LETTING THE LIVING DIE:

LEGAL ISSUES RAISED BY THE WITHDRAWAL OF ARTIFICIAL NUTRITION AND HYDRATION FROM PERSISTENT VEGETATIVE STATE PATIENTS

PENNY EDWARDS

1993

PENNY EDWARDS

LETTING THE LIVING DIE:

LEGAL ISSUES RAISED BY THE WITHDRAWAL OF ARTIFICIAL NUTRITION AND HYDRATION FROM PERSISTENT VEGETATIVE STATE PATIENTS

LLB (HONS) RESEARCH PAPER
LAW AND MEDICINE (LAWS 546)

LAW FACULTY
VICTORIA UNIVERSITY OF WELLINGTON

1993

CONTENTS

PAGE

ABSTRACT 1

INTRODUCTION 2

PART I 3

THE DEFINITION OF DEATH 3

WHAT IS THE PERSISTENT VEGETATIVE STATE? 4

REDEFINING DEATH AND THE ISSUE OF PERSONHOOD 7

PART II 10

BLAND - CIRCUMSTANCES OF THE CASE 10

FUNDAMENTAL PRINCIPLES 11
- *Sanctity of Life 11*
- *Self-Determination 12*
  - *Competent adult patients 12*
  - *Incompetent adult patients 13*

PARENS PATRIAE JURISDICTION 15
- *Judicial Intervention in the Medical Domain 15*
- *Should The Court Play Any Role? 17*
- *Further Reasons For Legal Intervention 18*

NECESSITY 18
- *Development Of The Doctrine Of Necessity 19*
- *Necessity: Applied By The House Of Lords 21*
- *Conclusion: Necessity 22*

PART III 23

CRIMINAL LIABILITY 23
- *The Approach: How To Consider Liability 24*
- *Acts of Commission And Acts of Omission 24*
  - *What is the reason for this distinction 25*
  - *House of Lords application of commission/omission distinction 26*
- *Practical Implications of the Commission/Omission Approach 27*
- *The Duty Approach 29*
- *Cause of Death 30*
- *AHB: Approach to Causation 33*
- *A Return to Duty 34*
- *Section 151 of The Crimes Act 1961 ..... 34*
- *Lawful Excuse 37*
- *Section 164 - Acceleration of Death 39*
  - *Applicability of section 164 ..... 40*
  - *Bodily injury 40*
  - *"Hastens his death" 41*
- *Conclusions on Liability 42*

PAGE

PART IV **42**

CRITERIA FOR GOVERNING DECISIONS TO WITHDRAW

ARTIFICIAL FEEDING 42
Patient's Best Interests Approach *42*
Do PVS patients have interests? *43*
House of Lords application of the patient's best interests test *44*
Substituted Judgment *45*
Good Medical Practice *48*

ADVANCE DIRECTIVES 49
Value Statements *50*
Living Will *50*
Living wills in New Zealand *51*
Enduring Powers of Attorney in New Zealand *52*

CONCLUSION 54

BIBLIOGRAPHY 56

APPENDIX

ABSTRACT

This paper considers the perplexing and controversial issues surrounding the withdrawal of artificial nutrition and hydration from patients in the persistent vegetative state. It analyses the recent, landmark decision in Airedale NHS Trust v Bland, where the House of Lords held that doctors could lawfully withdraw artificial feeding from a permanently insensate patient with no hope of recovery. It probes the dubious foundation of the decision, the criterion adopted to guide the decision to withdraw nutrition and hydration, and the extension of the doctrine of necessity.

The author suggests an alternative approach for New Zealand based on the New Zealand High Court decision in Auckland Health Board v Attorney-General should the courts be asked to consider whether doctors withdrawing artificial feeding regimes from persistent vegetative state patients will be criminally liable for culpable homicide.

Finally, it considers decision-making criterion on which withdrawal decisions can be made and the role for advance directives in these decisions. The author supports the adoption of a good medical practice standard to guide decisions and ultimately legislative initiative in this area.

Word Length

The text of this paper (excluding contents page, footnotes, bibliography and annexures) comprises approximately 14,776 words.

INTRODUCTION

Life and death used to be matters of fate, beyond human control. Now, life may be prolonged by the wonders of modern medicine, making death more a matter of human choice; a development which has provoked legal and ethical quandaries. These quandaries are not merely theoretical; they are an unwelcome reality for many health professionals and families.

Where competent adult patients refuse life-prolonging medical treatment, they bring the fundamental principles of sanctity of life and self-determination into conflict. More difficult problems arise where adult patients are no longer competent to make treatment decisions. If these patients did not indicate their treatment preferences whilst competent, the burden falls on others to decide. Should the incompetent patient become hopelessly and irreversibly unconscious the difficulties are compounded. Medical purposes and goals can no longer be achieved, but patients may still be maintained at extreme financial and emotional cost because of uncertainties in the law of homicide, or the psychological difficulties of removing the patient's life-sustaining treatment and care.

The law has not advanced with technology, leaving doctors and families to make difficult and painful decisions without clearly defined guidelines. Especially traumatic, are terminal decisions involving patients in the persistent vegetative state (PVS). Withdrawal of artificial nutrition and hydration may be the only effective way to ensure the death of physical tenacious PVS patients. However, doctors contemplating the withdrawal of life-sustaining nutrition and hydration may fear criminal responsibility for culpable homicide, and consequently, they may refrain from the proposed conduct.

The House of Lords[1] was given the opportunity to consider, for the first time, whether artificial nutrition and hydration and other medical treatment could lawfully be withdrawn from a permanently insensate patient with no hope of recovery. Unfortunately, the law in England is no more certain now than it was before the case, which provides little comfort for doctors. The New Zealand courts have yet to address the issue.

This paper will address the complex and contentious issues of liability for culpable homicide which would arise if, for example, *Bland* came before the

---

1 *Airedale NHS Trust* v *Bland* [1993] 2 WLR 316.

New Zealand courts.[2] As background to the paper and in order to understand the difficulties involved, the paper begins with an outline of brain death and the persistent vegetative state. It goes on to consider the fundamental legal and moral principles which are invoked by terminal decisions and the reasons for legal intervention in the medical domain.

The paper will then analyse the approach of the House of Lords in *Airedale NHS Trust* v *Bland*, and contrast it with the preferable approach of the New Zealand High Court in *Auckland Health Board* v *Attorney-General*.[3] The decisions will be used to assist in the consideration of liability for culpable homicide, and, to this end, the interpretation of sections 151(1) and 164.

Finally, the paper explores the criteria available to guide decisions to withdraw artificial feeding, and it concludes with a consideration of the role of advance directives in these withdrawal decisions.

PART I

THE DEFINITION OF DEATH

Historically, death was defined as the irreversible cessation of respiration and circulation. Once the person ceased breathing and her heart stopped beating for a short period, the brain would be deprived of oxygen which would produce irreversible brain damage, and eventually brain death.[4] With the developments in modern medicine respiration and circulation could be artificially maintained. This forced the reconsideration and clarification of the criteria for death, which led to the formulation of an additional and widely accepted criteria for death known as "brain death".[5]

---

2 Although the issues will be examined and developed in connection with adult patients in the persistent vegetative state, the analysis will apply to permanently comatose or unconscious patients in general.

3 *Auckland Health Board* v *Attorney-General* [1993] 1 NZLR 235.

4 D W Brock "Death and Dying" in R M Veatch *Medical Ethics* (Jones & Bartlett Publishers Inc, Boston, 1989) 329, 331-2.

5 Papers Produced By Conference of Medical Royal Colleges and Their Faculties in the United Kingdom (1976) BMJ 1187; "Report of The Medical Consultants on the Diagnosis of Death to the US President's Commission For The Study of Ethical Problems in Medicine and Biomedical and Behavioural Research" (1981) 246 JAMA 2184.

Brain death can refer to either whole brain death, which is the irreversible loss of brain stem functions and higher cerebral functions, or brain stem death.[6] Brain stem death is increasingly regarded as adequate; it can be firmly diagnosed once the stipulated procedures have been meticulously performed.[7] Although death is a continuous process not an isolated instance,[8] the time of death from a medical-legal perspective is a "discrete point in time".[9] The law has accepted the demarcation between life and death at the point of brain death.

Before death the individual has all the rights and privileges bestowed by law on living people. On the determination of death numerous medical and legal consequences are triggered. Not only do positive responsibilities of treatment cease, but certain liberties may also be taken. Organs and tissue may be harvested, research may be undertaken, and the body may be frozen, incinerated or buried.[10] Most importantly, death by natural causes obviates the criminal law of homicide.

The brain death criterion for death indicates a shift in perception of the final edge of life.[11] If the general perception were again altered to include neocortical death, then criminal liability for withdrawing treatment from PVS patients would no longer be an issue since the patient, by law, would be dead. Before proceeding further with this argument, an explanation of the PVS will help to illustrate how modern medical technology has blurred the distinction between life and death.

WHAT IS THE PERSISTENT VEGETATIVE STATE?

Jennett and Plum coined the term persistent vegetative state in 1972 to describe a condition where the patient has sustained acute damage somewhere in the cerebral cortex resulting in loss of cortical functions.[12] Cortical destruction

---

6 The Bioethics Research Centre *Persistent Vegetative State And The Withdrawal of Food and Fluids - A Report for the Medical Council of New Zealand*, University of Otago, February 1993, 5.

7 The Bioethics Research Centre, above n 6.

8 PDG Skegg "The Edges of Life" (1988) 6 Otago Law Review 517, 518. G Williams *Textbook on Criminal Law* (2ed, Stevens and Sons, London, 1983) 281.

9 R E Cranford and H L Smith "Some Critical Distinctions Between Brain Death and The Persistent Vegetative State" (1979) 6 Ethics in Science and Medicine 199, 206.

10 D J Cole "The Reversibility of Death" (1992) 18 Journal of Medical Ethics 26.

11 Skegg, above n 8, 520.

12 B Jennett and F Plum "Persistent Vegetative State After Brain Damage: A Syndrome In Search Of A Name" (1972) The Lancet 734. B Jennett "Vegetative Survival After Brain Insults" (1988) 43 Anaesthesia 921. The term PVS has been criticised because

occurs when the brain is deprived of blood (ischemia) or oxygen (hypoxia) for approximately four to six minutes.[13] The same deprivation does not necessarily destroy the brain stem, which is more resilient and may survive such insults relatively intact.[14]

The cerebral cortex is responsible for one of the two dimensions of the brain: consciousness or the higher cognitive level of human functioning.[15] It facilitates self-awareness, memory, learning and adaptive behaviour such as conscious control of movements.[16] The other dimension of the brain is controlled by the brain stem. The brain stem controls the body's basic internal functions including temperature, heart beat, pulmonary ventilation, digestive activity and primitive reflex activity (i.e. pupillary response to light).[17] (See Appendix A).

It is the functioning brain stem which clinically differentiates PVS from brain death. Brain death requires cessation of all brain stem functions as judged behaviourally. PVS patients, however, demonstrate a number of brain stem functions including cycles of sleeping and waking, spontaneous eye opening, the utterance of unintelligible, instinctive grunts or screams, the ability to breathe unassisted, gag and cough reflexes and sporadic movements of facial muscles and limbs.[18]

The PVS is characterised by a chronic state of unconscious in which the patient is totally unaware of herself or the environment, and a total absence of purposeful movements "reflecting consciousness, volition or emotion at the cerebral cortical level."[19] There is a large body of medical opinion which

---

"persistent" has been understood to mean "permanent" which "is a statement of final outcome rather than a comment on the present state". See K Andrews "Managing the Persistent Vegetative State" (1992) 305 BMJ 486; P Alldridge and D Morgan "Ending Life" (1992) NLJ 1536.

13 R E Cranford "The Persistent Vegetative State: The Medical Reality (Getting The Facts Straight)" (1988) Hastings Centre Report 27, 27-28. Cranford indicates that the cortex is the part of the brain most vulnerable to this type of deprivation because of its high metabolic rate. See also Bioethics Research Centre, above n 6, 4.

14 Cranford, above n 13, 27-28.

15 American Medical Association's Council on Scientific Affairs and Council on Ethical and Judicial Affairs "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support" (1990) 263 JAMA 426, 427.

16 Above n 15, Cranford, above n 13, 27.

17 Bioethics Research Centre, above n 6, 5; Cranford, above n 13, 27.

18 Above n 15, 427; Cranford et al, above n 9, 204.

19 Cranford, above 13, 28. See also American Academy of Neurology "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient" (1989) 39 Neurology 125. See also definition of PVS adopted by the Bioethics Research Centre, above n 6,4.

considers it impossible for PVS patients to experience pain and suffering.[20] The American Medical Association stated that PVS patients have neither the capacity to perceive such stimuli nor the neocortical functions to generate a self-perceived response.[21] Therefore, it is assumed that PVS patients do not experience pain based on their lack of cerebral capacity and the absence of physical symptoms commonly exhibited by conscious people when they experience pain.[22] However, a small number of PVS patients do exhibit physiological symptoms associated with pain which are alleviated by small doses of morphine.[23]

Discontinuance of treatment from PVS patients is not an option unless the diagnosis, and prognosis of irreversibility can be established with a high degree of certainty. The fundamental practical difficulty doctors face is deciding whether the patient is in the PVS. Unlike brain death, there are no published criteria to guide doctors, nor are there specific scientific laboratory studies to confirm the clinical diagnosis of PVS.[24] Diagnosis and prognosis may only be determined after the patient has been in the condition for a significant time period.[25] The suggested time period after which a patient can be reliably diagnosed as PVS is twelve months,[26] and no decisions regarding treatment may be made before a year has elapsed. After twelve months, the condition can be regarded as permanent and hopeless.[27]

It is possible for a patient in the PVS to survive for many years. Jennett and Dyer produced the following figures:[28]

---

20 Above n 15; American Academy of Neurology, above n 19; Bioethics Research Centre, above n 6; R E Cranford and D R Smith "Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood" (1989) 13 American Journal of Law and Medicine 233, 239-240; Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death "Withdrawal of Life-Support From Patients in a Persistent Vegetative State" (1991) 337 The Lancet 96, 97.

21 Above n 15, 428.

22 L J Schneiderman "Exile and PVS" (1990) Hastings Centre Report 5.

23 Biological and Medical Issues Committee of the New Zealand Law Society *Report For the Medical Council of New Zealand on "Persistent Vegetative State and the Withdrawal of Food and Fluids"* 1993, 2. The Committee notes that some PVS patients may require pain killing treatment if food and fluids are withdrawn.

