

## Life support withdrawal: who speaks for the patient?



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The L decision appears to be a sensible resolution of a difficult case. Thomas J's judgment is notable for his sensitive and compassionate discussion of the issues. The judge's comments in relation to futile medical treatment and the limits of a doctor's duty to treat are useful. In other respects, the judge's reasoning is troubling, particularly in relation to the legal definition of death and the role of doctors, ethics committees, and relatives in medical decision-making. However, before examining those issues, it is interesting to speculate why the L case ended up in the High Court in the first place.

### Why go to court?

In procedural terms, the L decision is rather unusual. Judges are ordinarily highly reluctant to grant a declaration in civil proceedings on a hypothetical issue of criminal law. Indeed, the Attorney-General, who intervened in the proceedings, initially submitted that such a declaration might amount to a "blanket future immunity" curbing prosecutorial discretion and would constitute improper judicial interference with clinical decision-making. (The latter submission was also made by counsel for the intensivist - doubtless an appropriate concern for a doctor, but surely a curious point for the Attorney-General to make.) Furthermore, the judge noted that his declaration would not bind the Court in any future criminal proceedings. Notwithstanding these points, Thomas J was persuaded to grant the unusual declaration sought in the "diffident hope" that his guidelines would help to clarify the law and would remove "the threat of a nightmarish criminal prosecution" from doctors who have to

Mr L, a 59 year old patient in the Intensive Care Unit at Auckland Hospital, suffered from an extreme case of Guillain-Barre Syndrome. Since 4 August 1991 he had been completely dependent upon artificial ventilation. He was totally paralysed and unable to interact in any way with his environment. Although he was not brain dead, at best his brain was in a drowsy, semi-working state. The intensivists unanimously considered that there was no prospect of recovery. In these circumstances, Thomas J ruled (High Court, Auckland, 13 August 1992) that the withdrawal of artificial ventilatory support from Mr L would not constitute culpable homicide (ie, murder or manslaughter) under the Crimes Act 1961, if the following conditions were fulfilled:

- 1 the doctors responsible for the care of Mr L, taking into account a responsible body of medical opinion, concluded that there was no reasonable possibility of his recovery;
- 2 there was no therapeutic or medical benefit to be gained by continuing to maintain Mr L on artificial ventilatory support, and to withdraw that support accorded with good medical practice as recognised and approved within the medical profession; and
- 3 Mrs L and the Ethics Committee of the Auckland Area Health Board concurred with the decision to withdraw the artificial ventilatory support.

Following the judge's ruling, Mr L's life support system was withdrawn, and he died almost immediately.

make decisions for dying patients. In the judge's colourful prose, "doctors are surely entitled to exchange the threat of the sword of Damocles for the protection of the sword forever proffered in the outstretched hand of Justice".

One may nonetheless question whether it was ever necessary to go to court. The judge stated that the doctors' concern about prosecution for murder or manslaughter was not groundless, and noted that the Solicitor-General and the Attorney-General had declined to give an assurance that no criminal charges would be laid. For all that, it appears that an excessively cautious approach was taken by the doctors and their legal advisers in the L case. As American commentators have observed, "the myth of the incarcerated physician ... haunts our nation's intensive care units" (Armstrong and Jones, "From *Quinlan* to *Jobes*: "The Courts and the PVS Patient" (1988) 18 *Hastings Center Rep* : 27-40. Similar myths are also evident in New Zealand. Nor is the spectre of large damage claims for wrongful termination a realistic concern for local doctors, since they are effectively protected from liability by the Accident Rehabilitation and Compensation Insurance Act 1992.

Indeed, a greater risk is that of civil proceedings against doctors who override a patient's previously expressed wish that treatment be discontinued. The improbability of criminal proceedings against Mr L's doctors was highlighted by the fact that, at the hearing before Thomas J, the Attorney-General consented to the draft form of declaration, which was effectively adopted by the Judge. Thus, although the Attorney-General was not prepared to give an advance assurance, his ready concurrence in the judge's ruling of criminal immunity supports the obvious inference that a prosecution would never, in fact, have been brought.

