emory LJ* 195, 203 (a correction was made in the 1826 report of *Beverley's Case*). The dubious pedigree of infants' entry into Chancery's parens patriae jurisdiction is also analysed in J Seymour, 'Parens Patriae and Wardship Powers: Their nature and origins' (1994) 14 *Oxford J. Legal Stud.* 159.

22 (1696) 2 Vern 333, 23 ER 814).

23 24 ER 659 (Ch 1722).

24 Ibid 664.

[18] In 1827 in *Wellesley v Beaufort (The Duke of)*[25] Lord Eldon noted Chancery's questionable acquisition of jurisdiction over infants via the King's parens patriae jurisdiction, without doubting what was by then the purely benevolent premise of that jurisdiction. Of that premise he observed:

> "[It] is founded on the obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is clear that some care should be thrown around them."[26]

[19] In the appeal of that decision, *Wellesley v Wellesley,*[27] the House of Lords were in no doubt of the Court of Chancery's parens patriae jurisdiction over infants because, despite the obscurity of its acquisition, successive Chancellors had "unquestionably assumed" and "repeatedly exercised" it for well over a century.[28]

[20] Thus, despite the mixed threads of its beginnings, the parens patriae jurisdiction has long involved the exercise of judicial power on the Crown's behalf to look after minors and those of unsound mind in fulfilment of the Crown's obligation to those who cannot look after themselves. It is a jurisdiction which passed to courts, including the Supreme Courts of Australia's states, which came to exercise the jurisdiction of the Court of Chancery.

[21] Ironically, long subsequent to the export of the parens patriae jurisdiction to the colonies, the jurisdiction was significantly curtailed in the country of its feudal origin. As Lord Brandon explained in *F v West Berkshire Health Authority and anor (Mental Health Act Commission intervening)*[29] the parens patriae jurisdiction relating to minors survives in the wardship jurisdiction of the High Court, Family Division and the jurisdiction over persons of unsound mind no longer exists by reason of the concurrent revocation of warrant under the sign manual of Chancery's jurisdiction and commencement of the *Mental Health Act 1959 (UK).*

**Broad scope**

[22] In the parens patriae jurisdiction the court's obligation on the Crown's behalf to protect the best interest of those who cannot protect themselves bespeaks a jurisdiction of broad scope.

[23] In 1828 Lord Manners presciently observed in *Wellesley v Wellesley*[30] that it was "impossible to say" what the limits of the jurisdiction were. More recently Lord Donaldson observed in *Re W (a minor) (medical treatment)*:[31]

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25 (1827) 2 Russ. 1, 38 ER 236, 243.
26 Ibid.
27 (1828) 2 BLI NS 124, 4 ER 1078.
28 Ibid 1081, 1085. At 1082 Lord Resdale entertainingly compared the absence of an originating source of the court's repeated exercise of jurisdiction to the unascertainable aspects of the constitution and the obscure origins of the two houses of parliament, eg "Will any of your lordships tell me how there comes to be a House of Commons and a House of Lords? I cannot tell you."
29 [1989] 2 All ER 545, 552-553.
30 *Wellesley v Wellesley* (1828) 2 BLI NS 124, 4 ER 1078, 1085.
31 [1992] 4 All ER 627, 637.

> "There is ample authority for the proposition that the inherent powers of the court under its parens patriae jurisdiction are theoretically limitless and that they certainly extend beyond the powers of a natural parent."

[24] Despite the purportedly unlimited scope of the parens patriae jurisdiction it ought be noted immediately that the jurisdiction does not own the field and its application may be limited by legislation.

**Subject to applicable legislation**

[25] Life support cases can attract the operation of statute in varying ways and extents. The legislation of potential relevance in such cases varies too broadly between jurisdictions to be shortly analysed here. However, it may include statutes relating to guardianship, adult guardianship, power of attorney, child protection, family law, medical treatment, human tissue, mental capacity, mental health, imprisonment and correction.