24 Cranford, above n 13, 29. See also D Thalblum "Persistent Vegetative State And Immortality: If This is Technically Life, The Legal Definition of Death Should Change" (1991) 59 UMKC Law Review 439, 443.

25 Cranford et al, above n 9, 205.

26 Above n 23, 1; Jennett et al, above n 12; AMA, above n 15, 428.

27 Above n 15, 428.

28 B Jennett and C Dyer "Persistent Vegetative State and The Right to Die: The United States and Britain" (1991) 302 BMJ 1256.

> Of patients in a vegetative state three months after injury, about half die by twelve months but more than half of those still alive at one year live for three years or more, some surviving 12, 15, 18 and 36 years.

The precise incidence of PVS in New Zealand are unknown.[29] *Rough* estimates based on the number of PVS patients in previous years place the number of cases in New Zealand in any one year, at approximately 3-4 ("a handful").[30]

It is appropriate now to return to the issue introduced earlier, the redefinition of death.

REDEFINING DEATH AND THE ISSUE OF PERSONHOOD

PVS and other permanently unconscious patients are in a separate category from the dead, the terminally ill and the neurologically impaired. This is supported by judicial decisions which have differentiated between patients lacking consciousness and those with minimal consciousness.[31] Nevertheless, judicial decision-making is constrained by the fact that, for legal purposes, only two categories of person are recognised: alive or dead.

The simple but crucial fact is that, under the current medical and legal definition of death, PVS patients are alive, even though their condition might be described as a "living death".[32] Recently, arguments have been advanced for the inclusion of neocortical death in the criteria for death,[33] to clarify the appropriate care for PVS patients. The term neocortical death has been used to

---

29 The Bioethics Research Centre recommended recording PVS on the death certificate as a condition relevant to the patient's death, as a means of clarifying the uncertainty. Above n 6, 29.

30 Dr R Worth *The Persistent Vegetative State - The Situation in New Zealand From a Doctor's Point of View* Submission to the Biological and Medical Issues Committee of the New Zealand Law Society, 12 June 1993. Dr Worth emphasised that this is a "guestimate" only, based on ICU figures for Wellington. However, informal inquiries support this conclusion. Dr S Williams, ex-Superintendent, Silverstream Hospital, stated that in 12 years, Silverstream Hospital treated three patients in the PVS. The Director of Anaesthetics, Palmerston North Hospital, advised that he had no knowledge of any PVS patients in recent years.

31 *Bland*, above n 1, 371; In *Re Jobes* 529 A 2d 434 (1987); In *Re Peter* 529 A 2d 419 (1987); see also Cranford et al, above n 20.

32 *Bland*, above n 1, 366; *AHB*, above n 3, 245-246. See also *Joe* v *Joe* [1985] 3 NZFLR 675, 680 where the court indicated that patients in an irreversible non-cognitive condition are alive for legal purposes and New Zealand doctors do not in practice certify them as dead; Skegg, above n 8, 521.

33 Cranford and Smith, above n 20. R S Shapiro "The Case of LW: An Argument For a Permanent Vegetative State Treatment Statute" (1990) 51 Ohio State Law Journal 439, 448; Thalblum, above n 24; D R Smith "Legal Recognition of Neocortical Death" (1986) 71 Cornell Law Review 850.

describe patients with an irreversible loss of consciousness and cognitive functions. Upon diagnosis of neocortical death, doctors would not be under an obligation to continue artificial feeding. Its withdrawal would not constitute homicide because the patient would already be dead, and the law of homicide only protects the living.

The proponents of neocortical death as a criterion for death consider the essence of human life and "personhood" to be the capacity for consciousness (i.e. the ability to think, feel and interact with society).[34] The permanent and irreversible loss of these distinguishing features of human life is considered to be as significant as the loss of brain stem functions, since the person is no longer "alive" in any ethically interesting sense.[35] Therefore, irreversible cessation of cortical functions, as exemplified by the PVS patient, constitutes the death of the person.[36]

The difficulty of redefining death in terms of neocortical death lies in the clinical uncertainties of diagnosing the PVS.[37] The acceptance of brain stem death as a criterion for death was inextricably linked to the certainty of diagnosis based on the results of specific, widely accepted tests. To date, the medical profession have not been able to pinpoint the cause of PVS and identify tests which would provide the same degree of diagnostic certainty associated with brain death.

Neocortical death as a criterion for death is difficult to accept for several other reasons. Neocortical death classifies PVS patients as non-persons, denying them the fundamental protection of the criminal law, which offends against all notions of morality and equality.[38] From the health professional's perspective, the

---

34 Smith, above n 33, 859-860; Cranford and Smith, above n 20, 233-234; Shapiro, above n 33, 448.

35 G R Gillet "Why Let People Die?" (1986) 12 Journal of Medical Ethics 83, 84. See also J A Gold "The Status of The Permanently Unconscious 'You Call That Living?'" (1991) 42 Mercer Law Review 1087; Shapiro, above n 33, 448.

36 Cranford and Smith, above n 20, 243; Shapiro, above n 33, 448.

37 Shapiro, above n 33, 448; Cranford and Smith, above n 20, 243.

38 Law Reform Commission of Canada *Protection of Life, Euthanasia, Aiding Suicide and Cessation of Treatment* Working Paper 28, 1982, 33-34. See also D Lanham *Taming Death By Law* (Longman Professional, Melbourne, 1993) 179.

extreme vulnerability of these patients does not classify them as non-persons, rather it leads to an attachment to the patient and a greater resolve to care for them.[39]

Redefinition of death would involve a significant departure from traditional notions of death.[40] Neocortical death paradoxically recognises that the *body* is alive, while the *patient* is not.[41] However, it is the physical characteristics of PVS patients which distinguish them from brain dead patients. Facial grimaces, spontaneous respiration and circulation, and other involuntary movements indicate that life is still present. It is, precisely, this reason why PVS patients are considered to be "alive".

If death is determined on the basis of neocortical death, the remaining bodily functions cannot be terminated immediately by the withdrawal of life-support systems. Burial and cremation would be possible, whilst the patient still exhibited signs of life. If there is a reluctance to do this, can it really be said that the patient is dead?[42]

Under the neocortical death criterion for death, not only would withdrawal of nutrition and hydration be permissible, but a quicker, more direct means of ending the bodily functions, by lethal injection, would be possible (and legal). This would spare health professionals and family from the further distress of watching the patient's prolonged death. These are thorny issues which are beyond the scope of this paper, but it is doubtful whether society is ready for such radical advances.

Furthermore, it is extremely doubtful whether neocortical death as a criterion for death is socially, legally or morally acceptable at the present time.[43] The redefinition of death as a means for withdrawing treatment from PVS patients is not supported in this paper. It is an extremely controversial step, which should be taken by Parliament, not the Courts, if it is to be taken at all. Although the

---

39 P W Armstrong and B D Colen "From *Quinlan* to *Jobes*: The Courts and the PVS Patient: (1988) Hastings Centre Report 37, 39. Dr R Worth, Neurosurgeon, Wellington Hospital, also confirmed this point.

40 Cranford and Smith, above n 20, 243-4.

41 D Wikler "The Definition of Death and Persistent Vegetative State" in TA Mapes and JS Zembaty *Biomedical Ethics* (3 ed, McGraw-Hill Inc, New York, 1991) 396, 398.

42 B A Brody "Ethical Questions Raised by the Persistent Vegetative Patient" (1988) Hastings Centre Report 33, 34.

43 R D Mackay "Terminating Life Sustaining Treatment - Recent US Development" (1988) 14 Journal of Medical Ethics 135, 138.

emphasis is increasingly on the irreversible loss of brain functions than on heartbeats,[44] there are still legitimate reservations which must be overcome.

PART II

BLAND - THE CIRCUMSTANCES OF THE CASE

Anthony Bland was a victim of the Hillsborough football stadium disaster. In the course of the disaster, his chest was severely crushed, which punctured his lungs and interrupted the oxygen supply to his brain. The injury caused irreparable damage to the cortex and destroyed all the higher functions of his brain. His condition was diagnosed as the persistent vegetative state. For maintenance of life, Mr Bland was artificially fed and hydrated through a nasogastric tube. The unanimous medical opinion of doctors who examined Mr Bland indicated that there was no hope for recovery or improvement of any kind. However, with vigorous medical care, he would have been able to survive for many years.

The responsible doctors, supported by Mr Bland's parents, concluded that no useful purpose was served by continuing medical care. They considered it was appropriate to cease artificial feeding and other life-prolonging medical treatment. The decision was supported by independent medical opinion. The proposed removal of medical care would inevitably result in the patient's death. Doubts about the lawfulness of the proposed conduct were raised, which prompted the responsible health authority to apply to the Family Division of the High Court for declarations as to the lawfulness of the proposed conduct.[45]

The declarations were granted by the Family Division of the High Court (19 November 1992), the Court of Appeal (9 December 1992) and the House of Lords (4 February 1993).

---

44 Skegg, above n 8, 521-522; Thalblum, above n 24, 460; Australian Law Reform Commission *Human Tissue Transplants* Report No 7, 1977, 53-4.

45 *Bland*, above n 1, 331; 334; 364-365. It is interesting to note that Sir Stephen Brown P in the High Court excluded the words "pain and suffering" from the second part of the declaration, unlike the Court of Appeal and the House of Lords. Their inclusion of "pain, suffering and distress" is bewildering. They are irrelevant to a PVS patient.

FUNDAMENTAL PRINCIPLES

The fundamental principles of sanctity of life and self-determination underlie the decisions in the *Bland* case. They will form the backdrop to any consideration of a proposal to withdraw life-sustaining nutrition and hydration. These principles will now be examined.

Sanctity Of Life

In our society human life has traditionally been recognised as a deeply ingrained value. The protection of this fundamental human value is a primary function of the criminal law, which forbids homicide and reprimands those who place others in serious danger.[46] Its importance receives expression through the principle of sanctity of life. Sanctity of life views all human life as intrinsically valuable, irrespective of its quality and kind, and absolutely inviolable.[47] This deeply rooted belief indicates why society considers it almost always wrong to intentionally kill another human being despite their disability or illness.

The New Zealand Bill of Rights Act 1990 recognises the individual's right to life, which may only be overridden by legally established grounds. Section 8 states:

> **Right not to be deprived of life** - No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.

Despite the respect afforded life, sanctity of life it is not an absolute value in itself.[48] It is more resemblant to a rebuttable presumption in favour of life. The decriminalisation of attempted suicide and the recognition of self-defence as a defence to culpable homicide illustrate this.

The Courts have been accused of merely paying lip-service to sanctity of life, the *Bland* case being the latest erosion of the principle because it implies that not all human beings are equally entitled to such concern and respect.[49] However, firm adherence to the sanctity of life principle is untenable given the enormous

---

46 *AHB*, above n 3, 244; Law Reform Commission of Canada, above n 38, 3.

47 H Kuhse *The Sanctity of Life Doctrine in Medicine - A Critique* (Clarendon Press, Oxford, 1987) 5.

48 *AHB*, above n 3, 244; *Bland*, above n 1, 367; Law Reform Commission of Canada, above n 38, 5. Limits must be placed on the principle otherwise the sanctity of life principle will require incompatible actions. See Kuhse, above n 47, 27.

49 A Fisher "The Road to Euthanasia" (1993) The Tablet 235.

advances in modern medicine.[50] Such advancements require a reconsideration of the sanctity of life principle in relation to medical decisions. The employment of all available medicines and machines to preserve human life regardless of the surrounding circumstances is impracticable, if not impossible given the limits in resources, and for many it would be unethical.[51]

Certainly, fundamental medical ethics require the preservation of life, but a doctor's role is not just that of life preserver.[52] Doctors must consider and abide by patients' wishes, which may require the removal of treatment, and in other cases doctors may consider life-sustaining treatment not to be in the patients' best interests.

Respect and concern for human beings are not necessarily illustrated by continuing treatment. They are shown by adherence to the prohibition on intentional termination of patients' lives. Thus, a qualified duty of life preservation allows doctors, in certain circumstances, to let patients die. The courts have condoned this approach, holding that it is always wrong to actively kill a patient (i.e. active euthanasia), but in certain prescribed circumstances, a doctor may refrain from preventing a patient's death.[53]

Self-Determination

Competent adult patients

It is a fundamental common law principle that any medical treatment involving interference with a person's body without the person's consent constitutes an

---

50 A M Gaudin "*Cruzan* v *Director, Missouri Department of Health*: To Die or Not to Die: That is the Question - But Who Decides" (1991) 51 Louisiana Law Review 1307, 1310.

51 LRC of Canada, above n 38, 6; *In Re Conroy* 486 A 2d 1209, 1250 (1985).

52 D Cook *Patients' Choice - A Consumer's Guide to Medical Practice* (Hodder & Stroughton Publishers, London, 1993) 122. Kuhse, above n 47, 26-27, suggests that a pure sanctity of life doctrine cannot be applied in today's technological environment:

> If we were to act in accordance with this principle, medicine would be entering its zealous phase, where the preservation of life would take precedence over all other medical and social objectives. Every wisp of life would have to be preserved, irrespective of whether such measures would be benefiting or harming the individual patient. However, such a position is not only intuitively implausible, it is ultimately unintelligible.

Jennett argued openly on the quality of life basis that life-sustaining treatment is "justified only if there is a reasonable probability of meaningful recovery and of regaining life as a social person." See B Jennett "Letting Vegetative Patients Die" (1992) 305 BMJ 1305.

53 *Bland*, above n 1, 368-369; Bioethics Research Centre, above n 6, 34.

assault, unless the touching is otherwise justified by law.[54] The requirement of consent is based on the principle of self-determination and individual autonomy which ensure respect for individuals and protect their right to live their lives as they choose.[55]

A person's right to self-determine and decline medical treatment is given statutory recognition in New Zealand. Section 11 of the New Zealand Bill of Rights Act 1990 provides that "everyone has the right to refuse to undergo any medical treatment".

The competent patient's right to choose is almost absolute and the decision must be respected, regardless of its rationality or reasonableness.[56] This principle allows a properly informed patient to require the removal of life-support systems.[57] To this extent, the sanctity of life principle is at variance with, and must yield to, the individual's right to self-determination.[58]

Incompetent adult patients

Situations commonly arise where the patient is in no condition to give or withhold consent to medical treatment. For example, due to a traffic or other accident, the person may be rendered unconscious. Consent is not essential in every situation to ensure that the doctor's conduct is lawful. If it was,

---

54 *Bland*, above n 1, 367; 381; see also C Lewis "Medical Treatment In Absence of Consent" (1989) 86 Law Society Gazette 32; Thalblum, above n 24; 444; However, Dr Collins emphasised that criminal proceedings are unlikely to be brought against a doctor on these grounds, unless there is an extreme breach of trust necessitating the intervention of the criminal law. D B Collins *Medical Law in New Zealand* (Brooker and Friend, Wellington, 1992) 67.

55 Collins, above n 54, 66; D Thalblum, above n 24; 445. *Schloendorff* v *Society of New York Hospital* 105 NE 92 (1914).

56 *Bland*, above n 1, 342; 367. C Bridge "Refusal of Medical Treatment on Religious Grounds" (1992) NZLJ 341; see also *Nancy B* v *Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385, 391, where the court stated that the patient's right was subject to the corresponding rights of others.

57 *Nancy B*, above n 56, 392. The doctors must respect the patient's refusal of treatment, even though the doctors may (paternalistically) consider the refusal to be adverse to the patient's best interest. See *Schloendorff*, above n 55, 93. The New Zealand Courts have yet to decide whether doctors acting on patients' instructions to withhold or withdraw life-sustaining treatment would be liable for culpable homicide.

58 *In Re T* [1992] 3 WLR 782. Lord Donaldson acknowledged the paramountcy of self-determination over society's conflicting interest in sanctity of life. However, the Court placed an important limitation on the right to self-determination. If the patient is considered, by the doctors, not to have given "a properly informed refusal" then the refusal of life-saving medical treatment may be overridden. See generally C Lewis "Freedom of Choice" (1992) 46 Law Society Gazette 27, 28; Bridge, above n 56.

incompetent patients would not receive necessary medical treatment. Difficulties do arise however, where life-sustaining procedures and treatment have been instituted and the patient is unable to request their removal should the patient's condition become hopelessly irreversible.

Suggestions have been made that the law should strenuously avoid any form of discrimination against incompetent patients, and on the basis of equality, these patients should have the same right to self-determination and choice that competent patients have.[59] However, these suggestions overlook the fact that incompetent patients are in no position to self-determine or make a choice about treatment.[60] Nevertheless, to be consistent with the primacy given to the principle of self-determination, the law must provide a means of enabling treatment decisions to be made on behalf of incompetent patients, which include in appropriate circumstances, the withholding or withdrawal of treatment.[61] Indeed to do otherwise would result in discrimination since

> the incompetent patient [would] always be subjected to what many rational and intelligent persons may decline [which would] downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.[62]

This introduces notions of what reasonable, competent people would desire were they in a persistent vegetative state, as factors guiding treatment to be administered to incompetents. These arguments and judicial observations proceed on the basis that concern and respect for incompetent patients are best demonstrated by treating them like competent patients.[63] Dresser objects that as a result, the patient's immediate position, which may differ considerably from that of competent patients, is completely overlooked.[64]

The law acknowledges that life-sustaining decisions must be made in relation to incompetents, and that consistency will be achieved if third parties are permitted to make treatment decisions on the patient's behalf. What must be recognised is that third parties are making the decisions, which is different from patients exercising their right to self-determination.[65] Therefore, the question arises,

---

59 LRC of Canada, above n 38, 57. *Bland*, above n 1, 368; *Superintendent of Belchertown State School* v *Saikewicz* 370 NE 2d 417 (1977).

60 Lanham, above n 38, 114.

61 *Bland*, above n 1, 368.

62 *Superintendent of Belchertown State School* v *Saikewicz* 370 NE 2d 417, 428 (1977).

63 R Dresser "Life, Death, And Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law" (1986) 28 Arizona Law Review 373, 375.

64 Dresser, above n 63, 373.

65 Lanham, above n 38, 114.

who should make the decisions for incompetent patients? The New Zealand High Court is one possible decision maker. Under its inherent parens patriae jurisdiction, the Court has the power to make treatment decisions on behalf of adult incompetent patients.[66]

PARENS PATRIAE JURISDICTION

The parens patriae jurisdiction refers to the High Court's penumbral residual protective capacity, under which the Court has the power and duty to protect mentally incompetent adults or those of unsound mind (formerly described as lunatics or idiots).[67]

In *Auckland Health Board* v *Attorney-General* it was open to the Court to invoke its parens patriae jurisdiction to consent to the withdrawal of a ventilatory system from a patient suffering from extreme Guillain-Barre Syndrome.[68] Thomas J considered that the High Court's inherent protective jurisdiction could be invoked to authorise the withholding or withdrawal of life-support treatment, since to preserve life at all costs may not be in the patient's best interests.[69]

Judicial Intervention In The Medical Domain

Although the Court has the power to consent on behalf of incompetent adult patients, it would be preferably if it did not invoke its parens patriae

---

66 The parens patriae jurisdiction is an ancient prerogative jurisdiction of the Crown, which still applies in New Zealand: see *Pallin* v *Department of Social Welfare* [1983] NZLR 266; *Re* X [1991] 2 NZLR 365; *Auckland Health Board* v *Attorney General* [1993] 1 NZLR 235. The basis for the parens patriae jurisdiction is section 17 of the Judicature Act 1908. See also E Grant "Consent to Medical Procedures and The Protection of Personal and Property Rights Act 1988" (1989) 7 Otago Law Review 161.

67 *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 57. Grant above n 66, 174.

68 Thomas J did not consider whether the Court's inherent jurisdiction should be invoked. Instead His Honour made declarations under the Declaratory Judgments Act 1908, that the doctors' removal of the ventilatory support was lawful. Above n 3, 242.

69 *AHB*, above n 3, 242. *In Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33 followed. See also *In Re Eve* [1986] 31 DLR (4th) 1. The applicability of the "patient's best interest" standard to PVS or permanently comatose patients will be disputed later.

Thomas J suggested that patient's best interests is one of two standards available in the exercise of the parens patriae jurisdiction, the other being substituted judgment. See *In the Matter of Karen Quinlan* 355 A 2d 647 (1976). These alternative approaches will be discussed in full later.

jurisdiction. Otherwise, applications would have to be made to the Court every time doctors and family agreed that artificial feeding should be removed from the PVS patient.

Decisions to remove artificial nutrition and hydration are essentially medical decisions. Applications to the court for judicial approval of such decisions involves the court in an area of expertise which is better left to members of the medical profession who are in "the ordinary business of providing clinical care" and frequently make life and death decisions.[70] Thomas J in the *AHB* case accepted that courts should not intrude into "the legitimate province of the doctors and their patients".[71] Furthermore, it was indicated that the New Zealand Courts would be hesitant to resolve issues which are essentially clinical, private decisions, and are more appropriately made by doctors, patients and their families.

Apart from intruding on the medical profession's "field of competence", such applications are cumbersome and an extreme financial and emotional burden on the patient's family.[72] If applications for court approval were mandatory, caring, conscientious families and health professionals may be deterred from making appropriate treatment decisions for two equally distressing reasons. Doctors may face criminal prosecution for culpable homicide if they withdraw life-sustaining nutrition and hydration without first applying for a declaration to determine the conduct's lawfulness. In order to secure judicial approval, it has been noted that considerable time, effort and money must be spent, which neither doctors nor relatives may be willing or able to undertake.[73] Furthermore, where applications are made, families who make the anguishing decision to allow their relatives to die peacefully, are exposed to media coverage and potential actions from extremist groups who would automatically oppose any withdrawal of life-sustaining procedures.[74]

---

70 This was a doctor's perspective, given by an eminent neurosurgeon, Dr Gillet, in the *AHB* case. See also submissions by Attorney-General and Counsel for the second plaintiff, above n 3, 241.

71 *AHB*, above n 3, 241.

72 *AHB*, above n 3, 241. See also *In the Matter of Karen Quinlan*, above n 69, 669. N L Cantor *Legal Frontiers of Death and Dying* (Indiana University Press, Bloomington and Indianapolis, 1987) 114.

73 Cantor, above n 72, 114.

74 After the House of Lords decision in favour of removal of the life-support regimes from Anthony Bland, and the attendant publicity, pro-life groups continued their protests outside the hospital where Mr Bland was a patient. See "Tony Bland Dies" (1993) Bulletin of Medical Ethics 5. In addition, because Mr Bland's parents supported the application by the Airedale NHS Trust to withdraw their son's artificial feeding regime,

Regularised judicial involvement in decisions to withhold or withdraw artificial feeding from PVS patients is neither practical nor desirable. It can be minimised or even avoided, if the court issues broad guidelines for doctors to follow in future cases as it did in the *AHB* case. Not only would guidelines avoid the need for unwieldy applications which would place unnecessary distress and burdens on families and doctors, they would also avoid judicial intrusion on "the medical profession's field of competence".

Even though the High Court in the *AHB* case stepped in to the medical domain to make a declaratory order, the judgment was designed to assist doctors to reach treatment decisions in the future without recourse to the courts.[75] The civil declaration could not change the legal status of the proposed conduct nor prevent criminal proceedings in respect of the same subject matter.[76] However, in practical terms, authoritative guidance from a court would normally inhibit or seriously prejudice a criminal prosecution.[77] Therefore a civil ruling should offer considerable assurance to health professionals that their actions will not cause repercussions with the criminal law. It frees them "in the pursuit of their heading vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their ... patients."[78]

Should The Court Play Any Role?

Withholding regular judicial participation in decisions to withdraw life-sustaining treatment will not exclude all judicial scrutiny of the delicate matter.[79] The court still has an important role to play. In a small number of cases parties involved in the decision whether to remove artificial nutrition and hydration may not agree and they should be free to approach the court for a ruling on the matter.[80] Occasionally, judicial review may ensue through

---

Scottish Roman Catholic Priest and Pro-Life Campaigner, Father James Morrow, threatened them with a private prosecution. Naturally, this caused the parents considerable distress in addition to the grief they were already suffering from the loss of their son. The threat turned out to be an idle one. J McLeod "Moral Maze" (1993) 90 Law Society Gazette 10.

75 Above n 3, 241.

76 *Imperial Tobacco Ltd* v *Attorney General* [1981] AC 718.

77 *Bland*, above n 1, 391; *AHB*, above n 3, 244.

78 *In the Matter of Karen Quinlan*, above n 69, 668.

79 Cantor, above n 72, 116.

80 Issues Committee, above n 23, 4. The Committee considered the Family Court should be the independent decision-maker in the event of a dispute for the following reasons:

criminal prosecutions, should doctors or other health professionals neglect duties owed to patients or make decisions which are not bona fide.

Further Reasons For Legal Intervention

Although decisions to remove artificial nutrition and hydration from PVS patients are primarily medical, there is still a need for legal intervention. As Professor Glanville Williams has noted, the diagnosis of death may be medical, but the definition of death is a legal issue.[81]

Doctors should also have recourse to the courts when uncertainties in the law require clarification.[82] They may be faced with uncertainties because of the ancient legislation, (i.e. the Crimes Act 1961), applicable to conduct which results in a person's death. While the principles encapsulated in the pertinent sections of the Crimes Act 1961 remain valid, the wording is outdated and inappropriate to cover the booming technological developments which have occurred in medical science.[83]

Therefore, the Courts will continue to play an important role in this area. A number of landmark decisions relating to the withdrawal of treatment from PVS patients have already been made,[84] but with advancing technology and social attitudes, new legal issues will continue to arise, mandating further judicial intervention.[85]

NECESSITY

An alternative basis for decision-making which avoids application to the court is the common law doctrine of necessity. The House of Lords in *Bland* used this

---

- They already exercise jurisdiction under the Protection of Personal and Property Rights Act 1988.
- They are in the best position to consider whether, for example, all family members have been consulted.

81 G Williams *Textbook on Criminal Law* (2 ed Stevens & Sons, London, 1983) 281.

82 Bioethics Research Centre, above n 6, 20; Dr G Gillet in *AHB*, above n 3, 241. See also Dr R Worth, above n 30.

83 The pertinent sections of the Crimes Act 1961 which will be considered later in the paper are sections 151 and 164, were originally drafted over a century ago, in 1879. *AHB*, above n 3, 247.

84 These are mainly United States decisions, for example *In the Matter of Karen Quinlan*, above n 69; *Cruzan* v *Director of Missouri Department of Health* 110 S Ct 2841 (1990); *Barber* v *Superior Court of State of California* 195 Cal Rptr 484 (1983). *Bland*, above n 1, is the only United Kingdom decision so far.

85 Bioethics Research Centre, above n 6, 21.

Necessity
HL in Bland used this

doctrine as the basis for deciding that doctors could lawfully remove artificial nutrition and hydration from a PVS patient. Consequently, there is compelling authority for the use of the doctrine in New Zealand, even though the New Zealand High Court could exercise its parens patriae jurisdiction to consent to the treatment (or its withdrawal) on the patient's behalf.

There are several advantages to using the doctrine of necessity (as outlined below) which make it a preferable decision-making tool. It has the advantage of permitting doctors to act immediately, and have their conduct excused retrospectively.[86] Doctors, institutions, or families would not have to apply to the Court to authorise their actions. Whereas invocation of the parens patriae jurisdiction involves an expensive, cumbersome application for a contemporaneous decision. Furthermore, section 20 of the Crimes Act 1961 retains all common law principles and rules which render any circumstances a justification or excuse for any act or omission.

Therefore, the *Bland* case, provides compelling authority for the suggestion that under the doctrine of necessity doctors' withdrawal of treatment should be considered lawful.

Development Of The Doctrine Of Necessity

It is well established that consent is a prerequisite to lawful medical intervention in almost every case. However, as already noted, there are situations where the patient is unconscious or otherwise incompetent, and unable to consent. Unlike the New Zealand courts, the English courts cannot consent to treatment on the incompetent patient's behalf since its parens patriae jurisdiction over incompetent adults no longer exists.[87] It seemed that the law provided no means by which necessary medical treatment could lawfully be administered to incompetent adult patients. Faced with this lacuna in the law, the House of Lords[88] developed a principle which would justify medical intervention in the

---

86 I owe this idea to Dr David Collins.

87 *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 57 (per Lord Brandon of Oakbrook) and 71 (per Lord Goff of Chieveley). See also *Bland*, above n 1, 369 (per Lord Goff of Chieveley), 377-378 (per Lord Lowry), 385 (per Lord Browne-Wilkinson). The English Courts' parens patriae jurisdiction over mentally incompetent adults ceased to exist as a result of the joint effect of section 1 of the Mental Health Act 1959 and the revocation by Warrant under the Sign Manual of the last Warrant dated 10 April 1956, by which the Crown's jurisdiction over persons of unsound mind had been assigned to the High Court.

88 *In Re F*, above n 87.

absence of consent on the basis of the common law principle of necessity. Lord Brandon explained the common law solution in the following terms:[89]

> [A] doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health.

Where the patient is in *need* of treatment, but unable to consent, a doctor can lawfully treat the patient on the basis of necessity and in many cases the doctors will have a common law duty to do so.

Lord Goff analysed the doctrine of necessity and concluded that, as a general rule, necessity will allow doctors to lawfully treat a patient in the absence of consent, provided the following criteria are met:[90]

> (1) [There must] be a necessity to act when it is not practicable to communicate with the assisted person, [and]
>
> (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.

Naturally, the defence of necessity would not avail a doctor if she treated the patient against the patient's clearly expressed wishes, which were communicated to the doctor before the patient became incompetent.[91] Furthermore, the doctor must, when deciding on the form of treatment for the incompetent patient, act in accordance with a responsible and competent body of relevant professional opinion, skilled in the particular form of treatment in question.[92] Treatment provided on this basis will be in the patient's best interests.[93]

The House of Lords in the *Bland* case considered how the doctrine of necessity could justify the removal of artificial feeding from a PVS patient. The starting point was a consideration of how the life-sustaining regime was initially instituted.

---

89 Above n 87, 55.

90 *In Re F,* above n 87, 75-76.

91 *Malette* v *Schulman* (1987) 67 DLR (4th) 321.

92 The House of Lords in *In Re F* adopted the test laid down in *Bolam* v *Friern Hospital Management Committee* [1957] 2 ALL ER 118.

93 The inapplicability of patient's best interests as a standard for decision-making for PVS patients will be discussed later.

Necessity: Applied By The House Of Lords

When Anthony Bland came into the doctors' care he was unconscious; it was an emergency situation. He was unable to consent to treatment so decisions were made for him on the basis of his best interests. At this point, Anthony's best interests required that he be treated aggressively which included the institution of life-support measures (i.e. artificial feeding).

The doctors arrive at a diagnosis of PVS and a prognosis of permanence only after the patient had received aggressive medical attention, undergone repeated diagnostic studies and been carefully observed for a prolonged period.[94] Prior to diagnosing the PVS, improvement was thought possible, even to the extent of a return to sapient life.[95] It is only at a later stage, when it became apparent that the patient would not regain consciousness, and there was no hope for recovery, that life-sustaining procedures and treatment needed to be re-examined.[96]

In these circumstances, the question arises, whether the artificial feeding regime can be justifiably continued. Non-consensual medical regimes will be lawful and justifiable only if it is in the patient's best interests to receive such medical care.

When Anthony Bland was diagnosed as permanently vegetative none of the following goals of medical treatment and care could be met:[97]

- prevention if death;
- curing illness, injury and disease;
- maintenance of the status quo (i.e. preventing deterioration of the condition);
- relieving pain and suffering (i.e. palliative care).

---

94 *Bland*, above n 1, 364; President's Commission For The Study of Ethical Problems In Medicine and Biomedical and Behavioural Research *Deciding To Forgo Life Sustaining Treatment* March 1993, 181.

95 D Mendelson *Legal and Ethical Ramifications of Withdrawal of Life Support Systems From Incompetent Patients* Law, Medicine and Criminal Justice Conference (Australian Institute of Criminology, Canberra, 1993) 7.

96 President's Commission, above n 94, 181.

97 *Bland*, above n 1, 361; I Freckelton "Withdrawal of Life Support: The 'Persistent Vegetative State' Conundrum" (1993) 1 Journal of Law and Medicine 35, 40.

Anthony Bland could have no interest in further treatment or maintenance, nor in fact, any interests at all which could justify continued medical care. Therefore, the House of Lords held that invasive life-sustaining procedures could not lawfully be continued. The doctors had no right nor corresponding duty to continue the non-consensual regime and it had to be withdrawn.[98]

The House of Lord's use of necessity in these circumstances to exculpate doctors' conduct from criminal responsibility for culpable homicide represents a considerable extension of the doctrine. The Court authorised, not the application of treatment, but the withdrawal of life-sustaining medical care which would inevitably result in the patient's death.

Conclusion: Necessity

The doctrine of necessity is a useful tool for permitting doctors to treat the patient initially, and later withdraw treatment, allowing the patient to die without breaching their duties to the patient or the criminal law. It is cognisant of the PVS patient's lack of interests and indifference to further treatment.

To summarise, the doctrine of necessity could be applied to future cases where doctors wish to withdraw life-sustaining regimes from PVS patients as follows:

1) Necessity justifies treatment which is provided in the patient's best interests.

2) PVS patients have no interests, they are totally indifferent to life and death.

3) In the absence of interests there can be no justification for the invasive treatment.

4) Therefore, the doctors are not entitled to continue the life-sustaining regimes, and they have no duty to do so.

5) Therefore, life-sustaining regimes, including artificial feeding, can lawfully be withdrawn.

---

98 *Bland*, above n 1, 385 (per Lord Browne-Wilkinson); 398 (per Lord Mustill).

It is appropriate now, to consider whether criminal liability will attach to the withdrawal of artificial nutrition and hydration from PVS patients.

PART III

CRIMINAL LIABILITY

If a doctor takes steps to end a patient's life, and is successful in his purpose, the conduct will be unlawful, implicating the criminal law of homicide. It is well established that an altruistic motive would be irrelevant to a consideration of culpability.[99] The patient's consent to the doctor so acting is also irrelevant since a person cannot lawfully consent to her death.[100] Therefore, it is understandable why doctors may be hesitant to withdraw or withhold life-sustaining treatment, be it artificial nutrition and hydration or antibiotics, from a PVS patient which would result in the patient's death.[101]

The crucial issue is whether withdrawing or withholding life-sustaining nutrition and hydration would constitute culpable homicide under the Crimes Act 1961. Homicide is defined as "the killing of a human being by another, directly or indirectly, by any means whatsoever."[102] Homicide will be an offence only if it is culpable within the terms of section 160 of the Act. If the killing is culpable then it may be murder under section 167 or section 168, and otherwise it is manslaughter.[103] Culpable homicide involves killing a person by an unlawful act or by an omission without lawful excuse to perform or observe any legal duty.[104]

---

99 Cantor, above n 72, 31; D Tribe and G Korgaonkar "Withdrawal of Medical Treatment" (1992) Solicitors Journal 1192; I Kennedy "The Law Relating To The Treatment of the Terminally Ill" in *Treat Me Right - Essays in Medical Law and Ethics* (Clarendon Press, Oxford, 1988) 315, 321.

100 Section 63 of the Crimes Act 1961. Furthermore, a doctor may be in breach of section 179 of the Crimes Act 1961 if he aids or abets suicide.

101 It is acknowledged that some health professionals are not concerned about criminal prosecution. They are reluctant to withdraw a nasogastric tube because they are not satisfied in themselves that that is the morally right thing to do. They want to be sure that it will not cause any further pain to family or medical staff. Dr R Worth, above n 30.

102 Section 158 of the Crimes Act 1961.

103 Section 160(3) states that "Except as provided in section 178 of this Act, culpable homicide is either murder or manslaughter." Section 171 defines manslaughter as "culpable homicide not amounting to murder" (excluding infanticide).

104 Section 160(2) of the Crimes Act 1961.

New Zealand Courts have not considered this issue to date. What follows is an examination of the approaches open to the court if it was asked to consider the legality of withdrawing of artificial nutrition and hydration from a PVS patient, and whether it would constitute culpable homicide. The House of Lords considered this issue for the first time in *Bland*. This landmark case will be analysed in an attempt to evaluate doctors' position in New Zealand. The strength of the House of Lords' decision and its conclusions will be tested here.

The Approach: How To Consider Culpability

The question which has received enormous attention from commentators[105] and was addressed for the first time by the House of Lords in *Bland*, is how can the humane withdrawal of maintenance-of-life regimes which result in the patient's death be distinguished from unlawful killing? To rationalise this distinction, attention has been focused on: the difference between acts of commission and acts of omission; the extent of doctors' duties to patients; and the issue of causation.

Acts Of Commission And Acts Of Omission

Traditionally, the law has drawn a distinction between acts of commission and acts of omission. This distinction supposes that intentionally *doing* something is somehow more culpable than allowing something to happen without interference.[106] People are held liable for all the adverse results of their commissions, but only some of their omissions.

In the medical domain then, the law is considered to draw a crucial distinction between cases where the doctor omits to provide the patient with life-prolonging treatment and those where the doctor commits an act (i.e. administration of a lethal injection) to end the patient's life.[107] This distinction between actively killing a patient and making a clinical decision to allow a patient to die, has found expression in the phrase "letting nature take its course",[108] which implies

---

105 Kennedy, above n 99; I Kennedy "Switching Off Life-Support Machines: The Legal Implications" in *Treat Me Right - Essays in Medical Law and Ethics* (Clarendon Press, Oxford, 1988) 349; H Beynon "Doctors as Murderers" (1982) Criminal Law Review 17; PDG Skegg *Law, Ethics, and Medicine - Studies In Medical Law* (Clarendon Press, Oxford, 1988).

106 H Kuhse *the Sanctity of Life Doctrine in Medicine - A Critique* (Clarendon Press, Oxford, 1987) 32-33.

107 *Bland*, above n 1, 368.

108 Cook, above n 52, 157.

that death resulted from the underlying condition rather than the doctor's conduct.[109] This explains why many doctors feel able to withhold antibiotic treatment (an omission) rather than withdraw "treatment" in the form of artificial feeding (a commission).[110]

What is the reason for this distinction?

In general, motive is seen as the *moral* distinction between acts and omissions. Someone who takes another person's life by some conduct designed with this primary intention is considered, morally, more blameworthy than someone who fails to save another.[111] This is not an accurate "moral evaluation" of doctors' intentions which are, generally, merciful whether treatment is removed or withheld.[112] Another reason for the distinction rests with society's general aversion to placing positive obligations on people towards strangers, and the difficulty in defining the extent of such obligations.[113] In some instances, however, the law imposes a duty on the person to act because of a special relationship between the parties.[114]

This legal and moral rule, that people have limited duties to save others is irrelevant in the medical domain because doctors are under a legal duty to use their skill, as far as possible, to benefit their patients, "and this duty removes any distinction between acts and omissions."[115] Failure to fulfil the duty will give rise to legal liability in the same way that an act of commission would.

Clearly, the commission/omission dichotomy was not formulated with medical conduct in mind.[116] As a result it is a difficult distinction to apply. Advances in medical technology enable doctors to prolong a patient's life, and in many cases, death will not occur without a positive human act. For example, discontinuing life-sustaining nutrition and hydration from a PVS patient involves removing the naso-gastric tube and withholding food and fluids. Is this an act or an omission? How do you tell the difference?

---

109 Cantor, above n 72, 32.
110 Dr R Worth, above n 30.
111 President's Commission, above n 94, 66-67.
112 President's Commission, above n 94, 66-67.
113 Cantor, above n 72, 32.
114 For example, parents or guardians have a duty to provide their children with food, clothing and shelter, see *Rex* v *Gibbons & Proctor* (1918) 13 Cr App 134.
115 President's Commission, above n 94, 66-67.
116 Cantor, above n 72, 32.

If this withdrawal is classified as a commission causing death, the doctor will probably be guilty of culpable homicide. If, however, it is classified as an omission, then the doctor will be criminally liable only if she had a duty to act.

House of Lords application of commission/omission distinction

The House of Lords decision in *Bland* illustrates the difficulties attendant on any attempt to categorise doctors' conduct as an act of commission or omission.

The Law Lords held the doctors' discontinuance of the artificial feeding regime to be an omission.[117] In doing so, Lord Goff relied on Glanville Williams' suggestion that the doctor's conduct "is in substance not an act but an omission to struggle" and "the omission is not a breach of duty by the doctor, because he is not obliged to continue in a hopeless case.[118] Williams supports his position with the following example: withdrawing life-sustaining treatment is no different from a failure to restart a machine which switches itself off automatically every 24 hours.[119] Failure to restart the machine was described as an omission.

The House of Lords, were trying to distinguish *Bland* from *R* v *Cox*[120] where a doctor was convicted of attempted murder after administering a lethal injection to his patient.

So, the Law Lords decided it was impossible to distinguish withdrawing a naso-gastric tube from withholding food and fluids or the non-initiation of the artificial feeding regime as this would introduce intolerably fine distinctions into the law.[121] The doctors were simply *allowing the patient to die* by refraining from providing treatment which might prevent death. Therefore, the withdrawal was considered an omission and lawful provided no duty was breached.[122]

---

117 *Bland*, above n 1, 369; 384; 398.

118 G Williams *Textbook of Criminal Law* (2 ed, Stevens and Sons, London, 1983) 282.

119 Above n 118, 282. See also comments by Beynon, above n 105, 20.

120 *R* v *Cox* [1993] 1 WLR 188.

121 *Bland*, above n 1, 369; 384. See also *Barber* v *Superior Court of State of California* 195 Cal Rptr 484, 491 (1983).

122 *Bland*, above n1, 369. See also G P Fletcher "Prolonging Life" (1966) 42 Washington Law Review 999; H Beynon "Doctors as Murderers" (1982) Criminal Law Review 17.

It is respectfully submitted that the Law Lords' categorisation of the doctors' conduct is unstable, and an acute deviation from common English usage.[123] Removing a naso-gastric tube clearly involves *affirmative conduct*, but common sense tells us that a doctor should not be guilty of culpable homicide on this ground alone. It is too simplistic to suggest that the difference between killing and letting die rests on the distinction between physically performing an action like withdrawing a naso-gastric tube which results in death, and not performing an act like administering antibiotics or feeding through the tube which would have *prevented* death.[124]

There is no morally relevant distinction in this situation between bodily movement and the absence of it. Indeed some omissions leading to death would be considered equally blameworthy as acts. In some instances, as already noted, the law recognises people's moral obligation to act by imposing legal duties to do so, making an omission as culpable as an act.[125]

The traditional commission/omission approach to liability should be abandoned in this area. There is no morally significant difference between commissions and omission. Categorising doctors' conduct results in the use of pure semantics and unacceptable distortions of language.

Practical Implications Of The Act/Omission Approach

Thomas J in the *AHB* case was able to provide the community with workable guidelines, avoiding the need for future judicial intervention in decisions to discontinue life-sustaining procedures because of his approach to the issue of culpable homicide. His Honour simply considered whether the doctors had a lawful excuse to discontinue artificial feeding, then proceeded to clarify the law in respect of the legal cause of death after medically indicated cessation of life-sustaining procedures.[126] This approach is considerably different to that of the House of Lords in *Bland*.

---

123 I Kennedy "Switching Off the Life-Support Machines: The Legal Implications" in *Treat Me Right - Essays in Medical Law and Ethics* (Clarendon Press, Oxford, 1988) 349, 351.

124 Kuhse, above n 106, 42-43; Cantor, above n 72, 32-33; Bioethics Research Centre, above n 6, 34.

125 For example, sections 151, 152 and 153 of the Crimes Act 1961.

126 Mendelson, above n 95, 13.

The Law Lords[127] became so entangled in commissions/omissions semantics they were unable to clearly indicate to doctors when life-sustaining nutrition and hydration may be withdrawn without fear of criminal prosecution.[128]

Therein lies the major practical difference between the House of Lords' decision and the New Zealand High Court decision:[129]

> Since, in the [United Kingdom], the whole edifice of legality of medical decision-making in respect of withdrawal of life-sustaining treatment depends upon the court's categorisation of the doctor's conduct in each particular case, the law is no more certain now than it was before the *Bland* case.

Despite its stated objective, of deciding, under the existing law, in which circumstances doctors can lawfully withdraw treatment, independently of the court's intervention, the House of Lords' categorisation of doctors' conduct means that doctors in England must continue to apply to the Court for declaratory relief prior to removing artificial nutrition and hydration.[130] Lord Browne-Wilkinson acknowledged this when he said:[131]

> I am very conscious that I have reached my conclusion on narrow, legalistic grounds which provide no satisfactory basis for the decision of cases which will arise in the future where the facts are not identical ... I therefore consider that, for the foreseeable future, doctors would be well advised in each case to apply to the court for a declaration as to the legality of any proposed discontinuance of life-support where there has been no valid consent by or on behalf of the patient to such discontinuance.

It has been suggested that the House of Lords' approach to the withdrawal of life-sustaining nutrition and hydration is "implicitly mistrustful of the professional autonomy of medical personnel."[132] This, it is argued is evidenced by Lord Lowry's articulation of the Law Lords desire to keep medical decision-making under judicial scrutiny when he said:[133]

> Procedurally I can see no present alternative to an application to the court such as that made in the present case ... [In] the absence of an application, the doctor who proposes the cessation of life-supporting care and treatment on the ground that their continuance would not be in the patient's best interest will have reached that conclusion himself and will be judge in his own cause unless and until his chosen course of action is challenged in criminal or civil proceedings.

---

127 Except, it seems, Lord Keith of Kinkel.
128 M Puxon "Mercy Without Certainty" (1992) 340 The Lancet 1343.
129 Mendelson, above n 95, 11.
130 Mendelson, above n 95, 11-12.
131 *Bland*, above n 6, 387; see also Lord Keith of Kinkel at 363, and Lord Goff of Chieveley at 376-377.
132 Mendelson, above n 95, 15.
133 Bland, above n 1, 378.

For the reasons given, it is more than apparent that the issuance of guidelines is eminently more suitable than an approach which requires continued judicial intervention in the medical domain.[134]

The Duty Approach

After its extensive use of semantics, the House of Lords addressed the real issue on which liability turned, whether or not the doctors would breach their duty owed to the patient in good faith. Lord Goff recognised that the true distinction between discontinuing life-support and administering a lethal injection does not emanate from the commission/omission distinction but from the limits of a doctor's duty. He stated that:[135]

> [W]hereas the law considers that discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony.

The determative legal factor is the extent of the doctors' duty to the patient.[136] This will dictate the lawfulness of the conduct. If the conduct forms no part of the doctor's duty then it will be unlawful, irrespective of whether it is an act or omission.

Therefore, an examination of doctors' duty is a useful means of judging the lawfulness of conduct. Where a doctor omits to provide or continue maintenance-of-life regimes, precipitating the patient's death, she may face criminal prosecution if she breached her duty to care for the patient in good faith.[137] Medical ethics and societal values are reflected in the principle of good faith, "so that, to cause the patient's death, ... by omission or commission would be a breach of [this] duty ..., and hence unlawful".[138] However, ethics and societal values both recognise that in certain cases, it is acceptable to let the patient die and therefore permits the withdrawal of life-maintaining regimes.

---

134 Dr R Worth indicated to the Biological and Medical Issues Committee of the New Zealand Law Society, that in *his* opinion, there is a general feeling amongst doctors that medical decisions should be made by members of the medical profession and not by the Courts. To ensure that doctors can do this without fear of liability, he indicated that, doctors want clear guidelines as to the legality of removing a naso-gastric tube in the PVS. See above n 30.

135 *Bland,* above n 1, 369.

136 Cantor, above n 72, 33; I Kennedy "The Law Relating to the Treatment of the Terminally Ill", above n 99, 322.

137 Kennedy, above n 99, 321-3; Cantor, above n 72, 33.

138 Kennedy, above n 99, 322.

Kennedy considers an analysis of conduct's lawfulness in terms of duties to be morally and legally preferable.[139] It assures doctors that withdrawing "treatment" is morally acceptable not simply because they did not *kill* the patient, but because they are not required to pursue life above all else, and continue futile medical procedures.

Furthermore, a judicial decision which incorporates the duty approach would not rest on tenuous legal distinctions. It would clarify whether doctors would be criminally responsible for the withdrawal of "treatment" by delineating the boundaries of the medical duty to treat patients in hopeless and irreversible conditions.

Like the House of Lords, Thomas J in the *AHB* case examined the boundaries of the medial duty to provide treatment to assess the lawfulness of withdrawing of life-sustaining treatment. However, His Honour embarked upon this analysis immediately without categorising the proposed conduct as an omission. The lawfulness of the doctors' conduct in *AHB* was determined by reference to the doctors medical duty and lawful excuse as governed by good medical practice.

Respectfully, this approach to the issue of liability for culpable homicide is preferable to that of the House of Lords'. Advances in modern medical practice have created unique legal and ethical problems for doctors. Life and death decisions in the medical arena do not fit neatly into traditional legal categories. The duty approach is flexible and accommodates changes in the medical field.

Cause Of Death

Causation offers a further basis on which to exculpate doctors discontinuing life-maintaining procedures. Causation is the *sine qua non* of liability. Criminal responsibility for murder or manslaughter will attach to doctors' conduct only if the conduct caused (or accelerated) the patient's death. Therefore, if the patient's death is attributed legally to the underlying condition, legal liability will not attach to the conduct.[140]

---

139 Kennedy, above n 99, 322.

140 Mendelson, above n 95, 2; I Kennedy "Switching Off Life-Support Machines", above n 105, 360; PDG Skegg "The Termination of Artificial Ventilation" in *Law Ethics and Medicine - Studies in Medical Law* (Clarendon Press, Oxford, 1988) 161, 165.

A persuasive argument can be advanced that withdrawal of artificial feeding will not cause (or accelerate) death.[141] The argument's cogency is linked to its simplicity:

> Where the PVS patient's condition is irreversible and hopeless, artificial feeding is no longer medically justifiable. If artificial feeding is withdrawn, the patient's death will be caused by the underlying condition, because it is the PVS which prevents the patient from eating and sustaining her vital functions. Therefore the doctors' conduct will not cause the patient's death, and they cannot be guilty of culpable homicide.

This argument is consistent with the widely held belief that compliance with a patient's instructions to withdraw life-sustaining treatment will not constitute suicide or homicide.[142] The patient's refusal of further treatment and its subsequent withdrawal allows nature to take its course and death is considered to be the result of the underlying disease. Different conclusions may well have been drawn, however, if treatment was withdrawn in these cases without the patient's express consent.

Several other cases also confirm that the withdrawal of life-support systems are not the cause of death, although this was done in the context of a criminal prosecution charging a third party with murder.[143] Despite the fact that the doctors were not on trial and the culpability of their conduct was not in question, it is interesting that the Courts invariably assumed that the decision to terminate life-support was within the doctor's field of competence.[144]

It may be argued that these cases involved the removal of a ventilator and as such are distinguishable because death was not inevitable. The patient might continue to breathe unaided. If she does not, then it is most probably because the underlying disease process prevents the body functioning normally. Where

---

141 A variation of this argument was advanced by Counsel for the second plaintiff in the *AHB* case, above n 3, 248. See also *Bland*, above n 1, 331, where Sir Stephen Brown stated that the true cause of Anthony Bland's death would be the massive injuries which he sustained at the football stadium disaster.

142 *Nancy B*, above n 56; *In Re Quinlan*, above n 69, In *Re Conroy* 486 A 2d 1209, (1985).

143 See *R* v *Malcherek* [1981] 1 WLR 690, 694-5. In *R* v *Trounson* [1991] 3 NZLR 690, 696, the Court of Appeal considered section 166 of the Crimes Act 1961, and stated that the discontinuance of life support was not a new or intervening cause.

144 *AHB*, above n 3, 252.

food and fluids are withdrawn, however, there is no doubt about the patient's fate.[145] How then, can it be argued that the removal of food and fluids would not *cause* death, when death is so inevitable, and the whole purpose of the removal is to bring about the patient's death?

The underlying disease, it is suggested, does not proceed to death, but a *new*, intervening cause - dehydration and malnutrition - is introduced.[146] The fallacy of this argument can be exposed by considering the reason for artificial feeding. Artificial feeding must be provided in order to maintain the patient because the PVS has impeded the patient's ability to eat. If artificial feeding is foregone, then the patient will die because of his inability to eat, which is a result of the underlying condition. Brock postulated that:[147]

> It would seem to be only when the patient's human ability to take nutrition is unimpaired, and a decision is then made not to sustain life, and so to stop feeding, that a new fatal process is introduced as opposed to withdrawing a life-sustaining treatment and letting the disease process proceed to death.

This approach is useful for distinguishing unlawful killing from lawful conduct which allows a patient to die. For example, the case of *Rex* v *Gibbins and Proctor*[148] is distinguishable on this basis, from a doctor's bona fide withdrawal of artificial feeding from a PVS patient. In the *Gibbins* case, the accused were convicted of murder because they failed to fulfil a fundamental duty to a child in their care; they did not feed her. The otherwise healthy child starved to death. Therefore, the accuseds' failure introduced a fatal process which caused the death. Whereas, in the case of a PVS patient, the underlying condition is the fatal process, which was not introduced by the doctors.

Determining liability on the basis of the connection between the conduct and the result renders a common sense solution in most cases. It does not require courts to manipulate the concept of causation, since the doctor's act would not, in fact,

---

145 D W Brock "Forgoing Life-Sustaining Food and Water: Is it Killing?" in J Lynn (ed) *By No Extraordinary Means: The Choice To Forgo Life-Sustaining Food and Water* (Indiana University Press, Bloomington, 1989) 117, 123-4.

146 Brock, above n 145, 124.

147 Brock, above n 145, 124-125.

148 (1918) 13 Cr App 134.

be the cause of death.[149] If the conduct and the result are not connected, then the accused will not be guilty of culpable homicide, irrespective of the bona fides of the conduct.[150]

AHB - Approach To Causation

The Court in *AHB*, rejected this simplistic test because it would exculpate doctors who failed to observe good medical practice by inappropriately terminating treatment from a patient whose life was sustainable.[151] The futility of the treatment in one case and the ability to sustain life in another would not be a relevant difference when causation is in issue.[152]

To combat this difficulty, the concept of causation requires manipulation in order that the courts may hold blameworthy conduct to be the cause of death but exculpate morally justifiable conduct resulting in death. The critical question is: *under what circumstances will the courts consider a doctor to be legally justified in withdrawing artificial nutrition and hydration, and not legally the cause of death?* Commentators have devised rationale, based on causation, which purportedly justify doctors' removal of life-maintaining procedures in cases where the patient's condition is hopeless, but not in cases where life is sustainable.[153] These rationale were not accepted by the Court in *AHB*.

Instead Thomas J clarified the issue by reference to the medical duty of care and lawful excuse:[154]

> If the doctor is not under a legal duty to provide or continue with the life-support system, or he has a "lawful excuse" for discontinuing it, it may then be said that he or she has not *legally* caused the death of the patient.

If the two primary conditions are met, the withdrawal would not be the cause of death as a *matter of law*. Both conditions depend on whether or not the doctor acted in accordance with good medical practice.

---

149 PDG Skegg "Drugs Hastening Death" in *Law Ethics and Medicine - Studies in Law and Medicine* (Clarendon Press, Oxford, 1988) 121, 136.

150 See *R* v *Cox*, above n 120, where the charge was reduced from murder to attempted murder because of the inability to prove the connection between the doctor's act and death.

151 *AHB*, above n 3, 248 and 254.

152 *AHB*, above n 3, 248.

153 Kennedy, above n 123, 360-361 ("non-blameworthy cause"). Skegg, above n 140, 166 ("medical practice considered proper in the circumstances").

154 *AHB*, above n 3, 249.

A Return To Duty

Under all the approaches outlined, it is necessary to consider the parameters of the doctor's duty. Section 151(1) of the Crimes Act 1961 (the Act) establishes these parameters. Section 164 of the Act is also pertinent to the issue of causation, and it will be addressed later. Neither section 151(1) nor section 164 create an offence in their own right. Their function is to assist in defining the term "killing" in section 158 and in determining the culpability of the "killing" for the purposes of section 160. Section 151(1) will now be addressed in order to ascertain the parameters of a doctor's duty to continue artificial feeding regimes.

Section 151 Of The Crimes Act 1961

Section 151(1) of the Crimes Act 1961 attempts to ensure that people in the care of others receive basic care by imposing a legal duty on those responsible to supply dependants with *necessaries of life*. The section states:

> **151. Duty to Provide the Necessaries of Life - (1)** 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 his life is endangered or his health permanently injured, by such omission.

The section clearly applies to a doctor-patient relationship, where the patient is admitted for hospital care.[155] There also can be no doubt that food and water are necessaries of life without which the patient would die. As such, their provision forms part of a person's fundamental duty to those in his or her care.[156] However, PVS patients are unable to eat, and consequently receive their nutrition via a nasogastric tube. Therefore, the question is whether the provision of nutrition and hydration by artificial means is a necessary of life.

A distinction has been drawn between the provision of food by ordinary means and by artificial means. Overwhelming medical opinion worldwide regards

---

155 *AHB*, above n 3, 249.

156 *Rex* v *Gibbins & Proctor* (1918) 13 Cr Appl 134.

artificial feeding as medical treatment.[157] The House of Lords in *Bland* followed medical opinion. Furthermore, tube feeding requires the application of a medical technique which may need to be administered under the supervision of qualified health professionals.[158] Therefore, even if tube feeding is not strictly medical treatment, it is a medical procedure which forms part of the patient's medical care.

Despite its label of medical treatment and care, the withdrawal of artificial feeding is "an extremely psychologically difficult thing for many health care professionals to do".[159] The notion of withdrawing such elementary support is contrary to every health professionals' training - to care for people.

It has been countered, that irrespective of how it is provided, food and water are essential to all people, well or ill; it is *basic* care and a fundamental expression of equal concern and respect.[160] Their provision is "symbolic" of care, compassion, and humanity, as eating is a basic human activity which sustains life.[161] However, the symbolic significance of feeding dwindles when its purpose and the context of its provision are considered. Life is sustained by artificial feeding to enable other medical treatment which facilitate recovery to be administered. But permanently vegetative patients will not recover, and the benefits of feeding are doubtful.

Resistance to the withdrawal of artificial feeding may also stem from the resultant "starvation death". The word "starvation" and the description of its effects conjures a revolting picture, suggesting that the patient endures a painful, gruesome death.[162] The inaccuracy of this view has been widely criticised.[163]

---

157 *Bland*, above n 1, 362; 372. See also Bioethics Research Centre, above n 6, 38. See also *In Re J (A Minor) (Wardship & Medical Treatment)* [1991] Fam 33, 41 for other ramifications of this finding.

158 Bioethics Research Centre, above n 6, 38.

159 P W Armstrong and B D Colen, above n 39, 40; J E Ruark, T A Raffin and the Stanford University Medical Centre Committee on Ethics "Initiating and Withdrawing Life Support" (1988) 318 The New England Journal of Medicine 25, 27.

160 A Fisher "The Road to Euthanasia" (1993) The Tablet 235, 236.

161 R E Cranford "Patients with Permanent Loss of Consciousness" in J Lynn (ed) *By No Extra-Ordinary Means: The Choice to Forgo Life-Sustaining Food and Water* (Indiana University Press, Bloomington, 1989) 186, 191; Institute of Medical Ethics, Working Party on the Ethics of Prolonging Life and Assisting Death "Withdrawal of Life-Support From Patients in a Persistent Vegetative State" (1991) 337 The Lancet 96, 97.

162 *Brophy* v *New England Sinai Hospital Inc* 497 NE 2d 626 (1986); *In Re Jobes* 529 A 2d 434 (1987); See also J C Ahronheim and M R Gasner *"The Sloganism of Starvation"* (1990) 335 The Lancet 278; Bioethics Research Centre, above n 6, 7.

Despite the manifestations of starvation, PVS patients are thought to be unable to experience or perceive pain and suffering.[164] In the absence of this capacity, there could be "no perception of what the conscious patient would describe as hunger or thirst".[165] Furthermore, only artificial feeding is withdrawn, palliative care continues. Therefore, "the cruelty and abandonment implied in the word 'starvation' are not relevant to the dying [PVS] patient".[166]

The courts have frequently held necessaries of life to include medical treatment and care.[167] In these cases, the medical intervention was necessary to "prevent, cure or alleviate a disease [which] threatened life or health."[168] Consequently, the Court in *AHB* considered the provision of artificial life support to be a necessary of life where it was required to "prevent, cure or alleviate" the condition.[169] Where the patient is surviving by virtue only of the mechanical means, the life support should not be construed as a necessary of life.

Similarly, the House of Lords in *Bland* considered that the doctors were not under a legal duty to provide artificial nutrition and hydration if the procedure was futile.[170] Lord Goff came to this conclusion by drawing an analogy between the function of nasogastric feeding and ventilatory support. Since they both provide a form of "life support", the same principles could be applied to decide whether artificial feeding could lawfully be discontinued.

However, an obvious difference between the two forms of "life support" is their physical appearance. A nasogastric tube is not an advanced, expensive piece of medical machinery, it is merely a tube which facilitates feeding. It is understandable why health professionals may feel more responsible for the patient's death after the withdrawal of artificial feeding[171] than after the removal of a host of machines which more obviously sustain life.

---

163 Ahronheim et al, above n 162; Armstrong et al, above n 39, 40; D Brahams "The Reluctant Survivor" (1990) 140 NLJ 639; Bioethics Research Centre, above n 6. 7; B Jennett "Letting Vegetative Patients Die" (1992) 305 BMJ 1305.

164 See above discussion on the PVS.

165 Armstrong et al, above n 39, 40; *Bland*, above n 1, 373.

166 Ahronheim et al, above n 162, 279.

167 *R* v *Burney* [1958] NZLR 745 (Medical care and hospital treatment); *R* v *Moore* [1954] NZLR 893 (Medical attention); see also *AHB*, above n 3, 249.

168 *AHB*, above n 3, 249; *R* v *Tutton* (1989) 48 CCC (3d) 129; see also D B Collins *Medical Law in New Zealand* (Brooker and Friend, Wellington 1992), 193-4.

169 *AHB*, above n3, 249.

170 *Bland*, above n 1, 362; 372-373; 386; 398.

171 Dr R Worth, above n 30.

Nevertheless, *Bland* provides highly persuasive authority for the argument that artificial is not a necessary of life because it will not prevent, cure or alleviate irreversible PVS. Artificial feeding in itself could not cure the condition, it would simply alleviate the effects of the condition long enough to enable recovery. Where there is no hope for recovery, and the patient survives by virtue only of the artificial feeding regime, continued medical intervention is futile and medically unjustifiable. Consequently doctors should not be under a legal duty to continue artificial feeding, and their omission to do so should not carry criminal responsibility.

Lawful Excuse

Even if doctors are considered to owe a duty to the patient to continue artificial feeding, they may for the purposes of section 151(1) be legally justified in discontinuing the maintenance-of-life regime, if the doctors had a "lawful excuse" for so acting.

In hopeless, irreversible cases of PVS, there is no medical justification for continued medical intervention and the purposes of medicine will be frustrated if doctors are required to maintain life-sustaining regimes. Although continued maintenance is lawful, doctors should have a lawful excuse for its discontinuance if this accords with good medical practice.[172] It would be unreasonable to hold doctors, following good medical practice, criminally responsible in terms of section 151.

What then, constitutes good medical practice? Reference to the fundamental duty attendant on the doctor-patient relationship is the most useful start point. This immediately indicates that neither law nor medical ethics impose a duty to prolong life - or to defer death - where "there is no reasonable possibility of the patient emerging from her (unconscious) condition to a cognitive, sapient state".[173] Indeed it was the futility of the medical procedures that decided the matter in the *Bland* case. Furthermore, a doctor's fundamental duty requires her to treat the patient in accordance with her best clinical judgment (i.e. in good faith and in accordance with good medical practice).[174] If, in the doctor's bona fide clinical judgment, the situation is hopeless, and treatment should be

---

172 *AHB*, above n 3, 250.

173 *In Re Quinlan*, above n 69; *AHB*, above n 3, 251; *Barber*, above n 84; Mendelson, above n 95, 14; Kennedy, above n 123, 361-367; Williams, above n 8, 279.

174 *In Re J*, above n 69, provides persuasive support for this position.

withdrawn, to require the doctor to act to the contrary would be "wholly inconsistent with the law."[175] This realistic approach should be, and most probably will be adopted in relation to the withdrawal of artificial feeding from PVS patients.

After considering these factors, Thomas J in *AHB* concluded that good medical practice would exist if the following criteria are fulfilled:[176]

1) That the doctor's decision to withdraw or withhold the life-sustaining treatment must be bona fide and in the patient's best interests.

2) That the decision "encompasses prevailing medical standards, practices, procedures and traditions which command general approval within the medical profession."

3) That the medical profession's recognised ethical body is consulted and approves the decision.

4) That the patient's immediate family[177] or guardian gives fully informed consent to the decision.

The utility of the patient's best interests decision-making basis, in relation to PVS patients is doubted[178] and this aspect of good medical practice should be omitted. Doctors would simply be required to make a bona fide clinical judgment whether treatment should be continued, and this must accord with objective medical opinion.[179]

The withdrawal of artificial feeding should be permitted on the same basis as the withdrawal of ventilatory support. If doctors comply with the criteria for good medical practice they should, and probably would, have a lawful excuse in terms of section 151.

Therefore, criminal responsibility should not attach to the doctor's withdrawal of artificial feeding, because the doctor's conduct was not legally the cause of

---

175 *In Re J*, above n 69.
176 *AHB*, above n 3, 251.
177 "Family" would need to be defined in a culturally sensitive fashion.
178 See later discussion of Patient's Best Interests.
179 This is consistent with the recommendation by the Issues Committee, above n 23, 3.

death. This argument would not be available to an interloper discontinuing the life-sustaining regime or a doctor not acting bona fide.

Section 164 - Acceleration of Death

There is one further section of the Crimes Act 1961 which is pertinent to the issue of liability for culpable homicide. It is section 164, which concerns acceleration of death.

Section 164 codifies a principle of law under which a person may be responsible for the death of another if the bodily injury caused by the person hastens death, notwithstanding that the conduct would not have killed if the victim had not been labouring under some condition.[180] The section reads:

> **164. Acceleration of Death** - 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.

Prima facie, section 164 seems to encompass the withdrawal of artificial feeding, because the patient will die when death would not have otherwise occurred. For section 164 to be invoked, it must be shown that the accuseds' conduct was a contributory cause of the victim's death.[181] The conduct need not be the substantial or only cause of death, but it must be more than a trivial or de minimus contribution.[182] The vital issue is what *caused* the victim's death.[183]

Common law cases establishing the principle codified by section 164 include *R* v *Burdee*.[184] This case concerned an elderly woman who was persuaded to fast for three days, in an attempt to cure her rheumatism. The woman died whilst fasting. A post mortem examination revealed that she had been suffering from a heart condition. At the trial, medical evidence indicated that the fasting accelerated the heart failure, which resulted in death. The person was convicted of manslaughter. On appeal, the court upheld the conviction, and reaffirmed that acceleration of death by improper medical treatment may readily constitute manslaughter.

---

180 Robertson (ed) *Adams on Criminal Law* (Brooker and Friend, Wellington, 1993) 1I-28.
181 Garrow & Turkington *Criminal Law* (Butterworths, Wellington, 1991) 257; Collins above n 54, 192.
182 Collins, above n 54, 192; Garrow & Turkington, above n 181; 257.
183 *R* v *Henningan* [1971] 3 ALL ER 133.
184 *R* v *Burdee* (1916) 86 LJ KB 871.

Applicability of section 164

The Court in *AHB* considered section 164, and much of its reasoning is applicable to the withdrawal of artificial nutrition and hydration from PVS patients. Most importantly, the *AHB* case clarifies the application of section 164 and it supports the conclusion that doctors acting in accordance with good medical practice should not be considered to have accelerated the patient's death.

To begin with, it is doubtful whether section 164 would be applicable at all. The conclusions reached earlier, regarding causation, under section 151 are pertinent here. Secondly, the purpose of section 164 is to assist in determining whether or not the accused "killed" the person in terms of section 158 and section 160. If there is no *unlawful act* causing death in terms of section 160, then section 164 will be of little relevance because a vital element of culpable homicide has not been established.

The lawfulness of the withdrawal can be determined by reference to the doctor's duty to continue the medical regime. It has been argued that doctors should not be under a duty to continue artificial feeding in futile case, and, they should have a lawful excuse for withdrawing the regime. Then, providing they have acted in accordance with good medical practice, the act of withdrawing artificial feeding would not be an "unlawful act" for the purposes of section 160.

Bodily injury

For section 164 to apply, the doctors must have inflicted some *bodily injury* on the patient which hastened death. Will the withdrawal of artificial feeding inflict bodily injury on the patient? It is doubtful. The removal of ventilatory support was not considered to constitute an infliction of bodily injury.[185] To do so would strain the natural and ordinary meaning of "bodily injury". A ventilator simply mechanically ventilates a patient's body, and the act of discontinuing this process does not inflict bodily injury.[186]

---

185 *AHB*, above n 3, 254.
186 *AHB*, above n 3, 254.

The same reasoning should be applied to the withdrawal of artificial feeding. A nasogastric tube provides food in the same way that a ventilator provides air. Removing the tube will not by itself inflict "bodily injury", it will simply prevent further feeding by artificial means. Therefore, it is submitted that no bodily injury will be caused, notwithstanding the fact that as the body expires, it will exhibit the unpleasant effects of starvation and dehydration, which may sustain damage to bodily organs.[187]

"Hastens his death"

The most problematic aspect of section 164 is the phrase "hastens his death". A PVS patient's death would seem to be hastened by the removal of artificial feeding because the patient may otherwise have continued to live. The death happened at the time it did because of the doctor's conduct.[188]

The observations made by Devlin J in *R* v *Adams*[189] are helpful here. His Honour contended that where doctor's conduct resulted in premature death, common sense would indicate that the illness and not the doctor was the cause of the death.

> [People] would suggest the cause of her death was the illness or the injury ... which brought her into hospital, and the proper medical treatment that is administered and that has an incidental effect of determining the exact moment of death, or may have, is not the cause of death in any sensible use of the term.[190]

The facts in *R* v *Burdee* are somewhat analogous to the case under consideration. To avoid the conclusion that the doctor's conduct hastened death, *Burdee* will have to be distinguished. This is possible because the phrase, hastens death, has been interpreted narrowly, and considered inapplicable to *doctors* who "in accordance with good medical practice, withdraw treatment which no longer serves any therapeutic or medical purpose."[191] Consequently, if artificial feeding fulfils no medical purpose, and its withdrawal complies with good medical practice, doctors should not be considered to have hastened the patient's death. Therefore, it is unlikely that section 164 will be applicable, or if it is, that it would fix the doctors with criminal responsibility.

---

187 See *AHB*, above n 3, 254.
188 D Cook, above n 52, 159.
189 [1957] Criminal Law Review 365.
190 Above n 189.
191 *AHB*, above n 3, 255.

Conclusion On Liability

It has been shown that doctors should not be held criminally responsible for withdrawing artificial feeding on the following grounds. Doctors should not be under a duty to continue futile treatment, and they should have a lawful excuse if they withdraw artificial feeding in accordance with good medical practice. Consequently, they should not be considered to have caused or accelerated the patient's death as a matter of law.

PART IV

CRITERIA FOR GOVERNING DECISIONS TO WITHDRAW ARTIFICIAL FEEDING

In light of the conclusion reached in this paper, that life-sustaining nutrition and hydration may lawfully be withdrawn from patients in a permanently vegetative state, the question which must now be addressed is: what criteria or standard should govern the decision to withdraw life-sustaining procedures from PVS patients whose treatment wishes are not known?

Three alternatives will be considered: patient's best interests, substituted judgment and good medical practice. There may be some overlap between the criteria available and several parties may be involved in the decision.

Patient's Best Interests Approach

In its pristine form, the patient's best interest test requires the decision-maker to balance the "benefits" and "burdens" of treatment, and to make a decision which will confer the greatest net benefit on the patient.[192] Theoretically, the inquiry focuses on the patient's contemporaneous interest.

In *Bland*, the House of Lords adopted the patient's best interests approach as the basis for deciding whether continued medical intervention was justified. Lord Goff considered that the "patient's best interests" did not place the doctors under an obligation to prolong the patient's life by every means available to them, regardless of the patient's quality of life.[193] He stated that:[194]

---

192 R Dresser, above n 63, 383.
193 *In Re J*, above n 69, followed.
194 *Bland*, above n 1, 370-371.

> [If] the justification for treating a patient who lacks the capacity to consent lies in the fact that the treatment is provided in his best interest, it must follow that the treatment may, and indeed ultimately should, be discontinued where it is no longer in his best interests to provide it. The question which lies at the heart of the present case is, as I see it, whether on that principle the doctors responsible for the treatment and care of Anthony Bland can justifiably discontinue the process of artificial feeding upon which the prolongation of his life depends.

Do PVS patients have interests?

In adopting the patient's best interests approach, the House of Lords overlooked one vital question: do PVS patients have interests? It is submitted that they have no discernible interests on which treatment decisions can be made.

Where a diagnosis of permanent unconsciousness or "permanent" vegetative state has been made, then the patient, by definition, will not experience any of the benefits or burdens of continued medical treatment which the patient's best interests test is designed to balance.[195] It is thought that PVS patients are unable to experience pain and suffering,[196] or any other human emotion. Disability is total; and there is no possibility of a return to even minimal social functioning.[197] The only interests the patient may have in being maintained are the possibility of misdiagnoses or cure. These possibilities are so remote that they would not tip the balance in favour of continued maintenance.[198]

Lord Keith was disconcerted by the argument that Anthony Bland's best interests favoured discontinuance of the treatment.[199] His Lordship thought it impossible to make a value judgment in the case of a PVS patient, unlike the case of a

---

195 *In Re Peter* 529 A 2d 419, 425 (1987). It is acknowledged that some may disagree with this conclusion, and it may not be possible to generalise about PVS patients and whether they have interests.

196 AMA, above n 15. The Biological and Medical Issues Committee have indicated that this assumption, sometimes stated as fact, is not true for all PVS patients. It was advised by "a prominent neurosurgeon that a small minority of patients in a (persistent) vegetative state exhibit symptoms such as elevated heart rate and spasms which can be alleviated by painkillers." Above n 23, 2.

197 President's Commission, above n 94, 182; Cranford, above n 13, 28.

198 R Dresser, above n 63, 384; President's Commission, above n 94; Shapiro, above n 33, 447-448; Cranford indicated that patients who regained consciousness after three months in the vegetative state suffered severe and permanent mental and physical disability. Above n 13, 29.

199 *Bland*, above n 1, 361.

sensate patient,[200] because his irreversible lack of consciousness left him indifferent to *all* treatment decisions. Lord Keith opined:[201]

> In the case of a permanently insensate being, who if continuing to live would never experience the slightest actual discomfort, it is difficult, if not impossible, to make any relevant comparison between continued existence and the absence of it. It is, however, perhaps permissible to say that to an individual with no cognitive capacity whatever, and no prospect of ever recovering any such capacity in this world, it must be a matter of complete indifference whether he lives or dies.

Therefore, it is apparent that the patient's best interests concept which imposes a positive obligation to do what is most conducive to the patient's good, is not a particularly useful concept for guiding decisions in cases where patients have no discernible interests. It is simply inapplicable to individuals in a permanent vegetative state.[202]

House of Lords application of the patients best interest test

The irrelevance of the patient's best interests standard to PVS patients was clearly demonstrated when the House of Lord utilised it to decide Anthony Bland's future. Account was taken of the invasiveness of the treatment, the indignity the patient was subjected to, and Lord Goff also included the family's distress as a relevant factor to be balanced.[203]

Respectfully, the decision illustrates conceptual confusion in the application of the test.[204] Instead of balancing the benefits and burdens for the patient in question, interests of a "reasonable person" in the patient's situation were considered. This was inevitable in *Bland*, because Anthony Bland was completely indifferent to continued maintenance. Consequently, a decision was made reflecting what a "reasonable person" in the patient's situation would want, under the guise of the patient's best interests.[205]

Lord Mustill, on the other hand, explicitly excluded certain factors from consideration including the family's distress, the strain on medical staff caring

---

200 In both *In Re F*, above n 87, and *In Re J*, above n 69, it was possible to weigh the alternatives available and make a value judgment regarding the consequences to the sensate patient of withholding or administering medical treatment.

201 *Bland*, above n 1, 361. See also B Jennett and C Dyer "Persistent Vegetative State and the Right to Die: The United States and Britain" (1991) 302 BMJ 1256, 1258.

202 Shapiro, above n 33, 447. See also Gold, above n 35, 1091.

203 *Bland*, above n 1, 372; 385.

204 Bioethics Research Centre, above n 6, 25; Dresser, above n 63, 383.

205 Bioethics Research Centre, above n 6, 25; Dresser, above n 63, 393.

for Anthony Bland and the huge expenditure of skill, labour and money which would be more fruitfully employed in treating other patients.[206] He considered Parliament alone to be responsible for a social cost-benefit analysis of that kind. In the end though, it was the futility of the medical treatment which justified its termination.[207] This prompted Lord Keith to hold, without reference to the patient's best interests, that:[208]

> [A] medical practitioner is under no duty to continue to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance.

Lord Keith's decision recognises that a decision to withdraw artificial feeding cannot be guided by the patient's best interests. The patient's best interest approach is clearly inapplicable to PVS patients. Consequently, 'reasonable person' considerations surreptitiously enter the decision making process and, inevitably, form the basis of the decision. This approach is conceptually unsound and should not be adopted in New Zealand.

Substituted Judgment

A further approach to decision-making which has received considerable attention in the United States, is substituted judgment. Substituted judgment describes an approach in which "the objective intent of the formerly competent patient is allowed to govern" decision-making.[209] Under this approach, the surrogate makes a decision whether to refuse treatment on the patient's behalf. The decision is based on an assessment of what the patient would have chosen if he were competent and cognisant of the information relevant to his current treatment situation.[210]

Courts have adopted this standard in an effort to respect the individual's previously held values. It is considered that these values should not be negated by incompetence, but should be voiced by family or friends and given

---

206 *Bland*, above n 1, 397; see also Lord Browne-Wilkinson, 382.

207 *Bland*, above n 1, 362, 372.

208 *Bland*, above n 1, 362. See also *Bolam* v *Friern Hospital Management Committee* [1957] 2 ALL ER 118.

209 Cantor, above n 72, 63.

210 *In Re Quinlan*, above n 69, 664; *In Re Conroy*, above n 51, 1230-32; *Cruzan*, above n 84; *Superintendent of Belchertown State School*, above n 62; Gaudin, above n 50; 1328; James Bopp "Reconciling Autonomy and the Value of Life" (1990) 38 Journal of American Geriatrics Society 600, 601.Dresser, above n 63, 376-377; President's Commission, above n 94, 132-133.

appropriate recognition.[211] This is not, by definition, an exercise of the patient's self-determination or autonomous choice.

Neither is substituted judgment a decision in the patient's best interests. The question is not whether the proposed conduct is more beneficial to the patient, but what would the particular patient have done if she had been able to choose. If the patient would have made a decision against her best interests, then the substituted decision must reflect this.[212] In most cases, patient's best interests and substituted judgment will overlap and result in the same decision, since people usually make decisions in their own interests. Furthermore, it is unlikely that a court would sanction a decision it considered adverse to the patient's best interests.

Surrogates acquire considerable power because patients are unable to dispute the surrogate's assessment of their values and wishes.[213] To curb possible abuses of power, the strictest application of substituted judgment requires the decision to be made on clear and convincing evidence of the patient's expressed treatment preferences.[214] A heightened evidentiary standard has positive and negative aspects.

Commentators have criticised the standard as insurmountable in cases where the court requires specific, express statements by the patient about the treatments or medical procedures they would wish to be withheld.[215] Clear and convincing evidentiary standards may thwart the substituted judgment approach because it requires patients to exercise a level of foresight they may not possess.[216]

Nevertheless, the clear and convincing standard itself is still appropriate, given the enormity of the decision being made. It ensures that the decision is made on evidence which accurately reflects the choices incompetent patients would have made if they were able. However, this evidentiary standard renders the substituted judgment approach inapplicable to the patients under consideration; those who have not provided reliable evidence of their treatment preferences.

---

211 Bioethics Research Centre, above n 6, 25.
212 Bopp, above n 210, 601.
213 Bopp, above n 210, 601.
214 *Cruzan*, above n 84; 2852-54.
215 Gaudin, above n 50, 1331; Shapiro, above n 33, 444.
216 Shapiro, above n 33, 445.

A less stringent evidentiary standard does not require specific indications of the patient's wishes, but allows a variety of evidence to be considered, including the family's best judgment as to what decision the patient would have made.[217] The family has been granted this discretion in some instances because it is assumed that family members will have the welfare of the patient at heart and they are considered best situated to know the wishes, tastes, and preferences of the patient.[218]

In most cases, the family will make a bona fide decision. However, the family's objectivity and neutrality may be strained by emotional (and possibly financial) pressure.[219] This standard is also open to abuse by family members who harbour ulterior motives for their relative's death. The failure to delineate clear evidentiary requirements on which to exercise substituted judgment may well subordinate the patient's previously held goals and values to third party interests.[220] Therefore, the lower evidentiary standard may also be unacceptable.

The House of Lords in *Bland* simply rejected the substituted judgment approach. Lord Goff considered that it formed no part of the English law in relation to incompetent adults. Lord Mustill categorically rejected the operation of substituted judgment:[221]

> To postulate a patient who is in such a condition that he cannot know that there is a choice to be made, or indeed know anything at all, and then ask whether he would have chosen to terminate his life because that condition made it no longer worth living is surely meaningless ... The ideas is simply a fiction, which I would not be willing to adopt even if there were in the case of Anthony Bland any materials upon which a surrogate could act ...

The writer agrees. A fundamental problem with any application of substituted judgment is that the surrogate's decision will in all probability be affected by his or her own views about continued treatment. The decisions are more likely to reflect the surrogate's own values than the patient's because the surrogate can never confidently state that the patient would have decided in a particular way, because the patient's position has changed dramatically since entering the PVS. Consequently, substituted judgment is abandoned in favour of quality of life

---

217 *In Re Quinlan*, above n 69, 664; *In Re Jobes* 529 A 2d 434,444-46 (1987); Gaudin, above n 50, 1331-34.

218 Cantor, above n 72, 107. These factors explain familial involvement in decisions to withdraw treatment generally.

219 Cantor, above n 72, 108.

220 Dresser, above n 63, 379.

221 *Bland*, above n 1, 396.

considerations.[222] For these reasons, substituted judgment should not be adopted as the decision-making standard.

Good Medical Practice

Good medical practice has already been examined in relation to liability under the Crimes Act 1961. It is the ideal and logical standard for decision making in New Zealand and should be incorporated into law.[223] Good medical practice reflects procedures and protocol currently adopted in hospitals, i.e. health professionals and family members conferring about treatment decisions. This approach is also sufficiently flexible to accommodate changes in medical practice and knowledge.

The primary decision making responsibility is confined to the parties with medical or familial involvement with the patient.[224] Requiring familial consent to the decision recognises the family's fundamental involvement in the situation. It also introduces elements of substituted judgment as most families would be guided by their honest perception of their relative's wishes.[225] Close family members would ordinarily make a compassionate decision and doctors would furnish a safeguard should families try to make arbitrary decisions.[226]

The patient's best interest cannot guide doctors' subjective decision, although other relevant factors may, including limited resources.[227] This is not a justification in itself for withholding treatment, but medical decisions are not made in an idyllic context; resources are scarce. Furthermore, the doctor's decision must be bona fide and command general approval in the profession.

Approval or review of the decision by an ethics committee provides an opportunity for societal perspectives to influence the delicate decision to

---

222 Bopp, above n 210, 602.

223 The Issues Committee of the New Zealand Law Society, above n 23, 3, recommended that legislative changes should incorporate a similar standard where there is no evidence of the patient's wishes. Pending legislative change, the Committee recommended that the New Zealand Medical Council adopt this standard in guidelines for the profession.

224 Mendelson, above n 95, 15; Cantor, above n 72, 110.

225 For example see *Bland*, above n 1, 324; 364.

226 Cantor, above n 72, 110.

227 See *In Re J* (A Minor) (Child In Care: Medical Treatment) [1992] 3 WLR 507, 517. See also *Bland*, above n 1, 359 where Hoffmann L J pointed out that the costs of maintaining PVS patients are high, and the allocation of resources between patients is a matter for the health authority.

withdraw life-sustaining nutrition and hydration.[228] Ethics committees could also provide useful guidance should they be approached by doctors or families.

ADVANCE DIRECTIVES

To this point, discussion has focussed on decision-making standards for incompetent patients who have left no indication of their treatment preferences whilst they were competent. Yet many patients have the foresight to leave instructions regarding medical treatment and procedures they would considerable acceptable should they become incompetent.

Lord Goff considered that the notion of self-determination extends to these situations, requiring the patient's earlier wishes to be respected in the event that they become incompetent.[229] Though, in these circumstances, especial care must be taken to ensure that the patient's prior indications regarding refusal of treatment are applicable in the circumstances that have subsequently occurred.[230] Despite the paramountcy of autonomy, if the patient's refusal is not clear and convincing it may be overridden. In this dictum the House of Lords supported the qualified recognition given by the Court *In Re T*[231] to advance directives for medical care.

This section will consider the validity of advance directives in New Zealand as a method of refusing maintenance-of-life regimes should the person fall into a permanent vegetative state.

"Advance Directive" describes two forms of arrangement a person can make for her future health care should she become incompetent.[232] The first is a "living will" (probably better termed an advance directive) and the second type refers to

---

228 The Biological and Medical Issues Committee of the New Zealand Law Society envisaged a reduced role for the ethics committees. They were visualised as arbitrators in the event of disputes. Above n 23, 3.

229 *Bland*, above n 1, 367.

230 *Bland*, above n 1, 367.

231 *In Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782.

232 *The Living Will - Consent to Treatment At the End of Life* A Working Party Report Under the Auspices of Age of Concern, Institute of Gerontology and Centre of Medical Law and Ethics, Kings College, London (Edward Arnold, London, 1988) 1. R Paterson "The Right of Patients to Refuse Medical Treatment" (1991) NZ Doctor 33. C Brennan "The Right To Die" (1993) 143 NLJ 1041.

the appointment of a proxy decision-maker through an enduring power of attorney (EPA). Before turning to consider living wills, Value Statements will be outlined briefly.

Value Statements

The Institute of Public Law at the University of New Mexico recognised the potential role evidence of a person's values could have in guiding surrogate decisions, since people's wishes are often a reflection of their values.[233] Consequently, the Institute devised a Values History Form for people to complete, if they wish to maintain maximum control over their person. The values statement is not a substitute for an advance directive; it is supplementary to it, and should provide valuable guidance.[234]

Living Will

A living will is a document in which a competent person directs what medical treatment or measures should be taken if he or she become, for example, permanently unconscious, and obviously unable to make medical care decisions.[235] In the United States, statutes regulate advance directives in 48 out of 50 states.[236] Legislation shields doctors from liability, criminal or civil, and from discipline for unprofessional conduct, if the doctor acts in accordance with the patient's directions in a living will.

Living wills provoke several legal problems. Some doctors feel that living wills give useful indications of patients' wishes, but unless they are current and clear, they do not provide absolute assurances and are not binding.[237] Hence, a decision not to follow an advance directive may be justified if the patient did not anticipate the particular situation she is in and within which the medical decision

---

233 Lanham, above n 38, 97.

234 Lanham, above n 38, 97. Lanham reproduces a Values History Form in the appendix to his book.

235 Age of Concern, above n 232; Paterson, above n 232.

236 Brennan indicates that the most recent development in the United States following the *Cruzan* case is the Patient's Self-Determination Act 1990 which requires federally funded institutions to inform patients about the possibility of making advance directives. Above n 232.

237 Cook, above n 52, 132. See also *Bland*, above n 1, 367.

must be made.[238] If the living will is not phrased with sufficient specificity to reflect the circumstances in which it is to guide treatment, then it may be overridden.

The second problem with living wills concerns the "triggering event",[239] or the condition the person must be in to invoke the living will. Traditionally, terminal illness is required to trigger the living will. However, advance directives are relevant not only in cases of incompetence and terminal illness, where life-sustaining procedures merely prolong death,[240] and they should not be so limited. They are also relevant in cases of incompetence generally, where, for example, the patient is permanently unconscious. A Canadian case, *Malette* v *Shulman*, has confirmed the validity of a living will executed by a Jehovah's Witness, refusing blood transfusions in all circumstances, even though the patient would have died if the treatment was not provided.[241] The Court held that the doctor was bound in law by the patient's choice and that the patient's right to self-determination was paramount. Therefore, incompetence alone could trigger the living will, through which the patient may refuse life sustaining medical care.

Living wills in New Zealand

There are several indications that living wills may be considered valid and binding in New Zealand. First, their judicial recognition in *Malette* and *Bland* provides persuasive authority for the suggestion that courts should uphold a patient's refusal of artificial nutrition and hydration through a clear and convincing living will as a legitimate exercise of personal autonomy.[242] In addition to overseas cases, the New Zealand common law has upheld the individual's right to self-determination and to decline medical treatment.[243] The refusal must be respected no matter how unreasonable it may appear.

Section 11 of the New Zealand Bill of Rights Act 1990 also reinforces individual's right to self determination and to decline medical treatment. A distinction should not be drawn between a competent patient's refusal of

---

238 President's Commission, above n 94, 137.
239 I Kennedy and A Grubb *Medical Law Text and Materials* (Butterworths, London, 1989) 1118; Age of Concern, above n 232, 52.
240 Kennedy et al, above n 239, 1118.
241 *Malette* v *Schulman* (1990) 67 DLR (4th) 321.
242 The Issues Committee made a similar recommendation, above n 23, 2.
243 *Smith* v *Auckland Hospital Board* [1965] NZLR 191.

treatment and a clear advance directive through which a patient refuses treatment should she become incompetent.[244] This section arguably provides broad legislative recognition of the validity of living wills.

Therefore, although there is no *definitive* statutory indication of living wills' legal status it is submitted that, if they are clear and current, they should be legally binding. Living will legislation governing the form, scope and requirements for the validity of these advance directives may be more of a hindrance than a help.[245] If advance directives are to be given definitive validity through legislation, then the preferable approach would involve amending the enduring power of attorney provisions in the Protection of Personal and Property Rights Act 1988 (PPPR Act).

Enduring Powers Of Attorney In New Zealand

An enduring power of attorney (EPA) is an alternative form of advance directive by which a competent person ('donor') authorises another ('attorney') to act on her behalf in general or specific medical matters should she be rendered incompetent to refuse or consent to medical care.[246] EPAs may operate more successfully than living wills because the attorney will be able to make a decision after considering all the circumstances, some of which may not have been foreseen earlier.

Under common law, powers of attorney terminate on the incompetency of the donor.[247] However, Part IX of the PPPR Act provides for the appointment of a proxy under an EPA.

---

244 Bioethics Research Centre above n 6, 24.

245 Living wills legislation may restrict people's freedom of choice instead of reinforcing it. For example, the Australian Natural Death Acts limit the scope of living wills to the refusal of extra ordinary treatment where the patient is terminally ill. Lanham, above n 38, 64-5. See also R Gillon "Living Wills, Powers of Attorney and Medical Practice" (1988) Journal of Medical Ethics 59.

246 Paterson, above n 232.

247 Paterson, above n 232; W R Atkin "Enduring Powers of Attorney in New Zealand" (1988) NZLR 368.

Section 98 of the PPPR Act permits a donor to authorise an attorney to make decisions in relation to the donor's personal care and welfare. However, the attorney does not have the power to refuse consent, on the patient's behalf, to any *standard* life-saving medical treatment or procedure.[248] Artificial feeding is a standard medical procedure. Therefore, the PPPR Act in its present form does not permit an attorney to refuse artificial feeding, and allow the PVS patient to die. Consequently, EPAs at present fail to uphold the patient's right to self-determination at the critical moment.

Ideally, this provision should be amended to allow attorneys to refuse standard medical procedures for permanently vegetative patients.[249] This would provide a clear means for those who wish to exercise their individual autonomy to its full extent, and maintain complete control over their body, to do so.

---

248 Sections 98(4) and 18(1)(c) of the PPPR Act. For an analysis of Section 18(1)(c) see E Grant "Consent to Medical Procedures and the Protection of Personal and Property Rights Act 1988" (1989) 7 Otago Law Review 161, 169-170.

249 Issues Committee, above n 23, 4.

CONCLUSION

Withdrawing artificial nutrition and hydration from PVS patients represents one of the least distasteful options of letting the patient die. Nevertheless, it is a very difficult and perplexing step, which many health professional may not be prepared to take just yet, irrespective of the conclusion on criminal responsibility. These health professionals need to be sure in themselves that withdrawal of a nasogastric tube is the morally correct step to take, which will not cause the relatives, or medical and nursing staff, any more pain.[250]

For those families and health professionals who are fearful only of criminal responsibility, judicial or legislative guidelines governing the legality of removing artificial feeding regimes are necessary. This should avoid regularised judicial involvement in these private decisions, which would become financially and emotionally expensive for all parties concerned. In the end, however, the only acceptable long-term solution to this problem requires legislative initiate.

It is unlikely that reform could provide an exhaustive guide to terminal decision-making on specifically defined objective criteria given the vast array of potential cases. It could, however, dissipate some of the uncertainties by outlining the bases on which the law feels terminal decisions should be made. To this end, it is suggested that Legislation could incorporate guidelines reflecting the good medical practice approach outlined earlier. It could also definitively recognise the validity of clear and convincing advance directives, and the PPPR Act could be appropriately amended. Decisions made on these criteria should be legislatively attributed death to natural causes. In this way legislation could shield doctors from any form of liability in the event that they removed artificial feeding from a PVS patient.

In the absence of legislative initiative, hospital protocol already seems to follow the good medical practice standard outlined in *AHB*. If an application is made for a declaratory ruling as to the lawfulness of withdrawing life-sustaining nutrition and hydration, the court should adopt the *AHB* approach not the *Bland* approach. Reference may be made to the House of Lords' decision to illustrate the propriety of withdrawing artificial feeding, or the operation of the doctrine of necessity to obviate criminal responsibility. Otherwise, the approach has serious weaknesses which must be avoided.

---

250 Dr R Worth, above n 30.

The New Zealand court has already illustrated its willingness to issue guidelines in order to avoid judicial intervention into the medical domain and the private domain of the family making the traumatic decision with health professionals. This is how it should be. There is every reason why a similar approach should be, and will be followed in a case involving the withdrawal of artificial feeding from a patient in the persistent vegetative state.

BIBLIOGRAPHY

J C Ahronheim & M R Gasner "The Sloganism of Starvation" (1990) 335 The Lancet 278.

P Alldridge & D Morgan "Ending Life" (1992) NLJ 1536.

American Academy of Neurology "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of Persistent Vegetative State Patient" (1989) 39 Neurology 125.

American Medical Association Council on Scientific Affairs and Council on Ethical and Judicial Affairs "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support" (1990) 263 JAMA 426.

K Andrews "Managing the Persistent Vegetative State" (1992) 305 BMJ 486.

P W Armstrong & B D Colen "From *Quinlan* to *Jobes*: The Courts and the PVS Patient" (1988) Hastings Centre Report 37.

W R Atkin "Enduring Powers of Attorney in New Zealand" (1988) NZLR 368.

Australian Law Reform Commission *Human Tissue Transplants* Report No. 7 1977.

G Baron "On Taking Substituted Judgment Seriously" (1990) Hastings Centre Report 7.

H Beynon, "Doctors as Murderers" (1982) Criminal Law Review 17.

Bioethics Research Centre *Persistent Vegetative State and the Withdrawal of Food and Fluids - A Report for the Medical Council of New Zealand,* University of Otago, February 1993.

Biological and Medical Issues Committee of the New Zealand Law Society *Report to the New Zealand Medical Council on "Persistent Vegetative State and the Withdrawal of Food and Fluids"* 1993.

J Bopp "Reconciling Autonomy and the Value of Life" (1990) 38 Journal of American Geriatrics Society 600.

D Brahams "The Reluctant Survivor" (1990) 140 NLJ 639.

D Brahams "Of Life and Death" (1992) 46 Law Society Gazette 3.

C Brennan "The Right to Die" (1993) 143 NLJ 1041.

C Bridge "Refusal of Medical Treatment on Religious Grounds" (1992) NZLJ 341.

D W Brock "Death & Dying" in R M Veatch *Medical Ethics* (Jones and Bartlett Publishers Inc., Boston, 1989) 329.

B A Brody "Ethical Questions Raised By the Persistent Vegetative Patient" (1988) Hastings Centre Report 33.

N L Cantor *Legal Frontiers of Death and Dying* (Indiana University Press, Bloomington and Indianapolis, 1987).

D J Cole "The Reversibility of Death" (1992) 18 Journal of Medical Ethics 26.

David B Collins *Medical Law in New Zealand* (Brooker and Friend, Wellington, 1992).

D Cook *Patients' Choice - A Consumer's Guide To Medical Practice* (Hodder and Stroughton Publishers, London, 1993).

R E Cranford "The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)" (1988) Hastings Centre Report 27.

R E Cranford & D R Smith "Consciousness: The Most Critical Moral (Constitutional) Standard For Human Personhood" (1989) 13 American Journal of Law and Medicine 233.

R E Cranford & H L Smith "Some Critical Distinctions Between Brain Death and The Persistent Vegetative State" (1979) 6 Ethics in Science and Medicine 199.

R Dresser "Life, Death and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law" (1986) 28 Arizona Law Review 373.

A Fisher "The Road To Euthanasia" (1993) The Tablet 235.

I Freckelton "Withdrawal of Life Support: 'The Persistent Vegetative State' Conundrum" (1993) 1 Journal of Law and Medicine 35.

Garrow & Turkington *Criminal Law* (Butterworths, Wellington 1991).

A M Gaudin "*Cruzan* v *Director, Missouri Department of Health*: To Die or Not to Die: That is the Question - But Who Decides?" (1991) 51 Louisiana Law Review 1307.

G R Gillet "Why Let People Die?" (1986) 12 Journal of Medical Ethics 83.

R Gillon "Living Wills, Powers of Attorney and Medical Practice" (1988) 14 Journal of Medical Ethics 59.

Jay A Gold "The Status of the Permanently Unconscious: 'You Call That Living?'" [1991] 42 Mercer Law Review 1087.

E Grant "Consent to Medical Procedures and the Protection of Personal and Property Rights Act 1988" (1989) 7 Otago Law Review 161.

Institute of Medical Ethics Working Party on The Ethics of Prolonging Life and Assisting Death "Withdrawal of Life-Support from Patients in a Persistent Vegetative State" (1991) 337 The Lancet 96.

B Jennett "Letting Vegetative Patients Die" (1992) 305 BMJ 1305.

B Jennett & C Dyer "Persistent Vegetative State and the Right to Die: The United States and Britain" (1991) 302 BMJ 1256.

B Jennett & F Plum "Persistent Vegetative State After Brain Damage - A Syndrome In Search of a Name" (1972) The Lancet 734.

B Jennett "Vegetative Survival After Brain Insults" (1988) 43 Anaesthesia 921.

I Kennedy & A Grubb *Medical Law: Text and Materials* (Butterworths, London, 1989).

I Kennedy *Treat Me Right - Essays in Medical Law and Ethics* (Clarendon Press, Oxford, 1988).

H Kuhse *The Sanctity of Life Doctrine in Medicine - A Critique* (Clarendon Press, Oxford, 1987).

D Lanham *Taming Death By Law* (Longman Professional, Melbourne, 1993).

D Lanham *Euthanasia, Pain Killing, Murder and Manslaughter* - Law, Medicine and Criminal Justice Conference (Australian Institute of Criminology, Canberra, 1993).

Law Reform Commission of Canada *Protection of Life, Euthanasia, Aiding Suicide and Cessation of Treatment* