OMISSIONS TO PROVIDE LIFE-PROLONGING TREATMENT

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In recent years the High Court of New Zealand has dealt with two cases involving proposals to omit to provide life-prolonging treatment. In the one respect in which these cases can be compared, the contrast could not be greater. In the first case the written judgment was provided to the media, and extensive extracts were printed in a leading newspaper. Even before the judgment had appeared in any law reports, appreciative comments were made about it in the House of Lords.[1] The judgment has been the subject of extensive comment and debate, in New Zealand and overseas, and it will continue to receive attention. In the second case, a different judge apparently suppressed not only all identifying details, but even the fact that the court had dealt with the matter. It is therefore not possible to take account of the decision in any discussion of this area of the law.

The first case has been reported as *Auckland Area Health Board* v *Attorney-General,*[2] but for the sake of brevity will be referred to in this article as *Re L*. The case concerned Mr L who, by the time of the hearing, had been maintained on an artificial ventilator for a little over a year. Mr L had deteriorated rapidly following the onset of Guillian-Barré syndrome. He was not merely unable to breathe spontaneously, but he was also totally paralysed. His nerves involving hearing did not function at all. The visual pathways appeared to be intact, so he may have continued to receive visual impressions. His brain was thought to be in a drowsy semi-working state, probably as a result of sensory deprivation rather than brain damage. Being totally paralysed, he had no responses and showed no awareness. He was unable to interact with his environment in any way, and his condition was irreversible.

In the past, doctors in New Zealand had often terminated artificial ventilation and "allowed the patient to die". However, in the case of Mr L there were particular reasons — not all of which are apparent from the report — why the doctors feared that they might be prosecuted for murder or manslaughter if they ceased to ventilate Mr L. Following an application for a declaratory order, Thomas J made an order which stated

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1 *Airedale NHS Trust* v *Bland* [1993] 2 WLR 316, 370 per Lord Goff ("Thomas J in *In re JHL* (unreported) . . . to whose judgment in that case I wish to pay tribute"), 397 per Lord Mustill ("the thoughtful judgment of Thomas J"), now reported (with the NZLR name of the case and citation substituted) [1993] AC 789, 867, 896.

2 [1993] 1 NZLR 235. In footnotes to this article, the case will be cited as *Re L,* followed by the page number of the relevant passage in the NZLR report.

that, if various specified conditions were met, sections "151 and/or 164 of the Crimes Act 1961 will not apply, and the withdrawal of the artificial ventilatory support from Mr L will not constitute cuplable homicide for the purposes of that Act".[3]

Thomas J acknowledged that it would have been desirable to have had more time to write a learned judgment, particularly if it was to be read as providing "guidelines". However, he was of the view that "the needs of Mr L, Mrs L, and the doctors who have charge of Mr L, must come first".[4] He therefore delivered his judgment within a few days of the hearing. Given the limited time available to him, the preparation of such a lengthy and thoughtful judgment was a remarkable achievement. The judgment deals with many difficult issues, only some of which are discussed here.[5]

This article focuses on the duty of health care professionals to provide life-prolonging treatment, and the related issue of when they have a lawful excuse for omitting to provide such treatment. The expression "life-prolonging treatment" will be used to refer to all treatments which could reasonably be expected to assist a patient to live for a longer time. Hence, as used here, the expression includes treatment which could be said to sustain life as well as treatment which could be said to do no more than defer death.[6]

In this article, a doctor will be taken to have "omitted" to provide life-prolonging treatment if the doctor did not provide the treatment which was most likely to prolong life. In practice, an omission to provide the most effective means of prolonging life will not usually be accompanied by a decision to do nothing which could prolong life in any way. For example, when artificial ventilation is withheld from a patient who is expected to die without it, the patient will sometimes be given other treatment which might prolong life for a time — such as antibiotics for a chest infection, and physiotherapy. Nevertheless, for the purpose of this discussion, there would be an omission to provide life-prolonging treatment.

The article pays particular attention to the judgment in *Re L,* but also tries to set some aspects of that judgment in a wider context. Its focus is on the criminal law, as it affects the provision of life-prolonging treatment for adults. It does not deal with the additional issues which arise in relation to the provision of life-prolonging treatment for children.

It may be helpful to explain that this article had its origin in a request for a paper to be delivered to a seminar sponsored by the Australian and

3 *Re L,* 255, lines 48-50.

4 *Re L,* 243, lines 1-4.

5 For a helpful discussion of various aspects of the judgment in *Re L,* see R J Paterson, "Life Support Withdrawal: Who Speaks for the Patient" (1992) 15 NZULR 213-217.

6 At one stage of his judgment in *Re L,* Thomas J appeared to think that this was a very significant distinction: *Re L,* 245, lines 41-43 and (especially) 49-51. However, the distinction did not feature prominently in the remainder of the judgment — although note *Re L,* 250, lines 7-8, 42; 253, line 46; 255, lines 11-12 (cf *Re L,* 251, line 51).

New Zealand Intensive Care Society.[7] The seminar was arranged because some well-informed New Zealand intensivists were concerned about the implications of the judgment in *Re L*. It is clear that Thomas J hoped that his judgment would assist doctors who deal with these difficult matters.[8] However, there was concern that, if the procedures approved by Thomas J had to be followed in more than a very few cases, resources could not be used in a way which would provide the greatest overall benefit for patients.

The article has four main parts. The first part outlines the different forms of criminal liability which can result from a failure to provide life-prolonging treatment. The second and longest part examines the statutory duty to supply the necessaries of life, especially in the light of the judgment in *Re L*. This is followed by a part that surveys some other duties which have a bearing on the duty to provide life-prolonging treatment. The fourth part draws attention to some other lawful excuses for omitting to provide life-prolonging treatment. It is followed by a brief concluding section.

I Potential Criminal Liability

In *Re L* the focus of attention was the law of homicide. There was no need for the judge to consider other crimes which could be committed by an omission to provide life-prolonging treatment. However, before examining Thomas J's comments about the statutory duty to supply the necessaries of life, it is as well to outline the range of offences that could be committed by the breach of a duty to provide treatment.

In New Zealand law, a "health professional"[9] who omits to provide life-prolonging treatment, when under a duty to do so, may incur criminal liability whether or not death results. Criminal liability will vary depending upon whether death is hastened, bodily harm is caused, or life or health is endangered. These different outcomes will be examined in turn.

A *If the patient's death is hastened*

If a health professional omits, without lawful excuse, to comply with a duty to provide life-prolonging treatment, and this omission is a significant cause of death, liability for murder or manslaughter is a distinct possibility.

7 The seminar was held at the Christchurch School of Medicine on 2 December 1994. I am grateful to the participants, from whom I learnt much. I am especially indebted to Dr Katherine Hall for helpful discussions and for drawing my attention to many of the non-law sources cited here, and to Dr Keith Hickling, whose brief background papers clarified many issues for me and provided helpful information about the realities of medical practice.

8 See *Re L,* 241, lines 43-45; 242, lines 10-12; 243, line 52 to 244, line 4.

9 The term "health professional" will be used on occasions in this article to reflect the fact that doctors are not the only health care professionals who are sometimes under a duty to provide life-prolonging treatment.

Given the structure of the law of homicide in New Zealand, there are three issues which often require consideration: whether it is homicide, whether it is culpable homicide, and whether it is murder or manslaughter.

Is it homicide?

Section 158 of the Crimes Act 1961 provides that: "Homicide is the killing of a human being by another, directly or indirectly, by any means whatsoever." Although section 158 does not contain an express reference to omissions, some related provisions[10] indicate that death may be caused by omissions as well as by acts. They also imply that for the purpose of section 158 "killing" is synonymous with the causing of death. New Zealand judges have followed their English counterparts in holding that conduct may be said to have caused death, for the purpose of the law of homicide, if it is a substantial,[11] or perhaps simply a significant,[12] cause of death. It does not have to be the sole cause of death.[13]

The Crimes Act contains several provisions which make it more difficult for defendants to claim that their conduct did not kill another person. One of these provisions is section 164, which was discussed in *Re L.*[14] It states:[15]

> Every one who by any act *or omission* causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while labouring under some disorder or disease arising from some other cause.

In many cases in which life-prolonging treatment is withheld, withdrawn, or reduced, it would be difficult for the prosecution to prove that if all possible treatment had been provided, death would not have occurred when it did. However, there will be other cases where it will be virtually certain that life could have been prolonged, and that the withholding, withdrawal, or reduction of treatment was a substantial cause of death.

Is it culpable homicide?

Conduct may come within the scope of section 158, and therefore be homicide, although it is lawful. To amount to culpable homicide it must also come within one or more of the five categories set out in section 160(2) of the Crimes Act 1961.[16] Two of these categories are most unlikely to

10 Crimes Act 1961, ss 164-165. See also ibid ss 160(2)(b), 162(3).

11 Eg *R* v *McKinnon* [1980] 2 NZLR 31, 35, 37. See also *R* v *Smith* [1959] 2 QB 35, 42-43.

12 Eg *R* v *Tomars* [1978] 2 NZLR 505, 510. See also *R* v *Malcherek* [1981] 1 WLR 690, 696; *R* v *Pagett* (1983) 76 Cr App R 279, 288.

13 Eg *R* v *McKinnon* [1980] NZLR 31, 36. See also *R* v *Pagett* (1983) 76 Cr App R 279, 288 ("need not be the sole cause, or even the main cause"), and Crimes Act 1961, ss 164-166.

14 For Thomas J's discussion of s164, see *Re L,* 254-255. Thomas J said that in his view s164 had "little or no application to the present case" (*Re L,* 254, line 35).

15 *Emphasis indicated by way of italics, in statutory materials quoted in this article, does not appear in the statute itself.*

16 See also Crimes Act 1961, ss 162-163, which also have a bearing on when homicide is culpable, for the purpose of New Zealand law.

have any application to health professionals.[17] The remainder of section 160(2) provides as follows:

> Homicide is culpable when it consists in the killing of any person –
> (a) By an unlawful act; or
> (b) *By an omission without lawful excuse to perform or observe any legal duty;* or
> (c) By both combined; or
> . . .