[26] The evolution of UK jurisprudence in life support cases has been materially influenced by statute, most recently the *Medical Capacity Act 2005* (UK) and the *Code of Practice* promulgated by the Lord Chancellor pursuant to it. In their article, *"Best interests" and withholding and withdrawing life sustaining treatment from an adult who lacks capacity in the parens patriae jurisdiction,*[32] Willmott, White and Spence urge an adoption in Australia of the United Kingdom "balance sheet" approach of expressly articulating the for and against factors relevant to determining best interest. The merit of such an approach is undeniable, in that the assessment of for and against arguments and articulation of reasons are quintessential features of discretionary judicial decision-making. Moreover, the modern English decisions are undoubtedly of continuing relevance because of the commonality of issues typically arising in life support cases.[33] Nonetheless, they must be considered in light of their legislative confines.

[27] In Australia, most potentially relevant statutes do not expressly oust the application of the parens patriae jurisdiction and some expressly preserve it.[34] In the absence of an express ouster provision courts are reluctant to infer legislative exclusion of the common law's parens patriae jurisdiction. For example, La Forest J observed in *E (Mrs) v Eve*[35]:

> "[T]he jurisdiction is a carefully guarded one. The courts will not readily assume that it has been removed by legislation where a necessity arises to protect a person who cannot protect himself."[36]

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[32] (2014) 21 JLM 920.

[33] See, for example, *Airedale NHS Trust v Bland* [1993] AC 789 and *Aintree University Hospitals NHS Trust v James* (SC (E)) [2014] AC 591.

[34] See for example s 109(1) *Powers of Attorney Act 1998* (Qld), which provides: "This Act does not affect the court's inherent jurisdiction, including its parens patriae jurisdiction, or the powers the court has other than under this Act."

[35] [1986] 2 SCR 388, 326.

[36] Also see, for example, *Secretary, Department of Health and Community Services v JWB & SMB, Marion's Case* (1991) 175 CLR 218, 253 where the court concluded the decision to sterilise a minor fell outside the ordinary scope of parental powers and thus outside the scope of the statutory powers, rights and duties of a guardian pursuant to s 63E(1) of the *Family Law Act 1975* (Cth).

[28] Nonetheless, even where applicable legislation does not exclude the parens patriae jurisdiction, it will be unnecessary to look to the exercise of that jurisdiction if, on the facts of the case, applicable legislation provides a complete answer to the issue at hand. For example, in *Re BWV; Ex parte Gardner,*[37] a 68 year old patient suffering from a progressive and fatal form of dementia, who had not appeared conscious or exhibited cortical activity or cognitive capacity for some years, was being kept "alive" by the provision of nutrition and hydration through a PEG[38] tube. The Public Advocate was the patient's guardian, pursuant to the *Guardianship and Administration Act 1986* (Vic), and sought declarations that the continued provision of nutrition and hydration by a PEG constituted "medical treatment" rather than "palliative care". That distinction, in the *Medical Treatment Act 1988* (Vic), bore upon the right of a person to refuse medical treatment. In deciding the declaration sought by the Public Advocate should be made, Morris J rejected the application of what he called the "reserve power" of the parens patriae jurisdiction:

> "In my opinion, the court would be failing to give effect to the will of Parliament if it refused to make the declaration sought by the Public Advocate in this case by reference to some discretionary consideration. The fact that a type of reserve power exists provides no logical justification for bypassing the *Guardianship and Administration Act* and the *Medical Treatment Act*.
>
> It is clearly *not* the intention of Parliament that the usual method whereby an agent might refuse medical treatment on behalf of a patient who is dying be one where the agent seeks to invoke either the common law jurisdiction or the parens patriae jurisdiction of the Supreme Court. The Parliament has set in place a careful statutory scheme whereby such decisions can be made by agents or guardians, subject to safeguards to prevent the abuse."[39]

[29] Assuming careful scrutiny of the potentially applicable legislation shows it does not preclude the exercise of the parens patriae jurisdiction, how is a jurisdiction of such unlimited scope to be exercised in life support cases?