### Legal definition of death

The judge noted that although the diagnosis of death is medical, the definition must be legal. In the absence of a statutory definition of death in New Zealand, this means that the courts must apply the common law to determine whether a person is dead. In *Joe v Joe* (1985) 3 NZFLR 675, Judge Inglis Q.C. suggested that, as a matter of law, a person will be dead when there is an irreversible cessation of brain stem function so that the person is in a state of permanent and irreversible unconsciousness and when respiration

and circulation can only be sustained artificially. Thomas J declined to give his own definition of death, although the tenor of his remarks support the *Joe* definition. He was content to leave it to the medical profession to determine whether persons in a permanent vegetative state or in a "locked out" state, like Mr L, should be considered dead. This approach is somewhat at odds with the judge's statement that the definition of death is a legal matter. Of more concern is Thomas J's use of the colloquial term "the living dead" to encompass not merely ventilated corpses (eg pending organ transplantation) but also "persistent vegetative state" patients (in a state of permanent unconsciousness) and "locked out" patients, such as Mr L, who may retain some degree of consciousness. These categories of patient raise very different ethical and legal questions, and it is unfortunate that the judge chose to treat them as equivalent (cf. Skegg, "The Edges of Life" (1988) 6 *Otago L.R.* 517, 518-522).

#### *Culpable homicide*

Section 160(2) of the Crimes Act defines culpable homicide to include the killing of any person by an unlawful act or by an omission without legal excuse to perform a legal duty. Thomas J. treated the withdrawal of life support as an omission (ie omitting to continue to provide ventilation) rather than an act, and on this basis the key issues were: (1) Did the doctors have a legal duty to continue Mr L's life support system? (2) Even if the doctors had such a duty, would they have a "lawful excuse" to withdraw the system?

Section 151 of the Crimes Act, applied to the hospital setting, imposes a legal duty on a doctor to supply a patient with the "necessaries of life". The judge ruled that "the provision of artificial ventilation may be regarded as a necessary of life where it is required to prevent, cure or alleviate a disease that endangers the health or life of a patient". Since in Mr L's case there was no prospect of improvement in his condition, the life support system was not a necessary of life. It followed that there was no duty to provide artificial ventilation and that failure to do so would not constitute an omission to perform a legal duty.

The judge's conclusion that the doctors' withdrawal of life support

would not constitute an omission to perform a legal duty was sufficient to negate culpable homicide. However, Thomas J went on to find that, even if doctors did have a duty to provide artificial ventilation, they would have a "lawful excuse" to discontinue ventilation if the discontinuance accords with "good medical practice". This requires: (1) a bona fide decision by the attending doctors, taking into account a responsible body of medical opinion, that life support withdrawal is in the best interests of the patient; (2) approval by the relevant ethics committee; and (3) fully informed consent of the patient's family or guardian.

#### *Judicial guidelines*

The attempt to lay down clear guidelines intended to enable doctors to make critical decisions without recourse to the courts is an admirable one. The troubling feature of the guidelines, however, is that the test of "good medical practice" is premised entirely on an objective determination of the best interests of the patient. The judge's confidence that doctors, ethics committees and relatives will reach the "right decision" (and one which receives a legal imprimatur) may be justified. But who speaks for the patient in all this? Thomas J seems to assume that a "substituted judgment" approach is essentially the same as a "best interests" approach (he expressed the view that "the two tests are inextricably linked"), yet there may be a world of difference between what the patient would have thought was in his best interests, and a decision made by others about his best interests. If, following the Cervical Cancer Inquiry, we are committed to patient autonomy as one ethical principle to be applied in medical decision-making, it is unfortunate that the first New Zealand decision on life support withdrawal contains not even a passing reference to what the patient would have wanted.

By contrast, in the United States much of the debate about termination of medical treatment has turned on the patient's so-called "right to die". The central issue in *Cruzan v Director, Missouri Department of Health*, 110 S. Ct. 2481 (1990) was whether there was "clear and convincing evidence" of Nancy Cruzan's previously expressed wish not to be maintained in a permanent vegetative state. In

upholding the Missouri state requirement of such evidence, the Supreme Court effectively took substituted judgment seriously, and guarded against surrogate decision-making by doctors and family members (see Baron, "On Taking Substituted Judgment Seriously" (1990) 20 *Hastings Center Rep.* 7-8. The English Court of Appeal has taken a similar stance in its recent *Re T* decision (*The Times*, 31 July 1992), upholding a patient's right to refuse medical treatment but requiring clear evidence that an advance refusal represents a fully informed and voluntary decision. And section 11 of the Bill of Rights Act 1990 affirms, in New Zealand law, the right of a patient to refuse medical treatment.

It is no answer to say that a right to refuse medical treatment is meaningless in the case of a semi-conscious patient like Mr L. Our guidelines for medical decision-making in such cases should surely look first for evidence of any previously expressed wishes of the patient. Obviously it will be a rare case where the patient has executed a "living will", but there may be evidence of oral discussions in which the patient expressed a firmly held view that he did not wish to be kept alive if reduced to a permanent vegetative state. In the majority of cases, where there will be no such evidence, it will necessarily fall to the doctors and family to make a surrogate decision for the patient. That decision should reflect what the family member closest to the patient believes he would have wanted had he contemplated his medical predicament (cf *Hastings Center Report, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*" (1987), 24).