When it comes to the omission to provide life-prolonging treatment, paragraph (b) is of particular importance.[18] It is not expressly restricted to duties specified in the Crimes Act, or even to those specified by statute: it refers to omissions to perform or observe "any legal duty".[19] The qualification "without lawful excuse" is important. It is not all death-hastening breaches of a duty which are significant in this context, but only those "without lawful excuse".

Is it murder or manslaughter?

If the conduct which hastened death is not merely homicide, but also culpable homicide, it will be either murder or manslaughter.[20]

If a health professional "means to cause the death of the person killed", within the meaning of that term in section 167(a) of the Crimes Act 1961, a culpable omission to provide life-prolonging treatment may amount to murder. Section 167(a) is not the only provision dealing with the mental element for murder, but the others are unlikely to have any application to a health professional's omission to provide life-prolonging treatment.[21]

Even if someone means to cause a person's death, by omitting to provide life-prolonging treatment, liability for murder or even manslaughter is not a possibility unless the conduct comes within one of the categories of culpable homicide.[22]

If the case is one of culpable homicide, but it is not murder, then it will be manslaughter.[23]

B *If the patient's health is harmed*

It is not only where death is hastened that a health professional could incur criminal liability by omitting to provide life-prolonging treatment.

17 Crimes Act 1961, s160(2)(d),(3).
18 This was the paragraph of s166(2) which was thought relevant in *Re L*. For the most part it seems to have been assumed, rather than argued, that para (a) was not relevant to the conduct of doctors in terminating life-support measures – although see *Re L*, 254, lines 37-41.
19 This matter will be touched upon again later in this article (Pt III, B).
20 The one other form of culpable homicide is "infanticide", which (as defined in New Zealand law) has no possible bearing on the provision of life-prolonging treatment for adults. The special circumstances which can reduce murder to manslaughter are also irrelevant in this context.
21 For the other mental elements for murder, see Crimes Act 1961, s167(b),(c),(d) and s168. Section 167(d) is restricted to cases where a person "does an act".
22 See Crimes Act 1961, s160.
23 Crimes Act 1961, s171.

The Crimes Act 1961 contains several offences which can apply if an omission results in an "injury". "To injure" is defined, in this context, as "to cause actual bodily harm"[24] – which is in turn defined as harm that is more than transient and trifling, but which need not be serious or permanent.[25]

Section 190 of the Crimes Act has the effect of providing a criminal offence that will apply to many omissions which cause bodily harm. It appears in the Act in the following form:

> **190. Injury by unlawful act** – Everyone is liable to imprisonment for a term not exceeding 3 years who injures any other person in such circumstances that if death had been caused he would have been guilty of manslaughter.

The heading is misleading, as the offence is not limited to injury by an unlawful act. It applies in just the same way where there has been an omission, without lawful excuse, to perform or observe "any legal duty".[26] This undoubtedly encompasses the breach of some duties in connection with the provision of medical treatment.

In addition to section 190, the Crimes Act contains other offences that might well apply if a health professional omitted to provide medical treatment with the intention of harming a patient, or with reckless disregard of that outcome.[27]

C *If the patient's life or health is endangered*

It is not only when death is hastened, or bodily harm caused, that a health professional may incur criminal liability in consequence of a failure to provide life-prolonging treatment. There are two offences of endangerment which will sometimes apply where there is a breach of a duty to provide life-prolonging treatment.

Section 145 of the Crimes Act 1961 creates a wide-ranging offence which could apply when a health professional breaches a duty to provide life-prolonging treatment, with the knowledge that the patient's life or health would be endangered by the omission. Section 145(1) provides:

> Every one commits criminal nuisance who does any unlawful act or omits to discharge any legal duty, such act or omission being one which he knew would *endanger* the lives, safety, or health of the public, or *the life, safety, or health of any individual.*

Although there is no express reference to the absence of lawful excuse, in connection with omissions, this qualification should be read into the provision.[28]

24 Crimes Act 1961, s2.
25 *R* v *McArthur* [1975] 1 NZLR 486, 487. See also *R* v *Donovan* [1934] 2 KB 498, 509.
26 See Crimes Act 1961, s160(2)(b). Note also ibid, s160(2)(c).
27 Crimes Act 1961, ss 188-189.
28 Cf Crimes Act 1961, s20.

Where there is a breach of the express statutory duty to supply the necessaries of life,[29] there is the possibility of a more serious offence applying. It is contained in section 151(2) of the Crimes Act, which provides:

> Every one is liable to imprisonment for a term not exceeding 7 years who, without lawful excuse, neglects the duty specified in this section *so that the life of the person under his charge is endangered* or his health permanently injured by such neglect.

There are other offences that would sometimes apply where a health professional omitted to provide medical treatment.[30] However, enough has been said to indicate that there are various offences which can apply to a failure to provide life-prolonging treatment. This makes it all the more important to determine the scope of such duties, and the circumstances in which there is a lawful excuse to omit to provide life-prolonging treatment.

II THE DUTY TO SUPPLY THE NECESSARIES OF LIFE

Section 151(1) of the Crimes Act 1961 provides an express statutory duty to supply the necessaries of life. Although it is not the only possible source of a duty to provide life-prolonging treatment, it is of particular importance. It requires close analysis, especially in the light of the observations of Thomas J in *Re L*.

Section 151(1) provides:

> *Every one* who has *charge* of any other person *unable,* by reason of detention, age, sickness, insanity, or any other cause, *to withdraw himself from such charge,* and *unable to provide himself with the necessaries of life,* is (whether such charge is undertaken by him under any contract or is imposed upon him, by law or by reason of his unlawful act or otherwise howsoever) under a *legal duty to supply that person with the necessaries of life,* and is criminally responsible for omitting *without lawful excuse* to perform such duty if the death of that person is caused, or if his life is endangered or his health permanently injured, by such omission.

This provision has long been part of New Zealand criminal law,[31] but it is no simple task to determine its applicability to modern means of prolonging life.[32] The judgment of Thomas J in *Re L* is now of the first importance in any consideration of section 151(1). It will be considered here in relation to three issues: that of the persons to whom the duty

29 Crimes Act 1961, s151(1), which is discussed at length in Pt II of this article.

30 Eg Mental Health (Compulsory Assessment and Treatment) Act 1992, s114 (cf ibid s66).

31 It appeared in almost the same form in the Criminal Code Act 1893, s148, and in the Crimes Act 1908, s166(1). For its origin, see the Draft Code of the English Criminal Code Bill Commission: *Report of the Royal Commission appointed to consider the Law Relating to Indictable Offences* (C.—2345, 1879), Appendix, s159.

32 This article does not attempt to assess the continuing effect of the approach favoured by the Court of Appeal in *R* v *Burney* [1958] NZLR 745 — as to which see the comments of Sir Francis Boyd Adams, reproduced in *Adams on Criminal Law* (J B Robertson ed, 1992), para CA 151.07. The issues does not appear to have been mentioned in *Re L*.

applies, the question of whether all life-prolonging treatment is a necessary of life, and the question of when there is a lawful excuse for omitting to provide the necessaries of life.

A *To whom does the duty apply?*

In *Re L* Thomas J said, of section 151, that there "is no doubt that the section applies to a patient admitted to hospital care".[33] Many hospital patients are unable to provide themselves with the necessaries of life, or at least with the medical treatment that can be regarded as one of the necessaries of life. One of the requirements of section 151(1) will therefore be met. However, by no means all patients who have been admitted to hospital are unable to withdraw themselves from the charge of the hospital authority or the relevant health professionals. Some are well able to discharge themselves or to make alternative arrangements for their medical care. Section 151 does not impose a duty to supply life-prolonging treatment to such patients.

Section 151 applies to some people who are not in any institution, as well as to many who are in hospital or some other institution.

In *Re L* there was no need for Thomas J to discuss the range of people to whom section 151(1) applies, as the section clearly applied to Mr L. However, the issue of who had charge of Mr L, for the purpose of section 151, could well have been discussed. The declaration concerning section 151 was sought by the Auckland Area Health Board[34] and by Dr Trubuhovich, an intensivist at the hospital at which Mr L was being maintained on a ventilator. The judgment indicates that Dr Trubuhovich was acting, not simply on his own behalf, but as a representative of the other doctors who were caring for Mr L.[35]

If the consultant whom an inpatient is "under" is the only health professional who has charge of the patient, for the purpose of section 151, then there will be a great many circumstances when section 151 will not apply. Unless there is some failure on the part of the consultant (who will often be absent), other members of the team could omit to provide necessary treatment, without section 151 being infringed by any individual.

There would be some advantages in adopting the view that all the health professionals who are supposed to provide medical assistance for a ventilator-dependent patient have "charge" of the patient for that purpose – and hence are under the statutory duty to supply these necessaries of

33 *Re L,* 249, lines 40-41.

34 Mr L was in one of the Board's hospitals, and was being cared for by staff employed by the Board. It is not clear whether Thomas J considered that the Board had charge of Mr L, for the purpose of section 151(1). If the Board had been held to have sole charge of Mr L, for the purpose of section 151, this could have had a significant effect on criminal liability arising out of any breach of the duty to supply the necessaries of life: see eg *R* v *Murray Wright Ltd* [1970] NZLR 476. A court might adopt the view that, in the context of section 151, "every one" refers only to natural persons, as section 151(1) commences "Every one who has charge of any *other* person . . .".

35 *Re L,* 238, lines 50-51.

life.[36] At the very least, the various doctors who have current responsibility for the patient should be regarded as having charge of the patient.[37]

B *Is all life-prolonging treatment a necessary of life?*

If particular treatment is in fact necessary to prevent a patient from dying, it might be thought that the treatment is clearly one of the necessaries of life for that patient. However, in *Re L* Thomas J held that artificial ventilation was not a necessary of life for Mr L, even though it was apparent that without it he would die within a very short time. His reasoning requires careful examination.

Thomas J had no doubt that the phrase "necessaries of life" included medical treatment. However, he placed emphasis on the fact that, in the earlier cases which he cited, the medical interventions that were considered necessaries of life were ones which were necessary to "prevent, cure or alleviate a disease that threatened life or health".[38]

There were no known cases which had dealt with the issue of whether a ventilator was a necessary of life. Thomas J said that to his mind "there is no absolute answer" to the question whether a ventilator is to be construed as a necessary of life; he said "the answer in each case must depend on the facts".[39] In one sense, this is clearly right: if a patient has no need for artificial ventilation, it cannot be regarded a necessary of life for that patient. Similarly, if the provision of artificial ventilation could not prolong the life of a patient who is dying, it is not a necessary of life for that person.

But Thomas J was not making these obvious points. He drew a distinction between cases where the artificial ventilation was required "to prevent, cure or alleviate a disease that endangers the health or life of the patient" and that where "the patient is surviving only by virtue of the mechanical means which induces heartbeat and breathing and is beyond recovery".[40]

Thomas J accepted that a life-support system was a necessary of life where it "served the purpose of preventing, curing or alleviating a disease which threatened the life or health of the patient".[41] In such a case, he

36 The use of the expression "every one", at the beginning of both section 151(1) and section 151(2), is consistent with the view that there may be more than one person who, for the purpose of section 151, has charge of a person who "is unable . . . to withdraw himself from such charge, and unable to provide himself with the necessaries of life". Thomas J's statement in *Re L* that section 151(1) seeks to ensure "that *those* who have care of *one* who cannot care for him or herself supply that person with the necessaries of life" (*Re L,* 247, lines 54-55, emphasis added) is also consistent with the view that section 151 can be taken to impose a duty on more than one consultant, registrar, or nurse.

37 In criminal proceedings, the issue whether a defendant had charge of a patient might be left to the jury to decide as a question of "fact": see generally *R* v *Phillips* [1971] Tas SR 99, [1971] ALR 740, and cases cited therein.

38 *Re L,* 249, lines 47-48.

39 *Re L,* 249, lines 52-53.

40 *Re L,* 249, line 53 to 250, line 22.

41 *Re L,* 250, lines 12-14.

said, artificial ventilation "has a therapeutic or medical advantage in that it may enable a patient to live long enough to recover from the illness".[42]

He contrasted this with the case where recovery was not possible. He said that if the patient "is surviving only by virtue of the mechanical means which induces heartbeat and breathing and is beyond recovery"[43] he did not consider that it could be construed as a necessary of life. Thomas J said:[44]

> In Mr L's case there is no prospect of any improvement. Neither further medical treatment nor nature itself can intervene to repel the disease. Without the life-support system death is unavoidable. In these circumstances it serves no purpose and, for that reason, properly cannot be regarded as a necessary of life.

Thomas J's statements might be taken to indicate that, in his view, a medical intervention is a necessary of life if it can prevent, cure or alleviate a disease, but that it is not a necessary of life if it cannot have this effect and the patient will die if the treatment is not continued indefinitely. Such an approach would be far from satisfactory. Artificial ventilation would never be a necessary of life for a patient who was permanently dependent upon it.

Fortunately, it seems that this is not Thomas J's view. In an earlier part of the judgment, he had said:[45]

> There may be many circumstances in which a patient is kept alive by a life-support system where it would not be appropriate to discontinue that support. A polio victim unable to breathe or to avoid cardiac arrest without medical assistance but who is nevertheless alive, and even perhaps desirous of remaining alive, is one example. No question of withdrawing the ventilator-support system would arise in such a case unless requested by the patient.

Thomas J was not at that stage discussing the meaning of "the necessaries of life". However, his example of a polio victim who is permanently dependent on artificial ventilation suggests that he regarded a ventilator as a necessary of life in those circumstances – even though it could be said of the polio victim, as Thomas J said of Mr L, that "the patient is surviving only by virtue of the mechanical means", "there is no prospect of any improvement", and that "[w]ithout the life-support system death is unavoidable".[46]

In the light of Thomas J's example of the polio victim, it seems clear that Thomas J would accept that many medical interventions are properly regarded as necessaries of life, even though the interventions do not

42 *Re L,* 250, lines 16-17.
43 *Re L,* 249, line 55 to 250, line 3.
44 *Re L,* 250, lines 20-23.
45 *Re L,* 248, lines 39-44.
46 *Re L,* 249, line 55 to 250, line 1; and 250, lines 20 and 21-22, respectively.

have "a therapeutic or medical advantage in that it may enable a patient to live long enough to recover from the illness".[47]

Thomas J's wish to exclude the artificial ventilation of Mr L from the ambit of "necessaries of life" would seem to depend on his judgment that the ventilator was "serving no other purpose than deferring certain death".[48] If there had been some prospect of improvement in Mr L's condition, or if Thomas J had not had the (surprising) conviction "that Mr L deserves the description of 'living dead' as much as if he were brain-stem dead",[49] it is possible that he would have accepted that artificial ventilation was a necessary of life for him.

The main group of patients who could be affected by Thomas J's interpretation of "the necessaries of life" are those in a persistent vegetative state. Although such patients can breathe spontaneously, there is reason to regard their condition as closer to that of brain-stem death, and more deserving of being regarded as "living dead", than was Mr L — who may still have had some cognitive function,[50] It might be said of them, as Thomas J said of Mr L, that they have "passed the point of 'life' and the obligation contemplated by the section is otiose".[51]

In the overwhelming majority of cases, treatment which is necessary to maintain life is likely to be regarded as one of the necessaries of life. However, Thomas J's judgment supports the view that for some patients life-prolonging treatment is not a necessary of life — even though it is clear that without it, they will die.

Section 151(1) provides an important "without lawful excuse" qualification. It is not every apparent breach of the duty to supply the necessaries of life that can result in criminal liability, but only those which are "without lawful excuse". However, this important exception applies only to exclude criminal responsibility. If there was any danger of section 151 being invoked in civil litigation, or in disciplinary proceedings, against

47 *Re L,* 250, lines 16-17.

48 *Re L,* 250, lines 7-8. See also *Re L,* 250, line 22-23.

49 *Re L,* 247, lines 11-12. See also *Re L,* 246, lines 41-55. Thomas J's views about the definition of death require fuller consideration than is appropriate here. However, it may be noted in passing that, once brain-stem death occurs, seeing and thinking are out of the question. Once brain-stem death is established the patient is commonly regarded as dead, and vital organs are sometimes removed while the body is maintained on a ventilator. As Mr L's brain had not been damaged, and as he may still have been able to see and think, it is difficult to accept that "Mr L deserve[d] the description of 'living dead' as much as if he were brain-stem dead".

50 Many of the arguments for regarding as dead patients in whom brain-stem death has occurred apply equally to patients in a persistent vegetative state. Professor Grant Gillett, the neurosurgeon and bioethicist whose affidavit Thomas J found "of considerable help" (*Re L,* 241, line 30), has written that patients in a persistent vegetative state are no longer "in any ethically interestingly sense, alive" (G R Gillett, "Why Let People Die?" (1986) 12 Journal of Medical Ethics 83, 85). But he would not have said the same of Mr L (G R Gillett, pers. comm.). See generally *Persistent Vegetative State and the Withdrawal of Food and Fluids* (Report for the Medical Council by the Bioethics Research Centre, University of Otago, 1993).

51 *Re L,* 250, lines 10-11.

health professionals who withheld life-support measures when it was good medical practice to do so, it would be highly desirable that the courts adopt a restrictive view of what is to be regarded as the necessaries of life. The judgment of Thomas J would provide a starting point for this development, but it would need to be taken much further than Thomas J took it in *Re L*. However, many decades of experience suggests that there is not a significant danger of section 151 and its equivalents being used to impose unwarranted burdens on health professionals.

In a criminal context, there is no need to seek to restrict the ambit of "the necessaries of life", so as to exclude some interventions which are in fact necessary if death is to be prevented. The life-prolonging interventions that might be excluded from the ambit of the term "necessaries of life" will invariably be those which there would be a lawful excuse to omit to provide. The possibility of some life-prolonging treatments being excluded from ambit of "the necessaries of life", even though the patient will die without them, will leave health professionals uncertain whether it is necessary for them to have a lawful excuse, if they discontinue treatment and let the patient die. Thomas J's judgment is itself a puzzle in this respect.

If the provision of life-prolonging artificial ventilation was not a necessary of life for Mr L, there was no need — at least for the purpose of section 151 — to establish that there was a lawful excuse for ceasing to provide artificial ventilation. But despite that undoubted fact, and despite Thomas J's decision to give a prompt decision and his realisation that it would "be desirable to have more time to write a learned judgment, particularly if it is to be read as providing 'guidelines' for the future",[52] Thomas J went on to deal at length with the question of lawful excuse. Indeed, his discussion of lawful excuse was nearly five times the length of his discussion of "the necessaries of life". Furthermore, the declaratory order he made at the end of the case related much more to his discussion of lawful excuse than to his earlier discussion of the meaning of necessaries of life. The attention given to the question of lawful excuse, and the terms of the declaratory order, could give rise to some doubts about how convinced Thomas J was by his own attempt to exclude some life-prolonging treatment from the ambit of "the necessaries of life".

It is not certain that other judges will adopt Thomas J's view, so it is as well to consider the question of lawful excuse in relation to the full range of cases where health professionals withhold or withdraw life-prolonging treatment.

C *Re L and lawful excuses for omitting to supply the necessaries of life*

Section 151(1) does not simply impose a duty to supply the necessaries of life. As has already been stressed, it also has the effect of providing an important qualification to that duty, for the purpose of the criminal

52 *Re L*, 243, lines 1-3.

law. Health professionals and others cannot be held criminally responsible for an apparent breach of the duty to supply the necessaries of life unless they are "without lawful excuse" when they omit to supply them. There are many circumstances where there will be a lawful excuse. Some of these circumstances will be outlined later in this article. At this stage, discussion will focus on Thomas J's discussion of lawful excuse in *Re L* – and, in particular, on the aspect of his judgment which has caused alarm in some medical circles.

In *Re L* Thomas J commenced his discussion of the expression "lawful excuse" by making it clear that, even if section 151 could be taken to impose on doctors a duty to provide artificial ventilation for Mr L, he was "of the firm view that for the purpose of the section they are legally justified in withdrawing that support".[53]

In the case of Mr L there had been exceptionally extensive consultation long before the case came before the court. Eight specialists had examined Mr L, and they were agreed that in view of his condition artificial ventilation should be withdrawn.[54] Mr L's wife and brother (his only immediate family) also agreed with the proposal that artificial ventilation be withdrawn,[55] and so too did an Auckland Area Health Board Ethics Committee.[56]

The declaratory order which Thomas J made at the conclusion of the case did not place any new obstacles in the way of the doctors in this case. The order was in the following terms:[57]

> If:
> (i) the doctors responsible for the care of Mr L, taking into account a responsible body of medical opinion, conclude that there is no reasonable possibility of Mr L ever recovering from his present clinical condition;
> (ii) there is no therapeutic or medical benefit to be gained by continuing to maintain Mr L on artificial ventilatory support, and **to withdraw that support accords with good medical practice,** as recognised and approved within the medical profession; **and**
> (iii) *Mrs L and the ethics committee of the Auckland Area Health Board concur with the decision to withdraw the artificial ventilatory support;*
> then, ss 151 and/or 164 of the Crimes Act 1961 will not apply, and the withdrawal of the artificial ventilatory support from Mr L will not constitute culpable homicide for the purposes of that Act.

Thomas J's discussion of "lawful excuse" placed great emphasis on "good medical practice", a concept to which he returned time and time again throughout his discussion. He said that it was "unacceptable to suggest

53 *Re L,* 250, lines 28-29.
54 See *Re L,* 238, line 34.
55 The agreement of Mr L's brother, and the fact that he and Mrs L were the only immediate family members, was not mentioned in the judgment, but has been reported by counsel for the intensivist: David Collins, "Prescribing Limits to Life-Prolonging Treatment" [1994] NZLJ 246, 247.
56 Idem. See also *Re L,* 251, lines 32-33.
57 *Re L,* 255, lines 38-50. The emphasis in bold type, and also in italics, has been added by me.

that what constitutes good medical practice should not at the same time constitute a 'lawful excuse' ", for the purpose of section 151.[58]

There is clearly considerable scope for discussion about what constitutes "good medical practice", about how the law should take account of diversity in medical practice, and about whether the courts should be willing to make an independent determination of what constitutes good medical practice. There is also considerable scope for discussion about the related issue of the extent to which doctors, or courts, can determine the best interests of a patient without taking account of what can be discovered about the patient's previously-expressed views and values.[59] The judgment of Thomas J has already provoked some discussion of these matters, but there is much that is yet to be said.

Important though these questions are, this discussion will concentrate on the different issue of whether, following *Re L,* doctors are required to obtain the consent of an ethics committee and of a family member before they withhold or withdraw life-support measures from incompetent (and perhaps other) patients.[60] This is the aspect of the judgment which has caused alarm in some medical circles.

There are two passages in Thomas J's judgment which are clearly relevant to this issue. One is the declaratory order which he set out at the end of the judgment. The other is the part of his judgment which dealt with the question of lawful excuse. There are some marked differences between these two parts of his judgment. In the face of such differences, it might seem sensible to focus on the terms of the declaratory order, which could be expected to reflect the judge's considered opinion. However, in this case there is reason to believe that the earlier discussion reflects Thomas J's views at least as well as the order. This is because he explained that, had it not been for the fact that an "agreed" form of declaratory order had been prepared for his consideration by counsel, he might not have made any order. He would then have left the doctors to act on his opinion as spelt out in the judgment. In part because counsel had provided him with an "agreed" form of declaratory order, Thomas J made an order "in terms of that draft with only slight modifications".[61] In view of his explanation, it would not be appropriate to focus exclusively on the terms of the order.

58 *Re L,* 251, lines 14-16.

59 In *Re L,* Thomas J was apparently provided with affidavit evidence about this matter, but it was not mentioned in the judgment.

60 In *Re L* Thomas J's attention was focused on the withdrawal of artificial ventilation from an incompetent patient, and this discussion will not deal separately with the withdrawal or withholding of life-prolonging treatment from a competent patient. It may be assumed that, where the patient is competent, Thomas J would not see a need for the consent of a family member. If the patient had refused consent to life-prolonging treatment, it may be assumed that Thomas J would not see any need for an ethics committee to be consulted as a matter of course — at least if there was no doubt about the patient's capacity, and about the applicability of the refusal of consent to the situation which has arisen.

61 *Re L,* 255, lines 26-35. See also *Re L,* 242, lines 40-51; and 244, lines 32-35.

It will be recalled that one of the conditions in the order, quoted above, was that *"Mrs L and the ethics committee of the Auckland Area Health Board concur with the decision to withdraw the artificial ventilatory support"*. This condition requires comparison with what the judge said in his discussion of lawful excuse. Having indicated that doctors have a lawful excuse to discontinue artificial ventilation where it is "good medical practice" to do so, Thomas J sought to give some content to the term. He said:[62]

> What is important is its perceived content. Clearly, it must begin with a bona fide decision on the part of the attending doctors as to what, in their judgment, is in the best interests of the patient. Equally, it must encompass the prevailing medical standards, practices, procedures and traditions which command general approval within the medical profession. All relevant tests would need to be carried out. In making vital decisions of the present kind specialist opinions and agreement will no doubt be required and extended consultation with other consultants is likely to be appropriate. *Consultation with the medical profession's recognised ethical body is also critical. It must approve the doctor's decision. Finally, the patient's family or guardian must be fully informed and freely concur in what is proposed.* It is the knowledge of this practice, and the assurance that the procedures are conscientously followed, which will provide the public with the confidence to accept the decisions which are then made.

There are some significant differences between this passage and the declaratory order, even in relation to the obtaining of agreement of an ethics committee and of family. In this passage the matter is seen as an aspect of good medical practice,[63] whereas in the order it appears as a separate requirement.[64] In this passage, Thomas J speaks of the need to obtain the approval of "the medical profession's recognised ethical body", whereas the order refers to "the Auckland Area Health Board Ethics Committee" – which was by no means the medical profession's recognised ethical body.[65] There is also a difference between this passage and the order when it comes to the concurrence of family members: in this passage it is said that "the patient's family or guardian" must concur, whereas the order requires only the concurrence of Mrs L.

These differences would provide a minor complication if Thomas J's judgment was to be used as a source of guidelines for future practice. However, if the judgment was to be used in this way, this complication would often pale into insignificance compared with other uncertainties and drawbacks.

62 *Re L,* 250, line 55, to 251, line 13. Emphasis added.
63 This is confirmed by the passage which follows from the part quoted in the text above. See, especially, *Re L,* 251, lines 29-34.
64 But note *Re L,* 254, lines 13-15.
65 The Auckland Area Health Board Ethics Committees were not brought into being by the medical profession, they were chaired by lay people, and the majority of members of the committees were not members of the medical profession. On the membership of such committees, see "Standard for Ethics Committees Established to Review Research and Ethical Aspects of Health Care" (Department of Health, December 1991), 5-6. For accounts of the establishment and functioning of the Auckland Area Health Board Ethics Committees, see *Unfinished Business* (Sandra Coney ed, 1993), 95-98, 103-124.

For all its merits as a way of dealing with the case before him, Thomas J's judgment cannot serve as the source of guidelines for doctors who have to deal with these issues on a daily basis. For one thing, the judgment does not give sufficient indication of the range of procedures and practices, the discontinuance of which should be subject to the concurrence of an ethics committee and of one or more family members. And, however that uncertainty is resolved, a requirement that the agreement of an ethics committee and of a family member be obtained, as a matter of course, would have a highly undesirable effect on medical practice in New Zealand. This requires explanation.

In his judgment, Thomas J's attention was rightly focused on the withdrawal of artificial ventilation. However, when it comes to obtaining the concurrence of an ethics committee and of family, it is far from clear that there could be a good reason to distinguish between the withdrawal of artificial ventilation and the withdrawal of other means of prolonging life. It is also far from clear that there is sufficient reason to distinguish, in this context, between the withdrawal of life-prolonging treatment and the withholding of such treatment in the first place. And even if these complications can be set aside, it is still apparent that, if it had to be followed in other cases, the approach approved in *Re L* would seriously handicap doctors in their attempts to make the best use of the resources available to them.

A rational policy concerning the provision and discontinuance of artificial ventilation needs to take account of two considerations. One is that immediately following a crisis which leaves a patient in need of artificial ventilation, it is frequently impossible for anyone to know, or even to predict with reasonable accuracy, what brain damage has been caused and what are the patient's chances of recovery.[66] The other important consideration is that resources are limited, both in terms of equipment and staff. There are many more patients who could have their lives prolonged by artificial ventilation than can in fact be provided with it. In New Zealand, there is not the least likelihood of enough ventilators being provided to enable health professionals to prolong the lives of everyone whose life could be prolonged by artificial ventilation – even assuming, for the moment, that this would be desirable.

Given the limited resources, and the initial uncertainty about outcomes, there is much to be said for doctors often providing artificial ventilation for a time, while a patient's condition can be evaluated, without thereby incurring an obligation to continue artificial ventilation indefinitely if the patient will die without it and a relative will not consent to its termination.

If, having once provided a patient with artificial ventilation, doctors were obliged to continue it until such time as an ethics committee and a relative consented to its discontinuance, there would be several unfortunate

66 Cf Editorial, "Failure of 'Predictors' of Cardiopulmonary Resuscitation Outcomes to Predict Cardiopulmonary Resuscitation Outcomes" (1993) 153 Archives of Internal Medicine 1293-1296.

consequences. One is that doctors would be more reluctant to provide artificial ventilation in the first place, for fear that they might thereby become obliged to continue it indefinitely. Another is that sometimes doctors would find themselves obliged to continue with artificial ventilation indefinitely, even if they believed it to be futile and against the patient's best interests, because a family member would not consent to its being withdrawn. A greater proportion of the available resources would be taken up with maintaining patients whose prospects were very poor, rather than on providing artificial ventilation on a short-term basis for patients who may have a much better chance of recovery.

It is desirable that, whenever possible, doctors obtain the agreement of family members before they terminate life-support measures. However, in the present state of New Zealand law, it is difficult to see why a spouse – much less "the patient's family" – should have the power to require doctors to continue with artificial ventilation, contrary to the doctors' own judgment and without regard to the interests of others who could benefit from the limited resource. In New Zealand law, a competent patient cannot require a doctor to provide a scarce means of prolonging life, such as dialysis or a kidney transplant, irrespective of any other claims on those resources. Furthermore, if an adult patient is incompetent, there is no general doctrine whereby a spouse or "the patient's family" can consent to treatment on the patient's behalf.[67]

The Protection of Personal and Property Rights Act 1988 makes provision for a welfare guardian to be appointed in some circumstances, and also enables people to make use of an enduring power of attorney, so someone can act on their behalf after they become permanently incapable of acting personally. However, when it comes to decisions to withhold life-support measures, the powers of a welfare guardian and attorney are strictly circumscribed by law.[68] There is no other legal basis for a spouse or close relative consenting, or refusing to consent, on behalf of an incompetent adult patient. Although some sort of case could be made for giving decision-making powers to a spouse, or to a wider family group, the few lines in Thomas J's judgment do not provide an adequate basis

67 See generally *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, esp 30 per Neill LJ ("except in the case of a child, there is in the ordinary way no one who is able to exercise the right on the patient's behalf") and 37 per Butler-Sloss LJ ("Other than in the case of a child there is no one who can give consent on his behalf"); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 103 per Lord Donaldson MR ("in . . . emergency circumstances . . . the next of kin has no legal right either to consent or to refuse consent"); *Airedale NHS Trust* v *Bland* [1993] AC 789, esp 872 per Lord Goff ("incompetent adults, on whose behalf nobody has power to give consent to medical treatment").

68 Protection of Personal and Property Rights Act 1988, ss 18(1)(c), 98(4).

for such a power.[69] On the present state of the law, it is far from certain that doctors are even entitled to continue with treatment which they do not regard as for the benefit of the patient.[70] The consent of the relatives of an adult patient cannot render lawful treatment which would otherwise be unlawful.

Very occasionally there will be a good reason for doctors to seek the advice of an ethics committee, before deciding whether to terminate life-support measures. However, there is little to be said for doctors having to obtain the agreement of "the medical profession's recognised ethical body", or one of the committees which have succeeded the Area Health Board Ethics Committees,[71] as a matter of course. The Medical Council and the Ethics Committee of the New Zealand Medical Association could both be regarded as, in some sense, "the medical profession's recognised ethical body" – although in both cases various caveats would have to be entered. However, neither body is remotely suitable for dealing on a case by case basis with decisions to withdraw artificial ventilation from patients who will die without it. Area Health Board Ethics Committees, or their successors the Regional Health Authority Ethics Committees, would be somewhat better placed to deal with cases on a case by case basis: most of them have monthly meetings, and members could sometimes be called together, or at any rate consulted, more frequently than this. However, even a weekly meeting would often result in the delay of decisions to withdraw artificial ventilation, with the consequence that patients who might have a much better chance of recovery would be denied access to this life-prolonging treatment.

There would be less likelihood of Regional Health Authority Ethics Committees refusing to concur with a decision to withdraw artificial ven-

69 See the authorities quoted in n 67, above. Some commentators favour an enhanced legal role for the family in medical decisionmaking. It is assumed that family members are well able to reflect a patient's views, but anecdotal evidence does not confirm that this is so. One experienced intensivist has informed me that relatives are often confident that they know what the patient would want, but disagree as to what that is. There is also a surprising tendency to overlook the fact that the death or survival of a patient will often have considerable financial and social consequences for a relative. It would be remarkable if relatives could always ignore such considerations when deciding what the patient's wishes would be. Cf *Airdale NHS Trust* v *Bland* [1993] AC 789, 817 per Lord Goff ("In some cases the evidence of relatives will require to be treated with great caution since there may be hidden motives").

70 Compare *Airedale NHS Trust* v *Bland* [1993] AC 789, 885 B, with *Re L*, 250, lines 43-44.

71 Following the abolition of the Area Health Boards, Regional Health Authorities took over responsibility for the major ethics committees. The first Funding Agreement provided: "The responsibility for funding and administering the ethics committees operated by Area Health Boards is to transfer to the RHAs" *(Crown Funding Agreement with Regional Health Authorities for 1993-94).* The current Funding Agreement provides: "The RHA will purchase local ethical review services in accordance with the national standard for ethics committees issued by the Minister of Health . . . . Local ethics committees may be committees of the board of the RHA or committees with whom the RHA contracts" *(Crown's Funding Agreement with Regional Health Authorities for 1994-95).*

tilation than would be the case with some relatives – in part because members of ethics committees would have little if any emotional involvement with the patients, and in part because people who believed that life should be sustained at any cost would not be appointed to the committees. However, there would be important resource implications if the committees had to be consulted whenever doctors wished to withdraw artificial ventilation from a patient who was likely to die without it.

It has already been suggested that a requirement that doctors obtain the agreement of an ethics committee would probably result in doctors being reluctant to provide artificial ventilation for some patients in the first place, or else continuing with artificial ventilation for longer than they thought appropriate, despite there being other patients who could benefit from this resource. But there would be other drawbacks. One is that these cases would deflect the committees from their primary task of dealing with research proposals.

There is also the issue of how well-suited the committees are to make decisions about these matters. Members of Regional Health Authority Ethics Committees are chosen primarily for dealing with health research proposals, not for making decisions about the withdrawal of treatment – which, in many cases, would be outside their terms of reference.[72] Few, if any, members of the committee will have experience of the issues which arise in the day to day work of intensivists. They will have little sense of the constraints which surround decision-making in this context, and the fact that resource limitation is invariably part of the decision to withdraw potentially life-prolonging ventilation. Issues of "prioritisation" would be particularly difficult for committee members to determine, given the circumstances in which decisions have to be made in Intensive Care Units.

Thus far, much of this discussion has proceeded on the assumption that the withdrawal of artificial ventilation can be seen as a case apart. But it is difficult to see why a distinction should be drawn between withdrawing artificial ventilation and ceasing to employ other means of prolonging life – and, it must be said, it is not at all clear that Thomas J would wish to draw such a distinction.[73] If, having started to provide any effective means of prolonging life, doctors were obliged to continue with it until such time as an ethics committee and relatives agreed to its termination, some of the practical considerations set out above would have still greater force. But this would be the least of it.

72 The current Funding Agreement does not envisage local ethics committees having any role in decisions about the withdrawal of treatment. It provides a role for the committees in three areas: health and disability support service research, clinical trials, and new and innovative treatment *(Crown's Funding Agreement with Regional Health Authorities for 1994-95)*.

73 Thomas J said at one point that "the proceeding is concerned with . . . whether a doctor is obliged *to continue treatment* which has no therapeutic or medical benefit, notwithstanding that the *discontinuance* of the treatment *may* result in the clinical death of the patient" (*Re L*, 245, lines 34-37, emphasis added; cf *Re L*, 238, lines 53-55).

In *Re L* Thomas J did not have to consider the omission to provide life-prolonging treatment in the first place, only the discontinuance of such treatment. But it is in fact very difficult to find a good reason for making a sharp distinction between the discontinuance of life-prolonging treatment and the omission to provide it in the first place.[74] In some legal contexts, it must be conceded, there is a distinction between acts and omissions. Some means of ceasing to provide life-prolonging treatment have been viewed as involving acts, rather than as omissions to provide further treatment. Hence there was a time when writers distinguished between the "act" of withdrawing artificial ventilation and an "omission" to provide it. However, this distinction has been much criticised and is now very nearly dead and buried.[75] It would be surprising if any judge wished to give it new life, and there is no reason to believe that Thomas J sought to do so.[76]

Unless there is an ethically and legally significant distinction between the termination of artificial ventilation and the termination of other means of prolonging life, and between ceasing to provide life-prolonging treatment and not providing it in the first place, guidelines based on *Re L* would needlessly handicap many doctors who wish to act in the best interests of their patients by making the best possible use of available resources. Such guidelines could contribute to the reallocation of health care resources — in the direction of treatments which doctors did not believe were appropriate, and of committees that would be needed to deal with the vast number of issues which arise in connection with the withholding and withdrawal of potentially life-prolonging treatment.

The disadvantages of a requirement whereby doctors must obtain the agreement of an ethics committee and of relatives before they withhold or withdraw life-prolonging treatment would far outweigh the advantages.[77]

In view of the time constraints under which Thomas J prepared his judgment, it would not be surprising if he overlooked some of its possible im-

74 See *Airedale NHS Trust* v *Bland* [1993] AC 789, 866-867 per Lord Goff ("For my part I can see no reason why, as a matter of principle, a decision by a doctor whether or not to initiate, or to continue to provide, treatment or care which could or might have the effect of prolonging such a patient's life, should not be governed by the same fundamental principle"), 875 per Lord Lowry ("I do not believe that there is a valid legal distinction between the omission to treat a patient and the abandonment of treatment which has been commenced . . .").

75 See now *Airedale NHS Trust* v *Bland* [1993] AC 789, 866, 872, 875, 881-882, 898. Compare ibid 866 D-E with *Re L,* 255, lines 16-20.

76 In his discussion of lawful excuse, Thomas J referred initially to the "withdrawing" of ventilator support, but soon went on to say that there can be "no single or fixed rule as to exactly when a doctor may *withhold* a life-support system" (*Re L,* 250, lines 28 and 48-49). The use of "withhold", in this context, could be taken as an indication that Thomas J did not see a significant distinction between withdrawing and withholding artificial ventilation.

77 Although the issue is beyond the scope of this article, it may be noted in passing that it is not always the decision to *omit* to provide treatment which is the ethically dubious one: life-prolonging treatment is sometimes provided when a strong case could be made for the view that it would be kinder to omit to provide it.

plications for medical practice, if it was taken to provide guidelines for future cases. It is easy to see how the situation came about. To minimise the chance of recriminations, the doctors responsible for Mr L had obtained the concurrence of an ethics committee, the patient's spouse, and the only other close family member. With the encouragement of counsel, Thomas J approved of the procedure which had been followed. For the purpose of resolving the case itself, this was perfectly satisfactory. But, as a possible source of guidelines for the future, it was less than satisfactory.

Thomas J noted that the process which had been followed in the case of Mr L, with an ethics committee and family members giving their consent, was "not dissimilar" to that adopted by the New Jersey court in the case of Karen Quinlan.[78] Dr David Collins, the barrister who appeared for the intensivist in *Re L* and whose submissions were very influential, has written that the approach was "very similar".[79]

There are perils in transplanting a procedure from one country to another with significantly different practices and traditions. Even names can be misleading: American ethics committees apparently have little in common with most of their namesakes in New Zealand. The major New Zealand ethics committees are primarily research ethics committees, and in the United States would not be called ethics committees at all, but institutional review boards.[80] Artificial ventilation is provided on a vastly greater scale in the United States than in New Zealand,[81] and in many cases there is not the same concern about the most effective use of limited resources. As it has been customary to provide, and to continue to provide, artificial ventilation in circumstances where it would not be provided in New Zealand, decisions to omit or cease to provide it have sometimes seemed more controversial. Related to this is the very different medico-legal environment, which was well-reflected in the debates leading up to the adoption of brain death as a sufficient test for the death of a human being. In the United States, one important consideration was that the new

78 *Re L,* 251, line 35. The case was reported as *In the Matter of Karen Quinlan* (1976) 70 MJ 10, 355 A 2d 647. The matter the ethics committee had to consider was more neurological than ethical. The court declared that: "Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital 'Ethics Committee' or like body of the institution in which Karen is then hospitalised. *If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive sapient state,* the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or other" (70 NJ 24, 355 A 2d 671, emphasis added).

79 David Collins, "Prescribing Limits to Life-Prolonging Treatment" [1994] NZLJ 246, 248.

80 D R C Chalmers, "Institutional Ethics Committees and the Management of Medical Research and Experimentation", *Proceedings of the 49th Annual Conference of the Australasian Law Teachers' Association, Hobart, 1994* (forthcoming).

81 J E Zimmerman et al, "Patient Selection for Intensive Care: A Comparison of New Zealand and United States Hospitals" (1988) 16 Critical Care Medicine 318-326.

approach would enable doctors to withdraw artificial ventilation without the risk of being prosecuted for homicide. However, in New Zealand, as in the United Kingdom, it was already customary to withdraw artificial ventilation in such cases and "allow the patient to die". When it comes to the legal status of relatives in medical decision-making, there are also some differences between the United States and other parts of the common law world.[82]

It is not certain that Thomas J intended that his judgment would serve as a source of guidelines,[83] whereby doctors would regularly be required to obtain the consent of an ethics committee and of relatives. He did, after all, say that there could be no single or fixed rule which would cover "the infinite variety of factual situations arising in practice", even in relation to the withholding of artificial ventilation.[84] His primary concern was to deal with the case of Mr L. Beyond this, his main emphasis was on good medical practice providing a lawful excuse, for the purpose of section 151.

Even if Thomas J did intend that his statements about the need for the concurrence of an ethics committee, and family, would serve as a precedent for future cases, doctors need not fear that they will be acting unlawfully if they do not follow the procedure approved in *Re L.* For one thing, if Thomas J's views about the meaning of "necessaries of life" are accepted, there is no need – at least for the purpose of section 151 – for doctors faced with a patient in Mr L's condition, or in a persistent vegetative state, to establish that they have a lawful excuse. On Thomas J's approach, there would be no duty in the first place.

Thomas J accepted that his decision would not bind judges in later criminal proceedings, even arising out of the same facts.[85] Other judges would not be obliged to follow it, and they would take account of the impracticality of some of the procedures favoured in it, if applied to the range of cases with which health professionals must deal.

Another reason why later judges are not likely to insist on the agreement of an ethics committee and of a spouse or close relative, before life-prolonging treatment is withdrawn, is that this could have the effect of

82 Compare *Deciding to Forego Life-Sustaining Treatment* (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983), 126-136, with the statements of various English judges quoted in n 67, above, and with the Protection of Personal and Property Rights Act 1988, s18(1)(c).

83 Counsel had encouraged the judge to deliver a judgment which provided guidelines (*Re L,* 241, lines 12-16; 242, lines 53-54 – although see 241, lines 22-28). Thomas J was aware of the possibility that his judgment would be read as providing "guidelines" for the future (*Re L,* 243, line 2) and there are a few passages which seem to indicate that he was laying down guidelines (*Re L,* 251, lines 8-10; 254, line 14). There are, however, other passages which do not support this interpretation (*Re L,* 247, lines 46-51; 250, lines 36-38 and 48-51; 253, lines 34-37).

84 *Re L,* 250, lines 48-50.

85 *Re L,* 244, lines 5-17.

requiring doctors to continue treatment which they did not believe to be in the patient's best interests.[86] Thomas J referred to a decision of the English Court of Appeal[87] which has a major bearing on this issue. He said:[88]

> The point, for the present purpose is, as I apprehend it, that a doctor acting in good faith and in accordance with good medical practice is *not* under a duty to render life-support necessary to prolong life if that is, in his or her judgment, contrary to the best interests of the patient.

Given the circumstances of *Re L,* there was no likelihood of the ethics committee or Mrs L withholding agreement.[89] However, were it to be followed in other cases, the procedure approved in *Re L* could well result in a doctor being required to continue with treatment that was "in his or her judgment, contrary to the best interests of the patient".[90]

Doctors should not lose sight of the fact that other New Zealand and Commonwealth case law does not suggest that life-prolonging treatment must continue until an ethics committee and a family member agree that it may be stopped.[91] The year before Thomas J delivered his judgment in *Re L,* the Court of Appeal dealt with an assailant's appeal from a conviction of murder.[92] It was accepted that death had followed from the withdrawal of life-support measures from the severely brain-damaged victim. The judgment of the Court of Appeal referred to "the informed judgment of the medical people concerned, who had concluded that there was no further point in postponing [the victim's] otherwise immediate and in-

86 See Lord Goff's comment in *Airedale NHS Trust* v *Bland* [1993] AC 789, 871. He noted that the Medical Ethics Committee of the British Medical Association was firmly of the opinion that relatives' views cannot be determinative of treatment and continued: "Indeed, if that were not so, the relatives would be able to dictate to the doctors what is in the best interests of the patient, which cannot be right."

87 *Re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15.

88 *Re L,* 252, lines 19-22, emphasis added.

89 See *Re L,* 251, lines 32-33.

90 *Re L,* 252, lines 21-22. On the question of the need to obtain the agreement of an ethics committee and of relatives, there were some passages in Thomas J's judgment which appear to be at variance with the two major passages discussed in this article. In an earlier part of his judgment, Thomas J said that he would expect that if there was a material change in the facts, such as Mr L changing her mind or the ethics committee reversing its earlier endorsement, "the doctors would act responsibly and *reconsider or reverse* their decision" (*Re L,* 244, lines 29-32, emphasis added). This seemed to imply that the doctors might be free to withdraw artificial ventilation without the agreement of Mrs L or the ethics committee – provided they took account of their views. And in a later passage, Thomas J said that if in the doctor's judgment the proper medical practice would be to discontinue the life-support system, and that would be in the best interests of the patient, "he may do so *subject to adhering to a procedure which provides a safeguard against the possibility of individual error*" (*Re L,* 253, lines 47-50, emphasis added). This, too, could be taken to indicate that Mrs L would not have a right of veto.

91 Note *Re L,* 252, lines 42-43.

92 *R* v *Trounson* [1991] 3 NZLR 690.

evitable death".[93] There was not the least hint of criticism of the doctors for withdrawing artificial ventilation without first obtaining the agreement of, for example, an ethic committee.[94]

It needs to be emphasised that the most striking thing about Thomas J's discussion of lawful excuse was not the passage in which he said that the "medical profession's recognised ethical body" and the "patient's family or guardian" must concur with the proposal to withdraw life-support measures.[95] It was his stress on the legal significance of good medical practice. For example, he said that:[96]

> There can be no single or fixed rule as to exactly when a doctor may withhold a life-support system which would cover the infinite variety of factual situations arising in practice. Consequently, the criterion can only be a general phrase such as "good medical practice".

He also said that:[97]

> A doctor acting responsibly and in accordance with good medical practice recognised and approved as such in the medical profession would not . . . be liable, in my opinion, to any criminal sanction based upon the application of s151(1). He or she will have acted with lawful excuse.

There are other passages with a similar emphasis on the relevance of good medical practice,[98] and they point the way to a flexible and realistic approach to these matters in future cases. Thomas J's view that doctors have a lawful excuse where they act in accordance with good medical practice should be encouraging to doctors, who should also welcome the fact that Thomas J wanted these matters to be resolved without recourse to the courts.[99]

The procedure approved by Thomas J in *Re L* is likely to prove helpful in exceptional circumstances, where doctors or administrators might otherwise feel obliged to seek court authorisation. For the most part, however, it is Thomas J's view that whatever constitutes good medical practice provides a "lawful excuse", for the purpose of section 151, that points this area of the criminal law in a realistic and desirable direction.

III Other Duties to Provide Life-Prolonging Treatment

Thomas J's judgment in *Re L* appears to have been prepared on the assumption that section 151 of the Crimes Act 1961 was the only possible

93 Ibid 696.
94 See also eg *R* v *Malcherek* [1981] 1 WLR 690.
95 *Re L,* 251, lines 8-10.
96 *Re L,* 250, lines 48-51.
97 *Re L,* 253, lines 51-55.
98 See *Re L,* 251, lines 14-16; 252, lines 18-21; and also 255, lines 15-18.
99 *Re L,* 241, lines 43-45.

source of a duty to provide life-prolonging treatment for adults. The declaratory order seems to reflect the assumption there were no other possible sources of a duty, breach of which could be characterised as an "omission without lawful excuse to perform or observe any legal duty", for the purpose of section 160(2)(b) of the Crimes Act.[1]

There are, in fact, other possible sources of a duty to provide life-prolonging treatment.

A *Some statutory duties*

There are a number of statutory provisions which have come bearing on the duty to provide treatment.[2] Three of the duty-imposing provisions of the Crimes Act 1961 will be outlined here.

Section 157 of the Crimes Act 1961 could sometimes have the effect of requiring a doctor to provide, and more particularly to continue to provide, life-prolonging treatment. It provides that:

> Every one who undertakes to do any act the omission to do which is or may be dangerous to life is under a legal duty to do that act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

There is no reason to believe that there must be an express undertaking for this section to be operative.[3] Once a health professional agrees to provide life-prolonging treatment, or commences providing it, it is arguable that this section sometimes has the effect of imposing a duty to provide that treatment. Where the section imposes a prima facie duty to act, the question of "lawful excuse" will often be of great importance.

Given the wording of section 157, it may sometimes be desirable that those who provide artificial ventilation make it clear that it is being provided on a temporary basis, while the patient's condition is being assessed, and that there is no undertaking to provide it indefinitely, irrespective of other considerations.

There are circumstances in which sections 155 and 156 of the Crimes Act 1961 could also have some bearing on the duty to provide life-prolonging treatment. Section 155 provides that:

> Every one who undertakes (except in case of necessity) to administer surgical or medical treatment, or to do any other lawful act the doing of which is or may be dangerous to life, is under a legal duty to have and to use reasonable knowledge, skill, and care in doing any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

1 It is possible that Thomas J reasoned that, if there was a lawful excuse for the purpose of section 151, there was also a lawful excuse, not merely for the purpose of sections 152-153 in the case of minors, but also for the purpose of any other duty. See *Re L,* 251, lines 17-18.

2 Eg Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 66, 114; Contraception, Sterilisation, and Abortion Act 1977, s5.

3 Cf Crimes Act 1961, s155 ("Every one who undertakes (except in case of necessity) . . .").

On the face of it, section 155 has more to do with the way in which treatment is provided than on a duty to provide it in the first place. But the two matters are not entirely distinct. The health professionals who have been convicted of manslaughter, on the basis of a breach of this duty, had acted without "reasonable knowledge, skill, and care".[4] However, to say that a doctor has done something negligently is often simply another way of saying that the doctor has omitted to do what a reasonably knowledgeable, skilful and careful doctor would do in the circumstances. A doctor who omitted to complete an operation could sometimes be held in breach of this duty. So, too, could a nurse who omitted to take reasonable steps to enable artificial ventilation to continue – by, for example, keeping the tubes connected.

Section 156 sometimes overlaps with section 155. It provides in part:

> Every one who has in his charge or under his control anything whatever, . . . or who . . . operates, or maintains anything whatever, which, in the absence of precaution or care, may endanger human life is under a legal duty to take reasonable precautions against and to use reasonable care to avoid such danger, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

A negligent omission to take reasonable steps to enable an artificial ventilator to continue to function would sometimes be in breach of this duty.

B *Non-statutory duties*

The "Duties Tending to the Preservation of Life"[5] set out in the Crimes Act cover a wide variety of situations. There are, however, some situations which are not encompassed by these or other statutory duties, where it can nevertheless be said that health professionals have a duty to provide life-prolonging treatment.

People who attend the "accident and emergency" departments of hospitals are often able to withdraw themselves from the charge of the health professionals who treat them there, and in such circumstances section 151 does not impose a duty to supply life-prolonging treatment. If the health professional undertook to provide treatment, or commenced doing so, other statutory duties would sometimes be applicable. However, none would apply to the doctor in the following example. Suppose that late one evening a woman accidentally consumed a poisonous substance and, on discovering her mistake, drove herself to the "accident and emergency" department of the local hospital to obtain treatment. The nurse on duty phoned the doctor on call and gave a full report of what had happened. However, the doctor did not wish to miss the remainder of a play on television, so did not respond to the call. Eventually the woman decided she could wait no longer, so drove herself to an "after hours" doctor's sur-

4 See eg *R* v *Yogasakaran* [1990] 1 NZLR 399.
5 This is the heading which precedes ss 151-157 in the Crimes Act 1961.

gery. However, by the time the antidote was provided it was too late for it to have effect, and the woman died of the poison. It is apparent that, had the hospital doctor responded immediately, the woman's life would have been saved.

The example is a far-fetched one, but it serves to illustrate the limits of the statutory duties. In this situation, the doctor would, at the very least, be guilty of professional misconduct.[6] There is also a distinct possibility that in such a situation the doctor would be held to owe a duty of care to the woman.[7] Assuming that this is so, there could be little doubt that there was a breach of the duty, and that damage resulted from that breach. Were it not for the fact that the woman was dead, rather than disabled, exemplary damages could be awarded against the doctor.[8]

If the doctor was in breach of a duty recognised by the law of torts, could she be convicted of some form of culpable homicide, on the basis that there has been "an omission without lawful excuse to perform or observe any legal duty"? It is not possible to give a categorical answer to this question.

On the face of it, the doctor's omission does come within the terms of section 160(2)(b) of the Crimes Act 1961, with its reference to "*any* legal duty". However, objections could be raised to breaches of tortious duties being used as the basis for criminal liability.[9] It could, for example, be argued that this approach would render nugatory the limits implicit in the statutory duties and the specific indications of when criminal responsibility can follow from a breach of some of the duties.

If the breach of a non-statutory duty can suffice for the purpose of section 160(2)(b), there are other possible duties[10] that will sometimes require consideration before it can be concluded that an omission to provide life-prolonging treatment does not amount to any form of culpable homicide.

It is by no means certain that breaches of common law duties to provide life-prolonging treatment will result in liability for some form of culpable homicide. But, by the same token, it is unwise to assume that, because there is not a breach of one statutory duty, there is no other basis on which a finding of culpable homicide would be possible.

6 Medical Practitioners Act 1968, s43. For an example of a doctor being found guilty of professional misconduct for omitting to respond to a request that he attend a former patient in an emergency, see the case of *Dr A* (1986) 99 New Zealand Medical Journal 921.

7 The example was based on *Barnett* v *Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428, where the doctor was held to have owed a duty of care to a patient, and to have been in breach of that duty.

8 Exemplary damages cannot be sought on behalf of the estate of a deceased person: Law Reform Act 1936, s3(2); *Re Chase* [1989] 1 NZLR 325.

9 See generally *Adams on Criminal Law* (J B Robertson ed, 1992), para CA 160.14. Consider, also, the policy underlying part of s9 of the Crimes Act 1961.

10 See eg *R* v *Miller* [1982] QB 532, 540, [1983] 2 AC 161, 176; *Re F* [1990] 2 AC 1, 55-56.

IV Some Other Lawful Excuses for Omitting to Provide Life-Prolonging Treatment

In *Re L,* Thomas J was well aware that he was dealing with only one of "the infinite variety of factual circumstances" which arise in practice, even in connection with provision of artificial ventilation. He was of the view that there can be no single or fixed rule as to exactly when a doctor may withhold artificial ventilation: "the criterion can only be a general phrase such as 'good medical practice' ".[11]

Thomas J's discussion of "lawful excuse" focused on cases where further treatment could be regarded as, in some sense, futile, or against the best interests of the person whose life was being prolonged. Both concepts are, of course, difficult ones, and there is much that is yet to be said about them. There are, however, many other situations where there will be a lawful excuse to omit to provide life-prolonging treatment. Many of these cases could be brought within the ambit of the concept of good medical practice on which Thomas J placed such emphasis. However, it is desirable to recognise that there will be many cases where there will be a lawful excuse to withhold or withdraw life-prolonging treatment, even though the health professionals are not of the view that treatment is futile or against the best interests of the patient. Two major categories will be outlined here.

A *Refusal of consent*

Where a competent patient refuses to consent to life-prolonging treatment, health professionals will have a lawful excuse to omit to provide it.

It has long been clear that a patient has a right to decline treatment, "however unreasonable or foolish this may appear in the eyes of his medical advisers".[12] This right has been affirmed in the New Zealand Bill of Rights Act 1990, section 11 of which states: "Everyone has the right to refuse to undergo any medical treatment."

Thomas J did not mention patient wishes in his discussion of lawful excuse. However, in an earlier passage in his judgment he referred to the right to refuse treatment as a "fundamental right".[13] He said that it had been held overseas, and would accord with his thinking, that this right "enables a patient, properly informed, to require life-support systems to be discontinued".[14]

It is often difficult to determine whether a patient has the capacity to consent, or to refuse consent, to medical treatment. The law on the mat-

11 *Re L,* 250, lines 48-51.

12 *Smith* v *Auckland Hospital Board* [1965] NZLR 191, 219 per TA Gresson J.

13 *Re L,* 245, line 3.

14 *Re L,* 245, lines 5-6. Thomas J went on to provide an account of the decision of the Quebec Superior Court in *Nancy B* v *Hôtel-Dieu de Québec* (1992) 86 DLR (4th) 385. The case provides an illustration of a patient with Guillain-Barré syndrome exercising the right to refuse life-prolonging treatment. (The patient was incapable of movement, but her intellectual capacity was unaffected.) Note also *Re L,* 248, lines 44-45.

ter is less than straightforward, and its application can be more difficult still.[15] In the context of artificial ventilation, there are not merely the difficulties resulting from impaired consciousness: endotracheal intubation prevents the patient from talking, so communication is difficult.

There is frequently room for disagreement concerning a patient's capacity to give or refuse consent,[16] and opinions about the wisdom of the patient's wishes will inevitably colour some judgments about capacity. There will be occasions where health professionals will be under a duty to provide a patient with additional information, in the hope of persuading the patient to consent to treatment. There will also be occasions where doctors should continue life-prolonging treatment for a time, while taking steps to ascertain whether the patient has the capacity to refuse consent.

However, despite these complications, there can be no doubt that, where health professionals reasonably believe that a patient has refused consent to life-prolonging treatment, they will have a lawful excuse for omitting to provide such treatment.

Thus far, this discussion has concentrated on the situation where the patient has the capacity to refuse consent at the time treatment is withheld or withdrawn. However, this is not the only situation where a refusal of consent will provide a doctor with a lawful excuse for omitting to provide life-prolonging treatment.

In the context of surgery to be performed under general anaesthetic, it has long been accepted that a patient can give consent while competent,[17] and that this consent can have effect at a time when the patient is not competent. The same is the case with the refusal of consent: a person, when competent, can refuse consent to treatment that would otherwise be provided for the patient once incompetent.

Quite apart from section 11 of the New Zealand Bill of Rights Act 1990, there is now strong judicial support for the view that the right to refuse medical treatment can have effect after the patient has become incompetent.[18] In the leading English case of *Airedale NHS Trust* v *Bland,*[19]

15 For a helpful examination of the issues, see *Re T (Adult: Refusal of Treatment)* [1993] Fam 95. Lord Donaldson MR said that a patient must have a capacity which is commensurate with the gravity of the decision which the patient purports to make (ibid 113).

16 See, for example, the disagreement between the judge at first instance and Lord Donaldson MR in both *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 107, 111 and *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 65, 80-81, 84.

17 The term "competent" is used here, as elsewhere in this article, to refer to people who have the capacity to consent, or to refuse consent, to the treatment in question. The term is convenient but potentially misleading, in that it could be taken to imply that capacity is always an all or nothing matter. In fact, people may have the capacity to make some decisions but not others.

18 In addition to *Airedale NHS Trust* v *Bland* [1993] AC 789, 857, 864, 882, 891, see eg *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102-103; *Malette* v *Shulman* (1990) 67 DLR (4th) 321; *Fleming* v *Reid* (1991) 82 DLR (4th) 298, 309-310.

19 [1993] AC 789.

Lord Goff stressed the importance of the principle of self-determination. He said:[20]

> if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so.

And, significantly, he went on to say that:[21]

> the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it; though in such circumstances especial care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred: . . . .

Lord Keith adopted a similar approach. He pointed out that "it is unlawful . . . to administer medical treatment to an adult, who is conscious and of sound mind, without his consent",[22] and then went on to say:[23]

> Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die. This extends to the situation where the person, in anticipation of his . . . entering into a condition such as P.V.S. gives clear instructions that in such event he is not to be given medical care, including artificial feeding, designed to keep him alive.

The specific reference to people in a persistent vegetative state (PVS) makes it clear that a valid refusal of consent can have effect even if the subsequent loss of capacity is permanent, rather than simply temporary.

B *Limited resources*

In a great many circumstances, limited resources will result in health professionals having a lawful excuse for omitting to provide life-prolonging treatment.

In practice, issues about limited resources often mingle with judgments about the patient's best interests. For example, if it would take three months of artificial ventilation to achieve two months of survival following this, the provision of artificial ventilation could often be regarded as against the patient's best interests as well as an inappropriate use of a scarce resource.

In some respects, the issues are simplest when the means of prolonging life could not possibly be provided, given the geographic location of the patient, the means of transport available, and the time available before death will supervene. If the non-availability of the means of prolonging

20 Ibid 864.
21 Idem.
22 Ibid 857.
23 Idem.

life is not the fault of the doctor, that doctor will undoubtedly have a lawful excuse for omitting to provide it.[24]

More difficult is the situation where the provision of life-prolonging treatment is not entirely out of the question, but there are not the resources to provide adequate, much less optimal, treatment for all who could benefit from it.[25] This is the day to day reality of medical practice in New Zealand, as in most other places. This consideration was not mentioned in the judgment in *Re L,* but it does in fact impinge constantly on the decisionmaking of intensivists, as of many other doctors.

In recent years the English Court of Appeal has acknowledged this reality in two cases, both of which have been reported as *Re J (A Minor).* In the first of the cases the matter was mentioned only in passing.[26] Lord Donaldson MR recognised that "in an imperfect world resources will always be limited and on occasion agonising choices will have to be made in allocating those resources to particular patients". But it was, he said, "outwith the scope of this judgment" to give any guidance about the considerations which should determine such allocation, "save to say that the fact that the child is or is not a ward of court is a total irrelevance".[27]

The issue of limited resources received more attention in the second case.[28] The English Court of Appeal was dealing with an appeal against the making of an interim order. The order provided in part that, if the child's life was at risk but was capable of being prolonged by artificial ventilation, the health authority was to "cause such measures (including, if so required to prolong his life, artificial ventilation) to be applied to [the child] for so long as they are capable of prolonging his life". The Court of Appeal did not accept that a court should ever require a medical practitioner (or a health authority acting by a medical practitioner) to adopt a course of treatment which, in the bona fide judgment of the practitioner, is not in the best interests of the patient. But another ground on which the appeal was allowed was that the order did not take account of "the sad fact of life" that health authorities may have too few resources "to treat all the patients whom they would like to treat in the way in which they would like to treat them".[29] In such a situation, said Lord Donaldson MR, it "is then their duty to make choices".[30]

Lord Donaldson MR went on to point out that the court had no knowledge of competing claims to a health authority's resources and was in no position to express any view about how it should deploy them. Balcombe LJ also stressed:[31]

24 Cf *Tifaga* v *Department of Labour* [1980] 2 NZLR 235.
25 Ibid 243.
26 *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33.
27 Ibid 41-42.
28 *Re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15.
29 Ibid 28.
30 Idem.
31 Ibid 30.

> the absolute undesirability of the court making an order which may have the effect of compelling a doctor or health authority to make available scarce resources (both human and material) to a particular child, without knowing whether or not there are other patients to whom those resources might more advantageously be devoted.

The third judge, Leggatt LJ, was of a similar view. He said that even if the health authority could comply with the order, it would then be obliged "to accord this baby a priority over other patients to whom the health authority owes the same duties, but about whose interests the court is ignorant".[32]

It is arguable that, if the procedure approved in *Re L* were adopted in future cases, it could have the same effect as the interim order set aside by the English Court of Appeal. Because a spouse was not willing to agree to artificial ventilation being terminated, doctors would be obliged to continue to provide it, whatever their view of the best interests of the patient or (more important in this context) their awareness that other patients could benefit more from this resource. However, there is, happily, very little danger of a court persisting with this approach once its implications become apparent to it.

The issues seem less difficult when the health professionals have not started to employ a particular means of prolonging life with a particular patient.[33] Especially difficult is the situation where health professionals have commenced employing a particular means of prolonging life, and the patient is benefiting from it to some extent, but the same resource could be used with greater effectiveness to benefit others.[34]

Very occasionally, there may be grounds for arguing that a health professional, or a health care provider organisation, is under a legal duty to continue to provide treatment, irrespective of the interests of others who could benefit from the resources being used in some other way. For the most part, however, it should be accepted that the criminal law should not be used to force doctors to continue to provide a particular treatment for one patient when there are others who could receive greater benefit from the resource.

In the past there there has been a strong tendency to favour the interests of the patient whose treatment has begun over the interests of others awaiting treatment. However, the courts should not adopt the view that it is only doctors who act in this way who are acting in accordance with a good medical practice. Given the ongoing debate about resource allocation issues, and the inherent difficulty of decisions which have to be made —

32 Ibid 31.
33 But see the observations quoted in n 74, above.
34 See H T Engelhardt and M A Rie, "Intensive Care Units, Scarce Resources, and Conflicting Principles of Justice" (1986) 255 Journal of the American Medical Association 1159-1164; M D Swenson, "Scarcity in the Intensive Care Unit: Principles of Justice for Rationing ICU Beds" (1992) 92 American Journal of Medicine 551-555; D Teres, "Civilian Triage in the Intensive Care Unit: The Ritual of the Last Bed" (1993) 21 Critical Care Medicine 598-606.

sometimes under great pressure, with limited information – the courts should at this stage be extremely cautious about insisting on one approach to the exclusion of another. There is also the issue of the scope of the criminal law. Section 151 of the Crimes Act 1961 and similar provisions are suitable for dealing with outrageous omissions to provide the necessaries of life. They do not provide a suitable vehicle for the courts to give guidance to the medical profession about matters on which opinions can reasonably differ and about which the courts have limited experience and understanding. As Thomas J said of a different though related issue in *Re L,* in exercising their judgment in these matters, doctors "should not be inhibited by considerations pertinent to their own self-interest in avoiding criminal sanctions".[35]

CONCLUSION

There are many reasons why a health professional may have a lawful excuse for omitting to provide, or to continue to provide, life-prolonging treatment. A neurosurgeon, Professor Bryan Jennett, has recently provided an account of inappropriate uses of medical technology. His analysis is helpful in connection with life-prolonging treatment which does not involve technology, as well as that which does. He wrote:[36]

> Use might be ***unnecessary,*** because the patient's condition is insufficiently serious to justify it . . . . The use of a technology may be ***unsuccessful,*** because the patient's condition is too advanced to respond to that intervention . . . . A less absolute type of inappropriate use is when a technology's use is ***unkind,*** because it prolongs life of poor quality; or when it is ***unsafe,*** because the expected complications outweigh the anticipated benefits. Lastly **the use of a technology may be deemed *unwise,* because it diverts resources from alternative health care activities that would bring more benefit to other patients.** The first four of these inappropriate uses are to be regarded as offending the ethical principle of disproportion between the probability of beneficence and of non-maleficence. A sixth type of inappropriate use might be that it is ***unwanted*** because it is against the wishes of the patient, and fails to respect his autonomy.

Some of these six categories – unnecessary, unsuccessful, unkind, unsafe, unwise, and unwanted – fit more easily into existing an existing legal framework than do others. The law does, for example, provide a reasonably adequate framework for dealing with cases where treatment is not wanted by the patient. For the future, a particular challenge is presented by the circumstances where treatment can reasonably be regarded as an unwise use of resources. As Professor Jennett points out:[37]

35 *Re L,* 253, lines 37-40.
36 B Jennett, "Medical Technology, Social and Health Care Issues" in *Principles of Health Care Ethics* (R Gillon ed, 1994), 861, 865. The italics are Professor Jennett's; the bold type has been added.
37 Ibid, 866.

> The failure to withhold or withdraw treatment from a hopeless patient soon after arrival may also deny treatment to another who could have benefited – an example of distributive injustice in the use of resources.

The concept of "good medical practice", on which Thomas J placed such emphasis in *Re L,* could easily be developed to take account of the desirability of health professionals using available resources for the maximum benefit.

The law has only a limited part to play in helping health professionals make the best use of available resources. Fortunately, given the main emphasis of Thomas J's judgment in *Re L,* there is a good prospect that New Zealand health professionals will be able to deal with these difficult issues without being "inhibited by considerations pertinent to their own self-interest in avoiding criminal sanctions".[38]

38 *Re L,* 253, lines 39-40.