**Exercised in accordance with principle**

[30] In the seminal decision of the Australian High Court in *Secretary, Department of Health and Community Services v JWB & SMB ("Marion's Case")*, a case concerned with the forced sterilisation of an intellectually disabled child, the plurality noted the absence of a theoretical limit on the jurisdiction but observed:

> "That is not to deny that the jurisdiction must be exercised in accordance with principle."[40]

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37 (2003) 7 VR 487.

38 Percutaneous Endoscopic Gastrotomy.

39 Ibid 510, 511. Also see, for example, *Qumsieh v The Guardianship and Administration Board & Anor* [1998] VSCA 45 where the court was involved only in reviewing the Victorian Guardianship and Administration Board's determination contrary to the wishes of a strongly committed Jehovah's Witness that life-saving blood transfusions ought be given, *Adult Guardian v Langham* [2006] 1 Qd R 1 where the forced nutrition and hydration of a mentally ill patient under a forensic order was decided under the provisions of the *Mental Health Act 2000* (Qld), *Krommydas v Sydney West Area Health Service* [2006] NSWSC 901 where it was only necessary for the court to declare a patient had died within the meaning of s 33 of the *Human Tissue Act 1983* (NSW), and *Aintree University Hospitals NHS Trust v James* (SC (E)) [2014] AC 591 where recourse to the *Mental Capacity Act 2005* (UK) provided the applicable guidance in a withdrawal of treatment case.

40 Supra 258 (citations omitted).

[31] That the *parens patriae* jurisdiction is to be exercised according to the ordinary principles of a judicial enquiry is unremarkable.[41] What then of the principles guiding the substantive decision whether life support should continue or end?

**The interests of the patient are paramount**

[32] In Canada's leading decision on sterilisation of the intellectually disabled, *E (Mrs) v Eve*,[42] La Forest J compellingly explained the court should look for guidance to the principle informing the jurisdiction:[43]

> "Though the scope or sphere of operation of the parens patriae jurisdiction may be unlimited, it by no means follows that the jurisdiction to exercise it is unlimited. It must be exercised in accordance with its underlying principle. Simply put, the discretion is to do what is necessary for the protection of the person for whose benefit it is exercised… The discretion is to be exercised for the benefit of that person, not for that of others." (emphasis added)

[33] In a similar vein, analysis of the Australian High Court's decision in *Marion's Case*[44] has also resulted in recognition that:[45]

> "[T]he overriding criterion for the exercise of the jurisdiction is the protection of the best interest of the health and welfare of the person the subject of its exercise." (emphasis added)

[34] By what criteria then is the determinative consideration of the patient's best interests to assessed? Perhaps unsurprisingly, the courts have avoided a prescriptive approach to the assessment. For example, despite the afore-mentioned legislative confines of modern English decision-making, Baroness Hale observed in *Aintree University Hospitals NHS Trust v James* (SC (E)):[46]

> "The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts."

[35] Nonetheless the following guiding considerations are readily derived from the authorities.

**Focus upon the patient's interests in treatment being given (not being withdrawn)**

[36] In assessing the patient's best interests the question is not whether it is in the patient's interests to terminate treatment. That is really to ask whether it is in the interests of the patient to die. Such a question misconceives the legal setting, as explained by Lord Browne-Wilkinson in *Airedale NHS Trust v Bland*:[47]

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41 *Official Solicitor to the Supreme Court v K & Anor* [1965] AC 201, 238.
42 [1986] 2 SCR 388.
43 Ibid 427.
44 (1991) 175 CLR 218, 240, 249, 252, 270-273, 295, 300, 316.
45 *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554.
46 [2014] AC 591, 606.
47 [1993] AC 789, 884.

> "The … question assumes that it is lawful to perpetuate the patient's life: but such perpetuation of life can only be achieved if it is lawful to continue to invade the bodily integrity of the patient by invasive medical care."

[37] In the absence of consent, life support constitutes an unlawful assault. As earlier mentioned, the consent of an unconscious patient to emergency lifesaving treatment may ordinarily be inferred. However, the force of such an inference fades as the duration of the treatment grows and the prospects of recovery dim. In exercising the parens patriae jurisdiction for the patient's protection it is for the court to decide whether or not it consents on the patient's behalf to continued medical intervention, a question it determines by whether or not it is in the patient's interests for medical intervention to continue.[48]

[38] It follows the focus is necessarily upon whether it is in the patient's best interests that the treatment is given or continued, not on whether it is in the patient's best interest that the treatment be withheld or withdrawn.[49]

**Medical intervention must be calculated at preserving or improving health**

[39] It is implicit in the above analysis that while death may follow upon the withdrawal of treatment it will not have been unlawfully caused by the doctor's actions in withdrawing treatment.[50] That is because, even though death was a foreseeable consequence of withdrawing treatment, the doctor would have been acting unlawfully by continuing treatment. No issue as to unlawful killing or aiding suicide arises.

[40] Nor can such issues arise through the continuation of treatment, because the treatment under contemplation is life support, that is, treatment calculated at keeping the patient alive, not causing his or her death. Even were the court's task erroneously looked at from the perspective of whether it is in the best interests of the patient to die, the parens patriae jurisdiction could not permit it to sanction medical intervention calculated at causing death or aiding suicide.[51]

[41] The position was succinctly summarised by O'Keefe J after a review of the authorities in *MAW v Western Sydney Area Health Service*:[52]

> "[O]perative procedures that are not necessary to preserve the life or ensure improvement or prevent deterioration in the physical or mental health or well-being of an incapable person <u>are not able to be consented to by the court</u> under

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48 *Cairns and Hinterland Hospital and Health Service* [2015] 2 Qd R 348, 356.

49 *Aintree University Hospitals NHS Trust v James* (SC (E)) [2014] AC 591, 601.

50 *Airedale NHS Trust v Bland* [1993] AC 789.

51 As to the latter see *In Re GM Kinney, Application by Talila Kinney* (unreported, Supreme Court of Victoria, 23 December 1988) where after a failed suicide by an inmate the court refused an application to prevent the medical intervention which was keeping him alive on the basis to have granted the application would have assisted in the inmate's suicide.

52 (2000) 49 NSWLR 231, 240. An arguable related exception also exists in the parens patriae jurisdiction in respect of court authorised abortions however such cases are prima facie not exceptions in that the intervention is to preserve the health of the pregnant woman – see for example *State of Queensland v B* [2008] 2 Qd R 562, *Central Queensland Hospital and Health Service v Q* [2016] QSC 89.

its parens patriae jurisdiction, except in the controversial special category or case of non-therapeutic sterilisation."

[42] The challenge in correctly characterising the nature of the medical intervention was starkly illustrated in *State of Qld v Alyssa Nolan & Anor*.[53] Chesterman J was confronted with an urgent application for declarations in respect of a proposed operation to separate conjoined twin babies, Alyssa and Bethany. They were joined at the head. Bethany had no kidneys or bladder and developed severe pulmonary oedema and critically high blood pressure with complications and had already experienced one episode of cardiac failure. She could not survive longer than 24 hours and if she died while joined to Alyssa, Alyssa would die too. It the twins were separated there was no prospect of Bethany surviving the operation. Alyssa's prospects of surviving the operating were between 20 to 40 per cent. In short, without prompt separation both would certainly die and with it one would die and the other might live. In deciding to make the declarations his Honour spurned any attempt to compare the respective worth or value of the two lives involved. He reasoned the operation was of decided advantage to one twin and of no corresponding detriment to the other, whose pending death was inevitable. He characterised the proposed operation as a good faith, legally justified attempt to save Alyssa's life.[54]

**Exercise with caution**

[43] The courts have repeatedly emphasised that although the jurisdiction is broad it should be exercised cautiously.[55] The need for caution is particularly acute in life support cases given the finality of the withdrawal of life support.

[44] *Northridge v Central Sydney* A*rea Health Service*[56] is an instructive lesson in the need for caution. There, a 37 year old man who suffered a cardiac arrest as a result of an overdose of heroin was, within a few days of his admission to hospital, diagnosed with being in a chronic vegetative state with no prospect of recovery. The court intervened on the urgent application of his family after doctors had ceased the administration of antibiotics and nutrition, ordered he not be resuscitated if his bodily functions ceased and transferred him from intensive care to a renal unit. O'Keefe J initially secured the hospital's consent to the restoration of the status quo by the resumed administration of antibiotics and nutrition, pending the filing of affidavits and a proper consideration of the relevant evidence. As the matter progressed, a divergence of medical opinion emerged. More particularly, in an intervening space of 17 days, the patient "progressed from being comatose, unresponsive and unable to have his eyes open manually, to a person who was sentient, responding well to various stimuli and animated".[57] O'Keefe J concluded the decision to withdraw treatment and nutrition was premature, the prognosis that he would soon die wrong, and the change in his treatment and support consequent on the intervention of the court helped ensure not only that he stayed alive but improved. His Honour observed: [58]

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53 [2001] QSC 174.

54 His Honour was assisted by the approach taken in a similar English case, *In re A (Children)(Conjoined Twins: Surgical Separation)* [2001] 2 WLR 480.

55 See for example *E (Mrs) v Eve* [1986] 2 SCR 388, 427, *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554, *Isaac Messiha (by his tutor Magdy Messiha) v South East Health* [2004] NSWSC 1061 [3].

56 (2000) 50 NSWLR 549.

57 Ibid 565.

58 Ibid 569.

> "These factors highlight the wisdom of allowing a sufficient time to pass between the trauma or other event giving rise to the unconscious state of the patient and the making of a diagnosis of permanent (or chronic) vegetative state, which may be, and in the present case was, a prelude to the withdrawal of treatment, support and nutrition."

[45] The approach of O'Keefe J, in ensuring a return to and maintenance of the life sustaining status quo, demonstrates the importance, where possible, of removing the pressure of potentially error inducing urgency upon the parties and the court. Such an approach has been said to reflect the principle a court should in urgent applications "take whichever course appears to carry the lower risk of injustice if it should turn out to have been 'wrong'".[59]

[46] *Cairns and Hinterland Hospital and Health Service v JT by JT's Guardian*[60] illustrates the ease with which an adjournment and gathering of more information can aid the court's decision-making. There, the patient's diabetic ketoacidosis and cardiac arrest had occasioned a severe hypoxic brain injury. He had been on life support for over a year and a half in what the preponderance of medical opinion considered to be a permanent vegetative state. One doctor dissented from that opinion because the patient's eyes had followed past eye movement tests administered by him, suggesting a possibility of improvement. Critically to that issue, unlike his colleagues, he had used a stimulating light source, an iPad, to test eye tracking. The matter was adjourned for that doctor to further examine the patient and on resumption he revised his earlier opinion and joined in the opinion there was no prospect of improvement in the patient's condition. It was then declared to be in the patient's best interests and lawful for life support to cease, indeed the court found it no longer consented on his behalf to such treatment, so that its continuation would be unlawful.

**Starting presumption in favour of life**

[47] The authorities reveal a strong presumption, at least as a starting point in the court's deliberation, "that it is in a person's best interests to stay alive".[61] Such an approach is obviously consistent with societal views as to the sanctity of human life. In the context of the parens patriae jurisdiction it merely reflects the inherent need for caution before concluding the patient's state has deteriorated so gravely and irredeemably that maintenance of life in the state supported is not in the patient's best interests.

**Extension of life is not inevitably in the patient's interests**

[48] Importantly however, it is the patient's best interests, not the maintenance of life, which is the determinative consideration. The extension of life is not of itself a goal which is inevitably in a patient's interest.

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59 *Slaveski v Austin Health* (2010) 32 VR 129, 132.
60 [2015] 2 Qd R 348.
61 *Aintree University Hospitals NHS Trust v James* (SC (E)) [2014] AC 591, 605.

[49] To be beneficial to the interests of the patient the prolonging of life should serve some therapeutic purpose.[62] The prolongation of life is not per se synonymous with the preservation of health. In *Application of Justice Health; Re a Patient*[63] Brereton J was concerned with an end stage lung cancer patient who was a prison inmate and for whom the state was obliged by s 72A *Crimes (Administration of Sentences) Act 1999* (NSW) to supply medical treatment "for the preservation of the health of the inmate". He declared s 72A did not require the patient to be given cardiopulmonary resuscitation, observing: [64]

> "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."

[50] Further, it is erroneous to assume because an unconscious patient has no apparent awareness or sense of pain or discomfort, that maintenance of life support cannot be against the patient's interests. It will be recalled the parens patriae jurisdiction is enlivened in such a case to protect the interests of the patient for the very reason that the patient's unconscious condition precludes him or her from doing so. Those interests cannot sensibly be assessed on the premise they do not exist by reason of the patient's present lack of consciousness of them. An unconscious patient has as much interest as a conscious patient in the privacy and dignity of the manner of his or her living and dying and in the impact of his or her artificial prolonging of life upon others.[65]

[51] In *Isaac Messiha (by his tutor Magdy Messiha) v South East Health*[66] it was argued the patient being in a deep coma meant there was no "down-side" to maintaining life support. Howie J unsurprisingly rejected such an argument as over simplistic, noting it would mean the court should always decide life support should be maintained.[67] He found the patient's life support in that case to be futile, burdensome and intrusive and declined to conclude it was in the patient's best interests for him to intervene to prevent the withdrawal of life support.[68]

**Excessively burdensome, intrusive or futile treatment weighs against patient interest**

[52] The notion of medical treatment, sustenance and support that is "excessively burdensome, intrusive or futile" was referred to by O'Keefe J in *Northbridge v Central Sydney area Health Service*[69] as a counterpoint to "ordinary reasonable and appropriate" medical treatment, sustenance and support.

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62 *In the application of Herrington; re King* [2007] VSC 151.
63 (2011) 80 NSWLR 354.
64 Ibid 357 [14].
65 *Airedale NHS Trust v Bland* [1993] AC 789.
66 [2004] NSWSC 1061.
67 Ibid [27].
68 Ibid [28].
69 (2000) 50 NSWLR 549, 554.

[53] Of those considerations, futility appears to be the most determinative. If it becomes clear that the maintenance of life support is futile, that it carries no hope of improvement, that will weigh powerfully against continuation of life support.[70] Importantly futility is not necessarily assessed by reference to whether a complete return to good health is achievable. The patient may not previously have been in good health and may have been suffering incurable disease or disability. The more appropriate assessment of futility is whether there is no prospect of the treatment allowing the patient to resume a quality of life which the patient would regard as worthwhile.[71]

[54] The weight to be given to the degree of burdensomeness and intrusiveness of the treatment will obviously vary commensurately with the degree of certainty as to the prospects and extent of improvement. For instance, it may readily be assumed undemanding life support is tolerably in the patient's interests at least for a short while, pending the emergence of reasonable certainty about the patient's future health prospects. It is conceivable that even very burdensome and intrusive life support treatment may be in a patient's interests if it has a realistic prospect of materially improving health. However, there will be a tipping point in the weighing of rival considerations, sometimes referred to as the "touchstone of intolerability",[72] when it is apparent the medical intervention being inflicted upon the patient and the quality of existence it is perpetuating can no longer be justified as being in the patient's best interest.

**Patient's wishes**

[55] The patient's wishes, if known, are an important consideration in assessing the best interests of the patient. With the exception of some laws relating to unborn foetuses, it is well established a competent adult has the right to control what is done to his or her body, including to reject medical treatment, however unreasonable that rejection may appear to others.[73] It might therefore be thought the patient's wishes, if known, should be determinative, in that the court is only involved because the patient is unable to articulate his or her consent or refusal of treatment. Those wishes may well be determinative if there is clear evidence the patient has contemplated the medical situation he or she is now in and indicated he or she does not consent to such medical intervention. However, the evidence will not always be clear. For instance, the patient may only have spoken of his or her wishes in general terms in the past and there may have been intervening circumstances of a kind which, if contemplated, may have provoked a different wish.

[56] The courts have received the hearsay evidence of relatives and friends as to the relevant wishes expressed in the past by the patient.[74] The weight to be given to such evidence will obviously depend upon the individual circumstances of the case.

[57] A more reliable source of evidence of the patient's wishes is an advance health directive, a written direction by a legally competent person identifying the type of medical intervention to which the person does or does not consent in the event of specified medical events. Most

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[70] See for example *Melo v Royal Darwin Hospital* (2007) 21 NTLR 197, 201.
[71] *Aintree University Hospitals NHS Trust v James (SC(E)* [2014] AC 591, 608.
[72] *Aintree University Hospitals NHS Trust v James (SC(E))* [2014] AC591, 606.
[73] The principles are helpfully summarised by McDougall J in *Hunter and New England Area Health Service v A* (2009) NSWLR 88, 90-93.
[74] *Cairns and Hinterland Hospital and Health Service v JT by JT's Guardian* [2015] 2 Qd R 348.

Australian jurisdictions have passed laws recognising and regulating the execution and operation of such documents.[75] The extent to which they will be regarded as giving or refusing consent so as to bind treating doctors will depend upon their apparent validity and the clarity and lack of ambiguity of the directive in its application to the medical circumstance which actually arises.

[58] For example, in *Hunter and New England Area Health Service v A,*[76] an adult member of the Jehovah's Witness faith, was admitted to a hospital emergency department suffering septic shock and soon developed renal failure. He was thereafter kept alive by mechanical ventilation and dialysis. It emerged that a year earlier he had completed a proforma document, distributed by his congregation, in which he had ticked the "I refuse" box in respect of dialysis. The document was unsigned and the hospital sought a declaration as to whether the document was a valid advance care directive and whether the hospital would be justified in complying with the patient's wish as expressed in it. Aided by evidence that the document was indeed completed by the patient and the choice to refuse dialysis was a considered decision the court gave the declarations sought.

**The interests to be considered are the patient's, not the interests of others**

[59] It flows from the premise upon which the parens patriae jurisdiction is based that in life support cases it is the interests of the patient, not the interests of other persons or entities which is determinative.

[60] The point attracted slightly divergent views in the leading sterilisation cases of Canada and Australia. In *E (Mrs) v Eve,*[77] La Forest J observed: [78]

> "The importance of maintaining the physical integrity of a human being ranks high in our scale of values, particularly as it affects the privilege of giving life. I cannot agree that a court can deprive a woman of that privilege for purely social or other non-therapeutic purposes without her consent. <u>The fact that others may suffer inconvenience or hardship from failure to do so cannot be taken into account.</u> The Crown's parens patriae jurisdiction exists for the benefit of those who cannot help themselves, not to relieve those who may have the burden of caring for them." (emphasis added)

[61] In contrast, in *Marion's Case*[79] the plurality observed: [80]

> "There is no doubt that caring for a seriously handicapped child adds a significant burden to the ordinarily demanding tasks of caring for children. Subject to the overriding criterion of the child's welfare, <u>the interests of other</u>

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[75] For example 'Advanced Health Care Directive' referred to in *Powers of Attorney Act 1998* (Qld), s 36; 'Advanced Care Directive' referred to in *Advance Care Directives Act 2013* (SA) s 19; 'Advanced Health Care Directive' referred to in *Guardianship and Administration Act 1990* (WA) s 110;), 'Refusal of Treatment Certificate' referred to in *Medical Treatment Act 1988* (Vic) s 5; 'Advance Consent Decision' referred to in *Advance Personal Planning Act 2013* (NT) s 41.

[76] (2009) NSWLR 88

[77] [1986] 2 SCR 388.

[78] Ibid 434.

[79] (1991) 175 CLR 218.

[80] Ibid 251-252.

> family members, particularly primary care-givers, are relevant to a court's decision whether to authorise sterilization. However, court involvement ensures, in the case of conflict, that the child's interests prevail." (emphasis added)

[62] On one view the plurality's observation in *Marion's Case* does not offend the paramountcy of the patient's interests, for in the event of conflict the patient's interests must prevail. Yet if the patient's interests always prevail it is difficult to reconcile the relevance to the decision of the interests of others, whether consistent or inconsistent with the patient's. This may explain a tendency in subsequent first instance cases in Australia to implicitly treat carers' interests in the sterilisation cases as an exception to the orthodox view that it is solely the interests of the patient which are relevant. For example, in *Northbridge v Central Sydney Area Health Service*,[81] O'Keefe J observed: [82]

> "The exercise of the parens patriae jurisdiction should not be for the benefit of others, including a health care system that is intent on saving costs."

Similarly, in *ACT v JT*,[83] Higgins J observed the fact an outcome may be contrary to the best interests of medical and other providers was not relevant to ascertainment of the best interests of the patient.[84]

[63] However, the reference to the relevance of family in *Marion's Case* may be reconciled if taken into account from the perspective of the patient's interest, as occurred in *Cairns and Hinterland Hospital and Health Service v JT by JT's Guardian*.[85] There the devastating impact which JT's living death was having upon his family was taken into account but not on the basis the family's interests were a relevant consideration in their own right. Rather they were considered on the basis they were relevant to the assessment of JT's best interests.[86] That is, the adverse impact which the artificial prolonging of his life was having upon his family was inconsistent with JT's own interest in the manner of his life and passing not causing unnecessary trauma to those he loved.

**Summary**

[64] It follows from the above analysis that, despite the purportedly unlimited nature of the parens patriae jurisdiction and despite the courts' aversion to prescribing guiding considerations, some limits, a guiding principle and some considerations are readily identifiable in the jurisdiction's application to life support cases.

[65] As to limits, the jurisdiction may be limited by statute, it must be exercised in accordance with principle and it cannot sanction euthanasia.

[66] The sole principle guiding the jurisdiction's substantive decision making, flowing from the jurisdiction's premise, is that the best interests of the patient are paramount.

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81 (2000) 50 NSWLR 549.
82 Ibid 554 (citations omitted).
83 [2009] ACTSC 105.
84 Ibid 45.
85 [2015] 2 Qd R 348.
86 Ibid 356.

[67] The following considerations guide the application of that principle:

(a) the focus is upon the patient's interests in treatment being given (not being withdrawn);

(b) medical intervention must be calculated at preserving or improving health;

(c) caution should be exercised;

(d) start with a presumption in favour of life;

(e) the extension of life is not inevitably in the patient's interests;

(f) excessively burdensome, intrusive or futile treatment weighs against patient interest;

(g) the patient's wishes are important and potentially determinative if certain; and

(h) the interests to be considered are the patient's, not the interests of others (save as they inform the patient's interests).

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