JUDICIAL VIEWS ON MEDICAL PROCEDURES

*Justice G N Williams, AO

Bryan Horrigan, an Australian Legal Academic, in the foreword to one of the chapters in his book "Adventures in Law and Justice" wrote:

> "'Playing god is playing with fire. That comment neatly captures the dilemmas confronting judges, politicians, and the community in a variety of life and death contexts. Those dilemmas raise a mixture of medical, moral, legal, and even political questions concerning abortion, stem cell research and cloning, wrongful births, withdrawal of unwanted medical treatment, surgery on conjoined twins, physician-assisted suicide, and even capital punishment."

They are issues I addressed in a paper I delivered to young lawyers in Brisbane in March 2001. Against that background I questioned what should be included in legal education; should the student have a broad, liberal education, or should a law course be designed to impart specialised technical competence. Few lawyers these days study philosophy. Whilst most lawyers have to pass a subject termed "legal ethics", there is no significant study of ethics in the broader sense.

Yet as the quote set out at the beginning of this paper demonstrates, lawyers nowadays require a deeper understanding of philosophy and ethics than did their forebears. Pressures are mounting to have studies of philosophy and ethics on a broader basis included in the law curriculum.

The next generation of lawyers will have to address significant challenges in the area of bioethics. The unravelling of the human genome has created a virtual minefield for lawyers. The wider community is only today beginning to appreciate how decisions of courts will impact upon life in the coming years. Many legal principles still of relevance today were formulated when medical science was far less sophisticated than it is now. An analysis of the reasoning of the members of the English Court of Appeal *In Re A (Children) (Conjoined Twins: Surgical Separation)*[1], exposes the efforts of judges to rationalise and justify what each regarded as the appropriate decision in conformity with past, accepted legal principle. But one also sees in such cases the acceptance of reasoning previously rejected. Some recourse in that case was had to the doctrine of necessity, an approach rejected for many years by liberal minded judges as a proper basis of legal reasoning.

Because of the issues involved it is not surprising that there is a wide disparity in judicial reasoning in these areas of the law. That is well demonstrated by considering *McFarlane v Tayside Health Board*[2] and *Cattanach v Melchior*[3].

Each case involved the question of the recovery of damages for maintenance of a child conceived after a failed sterilisation procedure. The first case progressed through the Scottish system, initially being heard by a single judge of the Court of Session and then by an appellate court of four. It then went to the House of Lords where five members sat. Some nine judgments in all were delivered, and it is difficult to find much common ground in them. It is obvious that the social background of the judges impacted significantly on the decision making process with respect to the "unwanted child".

The position was much the same in the Australian case. There is vast disparity in the reasoning of the judges involved in that case as it progressed through the Queensland Supreme Court to the High Court. The lack of a clear governing principle is further emphasised by the fact that the majority of the High Court in *Cattanach* declined to follow the majority reasoning of the House of Lords in *McFarlane*.

Cases such as those to which I have referred will continue to be at the forefront of the development of the law over the next few decades. The issues are so politically sensitive that legislatures are in all probability not going to clarify the applicable law by enacting statutes. The politicians have the easy way out – do nothing. That solution is not available to the judges. The problems will not go away; when such an issue is raised it has to be addressed, and moreover, reasons have to be given for the particular decision.

That is why I urged, in the paper to practitioners in 2001, that young lawyers should study in greater depth the moral and ethical issues which are raised in such cases. The courts ultimate capacity to arrive at acceptable decisions will to a large extent be dependant upon the input into submissions by the legal profession, and in consequence it is necessary for all lawyers to have a greater understanding of the medical, social and issues involved.

Computerised legal research will not provide the answer.

Computers have no capacity to deal with the reasoning that cases of the type I have been discussing require. There is no point in putting before a court a list of cases in which some aspect of the topic has been considered in the past. What is required is an in-depth consideration of the social and moral issues involved and, of course, some consideration of the way in which accepted legal principles impact upon such issues.

Regrettably, but understandably, decisions in these areas will often generate acrimonious public debate. The decision maker will have to bear the burden of criticism from at least a significant group in society. Much of that criticism of the decision maker will be due to the fact that the media are disinclined to publish reasons for judgment in full. That is understandable, particularly when the reasons may be quite lengthy, but the failure to give extensive exposure to the judge's published reasons for a decision often means that the public debate is conducted in ignorance of relevant reasoning.

What in my view must be stressed is that the judicial system has been able generally speaking to meet the demands placed on it by cases of this type. Both the conjoined twins case in England and that which came before the Queensland Supreme Court (*State of Queensland v Nolan*[4]) were dealt with expeditiously so that a timely decision was made with respect to the surgery in issue. In the Queensland case the condition of one of the twins deteriorated rapidly during the evening of 25 May 2002.

