



Speech by

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GUARDIANSHIP AND ADMINISTRATION AND OTHER ACTS AMENDMENT BILL

Mr LEE (Indooroopilly—ALP) (12.50 p.m.): It is a great pleasure to rise in support of the Guardianship and Administration and Other Acts Amendment Bill. I had the pleasure recently of reading the amended explanatory notes. This bill not only solves the difficulty that family members have often had with these sorts of issues in that they have felt that decisions would be made without adequate consultation with them; it also provides a legislative framework in which members of the medical profession can deliver adequate care for their patients.

However, the bill and the acts it will amend, should it pass, will rest ultimately upon current standards of medical ethics. Given those standards, the bills, although providing a complicated and somewhat complex legislative structure, are quite useful. I believe that a good deal of this bill rests upon what is consistent with Australian medical practice. It is important to reflect upon Australia's ethical standards in this regard, and that is something that I will do in a moment.

The explanatory notes are also significant to a bill of this nature. The Acts Interpretation Act 1954 makes it clear that the explanatory notes are part of that material used in interpreting a provision of an act. Given that the provisions in this bill might by many lawyers be considered obscure, I believe the explanatory notes will be important in guiding understanding of the act.

For the record, I wish to speak briefly about the absolute shemozzle in the United Kingdom as a result of some judicial rulings in medical areas. I make particular reference to the infamous Bland case, *Airedale NHS Trust v. Bland* 1983, in which the House of Lords gave judicial consent for a patient in what was described as a 'persistent vegetative state' to be starved to death. I believe the circumstances of the case arose as a result of the failure of the UK parliament to put sensitive legislation in place and to ensure that all patients had proper care while providing doctors with the ability to make appropriate decisions concerning the maintenance of treatment of dying patients. I feel it arose through a failure on the part of the House of Lords to understand the basic difference between a persistent vegetative state and terms such as 'brain dead'. I do not believe the Bland case was a restatement of the common law. I do not feel that it was a natural development of it.

The Court of Appeal had rejected the approach which found favour in Bland four years earlier in *Re C (a minor)* (1989), rejecting a judge's direction that treatment of serious infections and intravenous feeding were not necessary for a brain-damaged infant. The common law on medical treatment was framed against the background of medical treatment being a bodily invasion and therefore requiring consent of the patient. Of course, bodily invasion being a crime there is a point at which the consent of the patient is not for the medical practitioner a defence to what otherwise would be a criminal offence. The other aspect of the matter is that medical treatment includes the ordinary provision of victuals—those matters necessary for life. So discontinuance of hydration and nutrition would be a criminal act.

For example, in *R v. Gibbins* 1918 the appellant had a helpless person who could not furnish herself with nourishment in her care. The appellant withheld nourishment in order to bring about the death of the other. The conviction at that time was upheld.

In Bland the House of Lords attempted by judicial fiat to produce a regime which would allow medical decisions to be made by providing a safeguard by providing applications being made to the family division of the High Court. The court was mistaken. This decision has not given certainty to doctors or medical staff but has resulted in continuing litigation and, more recently, an attempt by the

British Medical Association to produce guidelines that clarify the matter—see *Withholding and withdrawing life-prolonging treatments: good practice in decision making*. The difficulties of the judicial approach can be seen in two recent decisions, one in which the persistent vegetative state guidelines are simply ignored by the family division and the other in which the wishes of the parents of a disabled boy for him to be kept alive were simply ignored by the court.

The *Times Law Reports* of Thursday, 17 May 2001 refer to the NHS Trust A v. H. It states—

Given that two sets of guidelines on the clinical criteria necessary for the diagnosis of the permanent vegetative state were in existence, it would seem that the time had come for a thorough review of the whole area.

Dame Elizabeth Butler-Sloss, President of the Family Division, so stated on March 30, 2001 when granting declarations to the applicant NHS Trust authorising the withdrawal of hydration and nutrition from the patient, H, following medical confirmation that she was in a permanent vegetative state (PVS) and had been for some eight years.

The President said that H did not fall entirely within the guidelines of the Royal College of Physicians which required the presence of certain crucial clinical criteria before a diagnosis of PVS could be made.

However, those guidelines were difficult to apply for both the medical and legal professions as they were unclear as to the significance of some of the clinical features and the extent to which they should be treated as absolute.

The Times & Metro of 13 July 2001 stated—

An English judge has abandoned the traditional notion of doctors having a duty to sustain life in ruling that a brain-damaged boy can be left to die. The case came to court because the child's parents objected. The boy, known only as 'I', is 19 months old and has a lung condition. His mother and father, who have dedicated themselves to his care, had argued that their son was able to derive enjoyment from life. He can smile with recognition, indicate feelings with his hands, and has even begun to show signs of some vocabulary. In giving a London National Health Service trust permission not to prolong the child's life, Mr Justice Cazalet, while expressing sympathy for the parents, directed that the child's life could be ended by use of 'palliative care'. In this case, the judge decided that continuing to keep the child alive was not in his best interests.

That situation can be contrasted with the Australian situation. The AMA code of ethics preamble states—

Because of their special knowledge and expertise, doctors have a responsibility to improve and maintain the health of their patients who, either in a vulnerable state of illness or for the maintenance of their health, entrust themselves to medical care.

...

Over the centuries, doctors have held to a body of ethical principles developed to guide their behaviour towards patients, their professional peers and society. The Hippocratic Oath was an early expression of such a code. These codes of ethics encourage doctors to promote the health and well-being of their patients and prohibit doctors from behaving in their own self-interest.

With reference to the dying patient, it states—

Remember the obligation to preserve life but, where death is deemed to be imminent and where curative life-prolonging treatment appears to be futile, try to ensure that death occurs with dignity and comfort.

As with most imprecise things, there are some difficulties in producing distinct definitions.

Sitting suspended from 1 p.m. to 2.30 p.m.

Mr LEE: As I was saying before the break, in his *Nicomachean Ethics* Aristotle discusses the nature of the good, observing that—

Our discussion will be adequate if it has as much clearness as the subject matter admits of, for precision is not to be sought for alike in all discussions ... for it is the mark of an educated man to look for precision in each class of things as the nature of the subject admits; it is evidently equally foolish to accept probable reasoning from a mathematician and to demand from a rhetorician demonstrative proofs.

Echoes of Aristotle's observation can be found in Thomas J's observations in [*Auckland Area Health Board v The Attorney-General* 1993] to the effect that we seek precision on the withdrawal of medical treatment, but—

... imprecision is inherent in the problem itself. 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...

In dealing with matters of judgments such as the withdrawal of treatment, the law should so far as possible provide a framework for decision-making where decisions can be made without excessive interference at what is generally a time when the families of dying people want privacy and peace while ensuring that these decisions are not made in an arbitrary manner based on non-clinical factors. The latter is an obvious concern in legislation where a guardian has significant sway over the outcome. The real distinction between the English jurisprudence, which had not had legislative guidance, and Queensland which has, centres on the provision of nutrition and hydration to non-dying but permanently incapacitated patients. The nub of the matter was well stated by Lord Justice Hoffman in *Bland* as follows—

If someone allows a small child or invalid to starve to death we do not say that he allowed nature to take its course. We think he has committed a particularly wicked crime. We treat him as if he had introduced an external agency of death. It is the same ethical principle which requires doctors and hospitals to provide the patients in their care with such medical attention and nursing as they are reasonably able to give ...

The giving of food to a helpless person is so much the quintessential example of kindness and humanity that it is hard to imagine a case in which it would be morally right to withhold it.

Given the disparate path taken by the English common law and particularly its conclusion that an invalid can be permitted to die from lack of food, that being justified solely by reference to an evaluation of the quality of the patient's life, it is important that the Queensland law strengthens the approach contemplated by the AMA ethical guidelines. We should not be putting our doctors into an uncertain world where others involved, like family members who are unfamiliar with the process of dying, can pressure for an outcome unguided by legislation. Our legislative process should not provide a mechanism for our standards to be undermined by an unjustified and obsequious deference to decisions such as that in Bland's case.

I am very pleased that in fact this bill does provide the appropriate legislative framework to ensure that medical practitioners have some very clear guidelines. I commend the minister for the tremendous work he has done on producing this bill.