At a time when our intensive care units are under increasing pressure, it is worrying that the L guidelines give so much discretion to the medical profession. Thomas J expresses the view that end of life decisions should be resolved by "common principles of humanity and common sense" rather than by "legal logic". But as the debate surrounding "core health services" intensifies, withdrawing life support systems in marginal cases may seem a common sense solution, at least in economic terms. In theory the need for ethics committee approval provides a safeguard, but the Area Health Board Ethics Committees effectively operate

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as research ethics committees and are not generally involved in the clinical decision-making process. And the additional safeguard of consent by family members (a rather open-ended group) is not infallible - consensus decision-making may be particularly difficult when a family is stressed (both emotionally and financially) by maintaining their relative on artificial life support (see, however, Rhoden, "Litigating Life and Death" (1988) 192 Harv. L. Rev. 375). In any event, it cannot be right that family members can compel doctors to continue to administer futile medical treatment, in light of the judge's separate conclusion that there is no legal duty to do so (cf the *Wanglie* case (Minnesota, 1990)).

### Conclusion

Thomas J noted that this topic "has not benefited greatly from the attention which it has received from lawyers". Unfortunately, it must be stated that his own judgment is not free from difficulty. It is regrettable that no *amicus curiae* (independent counsel to advise the Court on general issues) was appointed at the L hearing. Given that the judge chose to issue guidelines which were not strictly necessary for his decision, it is also a pity that he did not simply deliver a brief oral decision, to be followed by written reasons for judgment at a later date. As stated in *Barber v Superior Court of California*, 195 Cal Repr 484, 486 (1983), ironically in a passage cited by Thomas J, litigation is "a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary 'life support' equipment". It is hardly surprising that the attempt to design such a code within the time constraints of the L case has resulted in arguably flawed guidelines.

The New Zealand Court of Appeal has previously commented in relation to medical manslaughter that "evidence of accepted professional standards would not necessarily be conclusive": *R v Yogasakaran* [1990] 1 NZLR 399, 407. Yet the Court's declaration in the L case effectively permits the medical profession to determine doctors' liability for life support withdrawal decisions. There must be a residual role for the courts to protect patients who cannot speak for themselves; history suggests that "good medical practice" may not always be a sufficient safeguard.

In 1984 the U.K. "Warnock Report" proposed that a statutory body should be set up to oversee the practice of certain advanced assisted conception techniques and embryo research. Seven years later, after extensive debate and consultation, the Human Fertilisation and Embryology Act was passed (1990). One of the major components of that Act was the establishment of the Human Fertilisation and Embryology Authority, whose principal statutory function was to regulate certain practices involved in the treatment of infertility and research on human embryos. A licensing system was to be established, this being the core of the Authority's work. The Authority also was required to maintain a register of all treatments given, all people born as a result of a treatment, and all donors.

The Authority's licensing powers and other responsibilities under the Act took effect on the 1 August 1991, and in June of 1992, the Authority presented their first Annual Report to 250 professionals from various programmes and clinics from throughout the United Kingdom on their first year of activity. The author managed to obtain an invitation to the meeting and was impressed with the development of the Authority over the previous year. Given the recent announcement by the Associate Minister of Health that a two-person study team is to be set up in New Zealand to review developments in the assisted reproduction field and to advise Government on action that should be taken regarding the need for legislation and regulation, the model developed in the UK has some interesting implications. The UK report clearly shows that a comprehensive and thorough system had been set up and my assessment, based on the comments made at the meeting, was that the system was receiving widespread support. One area that had not worked well involved the confidentiality clause and the difficulties that this has caused in communications between doctors. A

Government Minister who spoke at the meeting advised that changes to the legislation were about to be enacted.

The Human Fertilisation and Embryology Authority's Report - a copy of which is held by the Bioethics Centre, and another by the author - outlines the work of the five committees that had been set up. These are:

- . The Licensing and Fees Committee
- . The Code of Practice Committee
- . The Information Committee
- . The Organisation and Finance Committee
- . The Committee on Social and Ethical Issues

Guidelines have been set up for the licensing of centres and such centres must forward information on treatment, donations etc to the Authority for inclusion in their Register. The information is designed to be the minimum necessary to allow the Authority to answer questions from children about their genetic background at the appropriate time. Several items are highlighted by the Committee on Social and Ethical Issues as requiring attention, including payment to gamete donors, sex pre-selection of embryos for social reasons, donor anonymity, surrogacy, and the use of research on fetal and other human tissues. The Report is extensive in its coverage of the work undertaken. Its focus is on the previous year but there are also pointers to future work that needs to be undertaken. A more extensive summary of the report appears in the December 1992 issue of the Australian Fertility Society newsletter.

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