The application in question was bought on as a matter of urgency before Justice Chesterman at 11.00 pm that evening. The operation to separate the twins was scheduled for 6.30 am the following morning. The hearing before the judge lasted until about midnight and the judge sanctioned the operative procedure indicating he would publish formal reasons subsequently. The operation was a success in that one of the twins survived.

The capacity of courts to deal expeditiously with such cases is well illustrated by reference to the case of *K v T*. *T* became pregnant after an isolated act of intercourse with *K*. They were not married and did not live together. *T* decided to have an abortion which on the evidence, applying the test formulated in *R v Bourne*[5] and in *R v Davidson*[6], was arguably legally justifiable. Because of his religious beliefs *K* was opposed to the abortion, wanted to support *T* during the pregnancy, and ultimately to have the child adopted. *K* applied to the Supreme Court for an injunction to restrain the carrying out of the operative procedure and the matter was of some urgency given the stage of the pregnancy. In consequence the matter came before me at about 9.00 pm on Wednesday, 23 March 1983. The hearing lasted until about midnight, and I delivered my reasons for refusing the injunction at 9.30 am on Friday, 25 March 1983[7]. *K* secured the fiat of the Attorney-General to appeal and the appeal was heard by the Full Court the following Tuesday, 29 March 1983. The reasons of the Full Court dismissing the appeal were delivered on the following day, 30 March 1983[8]. Later that day, 30 March 1983, an application for special leave to appeal to the High Court of Australia and for an interlocutory injunction was heard by Mr Justice Gibbs, Chief Justice of the High Court. He delivered reasons that day refusing the relief sought[9]. Thus within a week the case progressed through a hearing before a single judge of the Supreme Court, an appeal to the Full Court of the Supreme Court, and to the High Court. That clearly demonstrates that from a

practical point of view the judicial system can deal expeditiously as required with cases of this type.

It is worth listing some of the various ways in which questions about medical procedures have come before the courts, if only because the diversity of the list demonstrates that there is no single principle which provides the answer in all cases. The following has been compiled from a brief review of decisions in a number of jurisdictions worldwide, but it is by no means comprehensive:

(1) Consent to treatment generally. This can arise either because the patient is a child who in law cannot give consent, or is an adult who is deprived of the capacity to give consent or has only an impaired capacity to do so. The consent may be either to a minor procedure (such as an injection) or a major procedure (such as amputation of a leg).

(2) Consent to sterilisation of a child. This always requires consent from the appropriate tribunal and in some instances is the subject of legislation (see sections 80C and 80D of the *Guardianship of Administration Act* 2000 Queensland).

(3) Consent to an operation separating conjoined twins where the procedure is necessary to save one but will cause the death of the other.

(4) Whether doctors should take skin from a healthy child for grafting to a severely burned twin.

(5) Whether a child should be subjected to paternity testing.

(6) Whether a child should donate an organ to an adult relative where the child wished to do so.

(7) Whether doctors should be authorised to perform a caesarean section to deliver a child against the mother's wishes where the mother was HIV positive and where there was a strong possibility that vaginal delivery would infect the child.

(8) Whether doctors should be authorised to perform a caesarean section against her wishes on a mother suffering severe pre-eclampsia where the baby was likely to die if that procedure was not carried out.

(9) Whether or not doctors should be authorised to carry out a blood transfusion necessary to save the patient's life. This question may arise either with respect to a child incapable of giving consent or with respect

to an adult who refuses to give consent (for example, for religious reasons).

(10) Whether or not doctors should be authorised to operate to remove a bowel blockage on a child with severe Down's syndrome.

(11) Whether doctors should be authorised to carry out a liver transplant on an extremely ill four week old baby where the prognosis was not good and where the parents objected to that procedure.

(12) Whether damages should be awarded to a mother who gave birth after a failed sterilisation procedure either on herself or her partner. There is also the associated question of under what headings damages should be awarded if awarded at all.

(13) Whether an order should be made authorising the switching off of life support systems.

(14) Whether or not authorisation should be given for genetic testing for hereditary diseases.

(15) Applications seeking court approval to assisted suicide.

(16) Whether authorisation should be given to use the sperm of a deceased partner for IVF purposes.

(17) Applications seeking authorisation for surgical procedures to change sexual orientation.

(18) Applications seeking authorisation to remove stem cells for research purposes.

(19) Applications for the destruction of frozen embryos.

(20) As a corollary to most of the above, applications seeking orders restraining the carrying out of the procedures mentioned.

In determining most of such applications the court would have regard to the "best interests" test – that is, what decision would maximise benefits to the patient. The exercise is essentially a balancing one, determining on a proportionality approach whether the benefits outweigh the burdens. In carrying out that exercise the court would have regard to matters such as the extent of anticipated relief from suffering, the therapeutic efficacy of the procedure, and the degree of bodily invasion involved. In deciding whether or not to approve the procedure the court would not necessarily adopt majority, or even unanimous, medical opinion. After a court recognises that

letting nature take its course does not necessarily contradict best interests, even where death may result. In applying the best interests test where a child is involved the court's power to authorise a procedure is wider than that of a parent.

Consent is a recurring theme in cases of this type under consideration. Consent transforms what would otherwise be a trespass or assault (and that would include a surgical procedure) with an act which is authorised and justified.

But it must be appreciated in this context that there may be sufficient consent to afford a defence to assault, but not sufficient to defeat a claim for damages for much of the duty imposed on a medical practitioner to provide the patient with adequate warning as to the risks involved in the relevant procedure. So much is made clear, at least for Australians, by the decision of the High Court in *Rogers v Whitaker*[10].

Where consent is in issue, the test is whether the subject had sufficient understanding and intelligence to be capable of making his or her own decision on the issue regarding consent. To do that the person must have an understanding of the nature, performance and effect of the treatment and the risks involved. The decision of the House of Lords in *Gillick v West Norfolk Health Authority*[11] establishes that.

In determining whether or not an adult has capacity to give the requisite consent courts have recognised that an adult with some mental illness may be able to make a clear and considered choice. A person who is competent can make decisions which may appear to others to be irrational or dangerous (eg in *re T*[12]). A court will not lightly overrule the decision of an adult with respect to medical treatment simply because the court considers that the decision is not in the best interests of the adult.

However, in determining whether or not the adult is competent to make the decision the court may have regard to the nature of the treatment; the consequences of undergoing or not undergoing the treatment may be so serious that the court comes to the conclusion that the adult does not have the requisite degree of competence to make an informed decision.

Consent is valid once the patient is adequately informed of the nature of the intended procedure and the choice is made on the basis of information made known by the medical practitioner; that is, the patient has been given all relevant information enabling a choice to be made between undergoing and not undergoing the treatment.

Where the medical procedure is to be performed upon a child particular issues arise for consideration by the court in determining whether or not the procedure in question should be authorised. The views of the parents will always be a relevant consideration, and in borderline cases greater weight may be given to the wishes of the parents. Because emotional issues are involved some evaluation has to be

made by the court of the reasons behind the expressed wishes of the parents. Religious considerations will in general be disregarded.

In *Re A*, the English conjoined twins case, the parents opposed the separation surgery, but Ward LJ observed that in the circumstances of that case the parents were paralysed by grief and were hardly capable of making a rational decision. In *Nolan*, the Queensland conjoined twins case, the parents wanted the separation surgery to take place. Where the child is of an age to have some appreciation of the issues involved the court would have regard to the wishes of the child, but again that is not a determinative consideration.

Generally the court would balance the nature and degree of risk to the child of the medical condition giving rise to the problem against the nature and degree of risk to the child of the proposed treatment. In considering those matters the court would have regard to the long term physical, social and psychological effect of both the underlying medical condition and the consequences of the proposed treatment. Whilst preservation of life is always the preferred option, that is rebuttable, and the long term physical, social and psychological effects of the proposed treatment could in particular cases outweigh the consideration that life would be preserved. The quality of life post-procedure is therefore always a relevant consideration.

In most cases the court would require the medical evidence before it to deal with the alternatives available to the proposed procedure. Generally the court would also require the medical evidence to indicate whether further invasive procedures would be likely even if the proposed initial treatment was successful.

Whilst the foregoing considerations have been more specifically applied to a situation where a child was involved, they would also be relevant considerations where an adult was involved. Courts have generally recognised an adult's right to reject an invasive operative procedure even where, for example, that may have some adverse impact upon an unborn child.

Another relevant consideration will always be the fact that grave consequences may flow from the making of a wrong decision, particularly where the treatment leads to an irreversible condition. Whilst the focus of medical practitioners will almost always be on clinical grounds, the decision of the court must be based on the wider considerations I have been referred to above.

The court, as well as medical practitioners, will frequently have recourse to the doctrine of double effect; a procedure is morally permissible if the action is good in itself, the intention is solely to produce the good effect, the good effect is not produced through the bad effect and there is sufficient reason to permit the bad effect. The best example of the operation of the doctrine is the administration of pain

killing drugs for the sole good purpose of relieving pain, whilst appreciating the bad side, the bad effect, will be that the patient's death will thereby be hastened.

In this area there is often a distinction drawn between acts and omissions when considering the legal and moral significance of conduct and outcome. Such distinctions call for a clearer understanding of the philosophy behind the relevant social and moral ethics and highlight why both medical practitioners and lawyers drawn into this area of decision making bear such a significant social responsibility.

One cannot discuss these matters without having regard, at least as a general background, to various provisions of the criminal law. I will refer to specific provisions of the Queensland *Criminal Code* ("the *Code*"), but they reflect substantially the law in most other jurisdictions.

Section 282 of the *Code* provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of their mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

Case law on the provision recognises that the question of good faith is to be decided not by the evidence of members of the medical profession alone, but by the jury on the totality of the evidence. What constitutes reasonable care and skill is that of the ordinary skilled person exercising and professing to have that special skill; in other words the medical practitioner would not be criminally negligent if he acted in accordance with a practice accepted by a responsible body of medical opinion.

Section 282A of the *Code* provides that a person is not criminally responsible for providing palliative care to another person if the care is provided in good faith and with reasonable care, the provision of the care is reasonable having regard to the person's state at the time and all the circumstances of the case, and the person providing the care is properly qualified. The section goes on to state that the provider is not criminally responsible even if an incidental affect of providing the palliative care is to hasten the other person's death.

The section, however, does not authorise, justify or excuse an act done or omission made with intent to kill or an act of aiding another person to kill himself or herself. It is also provided that palliative care is reasonable where the care is in accord with good medical practice for the medical profession in Australia having regard to recognised medical standards, practices and procedures, and the recognised ethical standards of the medical profession in Australia. That provision was introduced into the Queensland *Code* by amendment in 1992 and it has not yet been the subject of extensive judicial consideration.

Section 284 of the *Code* provides that consent by a person to the causing of the person's own death does not affect the criminal responsibility of any person by whom such death is caused. That section would obviously apply to the case of assisted suicide. If the doctor's conduct was not in accord with practice accepted by a responsible body of medical opinion and the patient died, the patient's consent to the treatment would not provide the doctor with a defence.

Section 285 of the *Code* imposes a duty to provide necessaries upon every person having charge of another who is unable by reason of age, sickness or unsoundness of mind to provide himself or herself with the necessaries of life. An omission to perform that duty renders the person in charge liable for the consequences which follow from the withdrawal.

There have been a number of cases where failure, particularly by parents, to provide necessaries of life resulting in the death of an infant has resulted in a charge of manslaughter being upheld. Section 286 of the *Code* is the corollary of section 285 and applies specifically to persons having the care of a child under the age of 16 years. There is a duty to provide the necessaries of life, to take precautions that are reasonable in the circumstances to avoid danger to the child's life, health or safety, and to take reasonable action to remove the child from danger.

Sections 282 and 286 of the *Code* were considered by Chesterman J in *Nolan's* case where the practical consequence of carrying out the separation procedure would be the death of one of the conjoined twins. He held in the circumstances that no criminal offence would be committed by the doctors performing the operation in question. A similar conclusion was reached in the English case.

But the discussion of criminal responsibility in those cases indicates that there will often in this area of the law be a fine dividing line between conduct which is lawful and conduct which constitutes a criminal offence. To that extent seeking the approval of the court to the procedure affords a safeguard to the hospital and the medical practitioners performing the operation in question.

As I indicated earlier, the problems are likely to become more acute and more frequent as there are advances in medical technology. There are already instances of parents conceiving a child with the intention of that child being an organ donor to a sibling requiring a compatible transplant. Is the child so conceived to be treated differently because the conception was for a particular purpose? Should that child's quality of life be downgraded so that the sibling may live for a longer period? I venture to suggest that courts would be very reluctant to give blanket approval to procedures based on such background facts.

What is clear, however, is that the problems will not go away. Though judges will find the task of making such decisions even more difficult in the future it is a task they will

have to embrace. Society, rather than individual medical practitioners or parents or patients, will be responsible for determining what procedures are appropriate, and it will be for the courts, after hearing argument from all interested sides, to determine what is the acceptable solution in the best interests of a society as a whole after giving due weight to the interests of the individual in particular.

----

* Justice of the Supreme Court of Queensland

[1] [2001] Fam. 147
[2] [2000] 2 AC 59
[3] [2003] 215 CLR 1
[4] [2002] 1 Qd R 454
[5] [1939] 1 KB 687
[6] [1969] VR 667
[7] [1983] 1 Qd R 396
[8] [1983] 1 Qd R 404
[9] [1983] 57 ALJR 285
[10] (1992) 175 CLR 479
[11] (1986) AC 112
[12] [1993] Fam 95 at 102 and 115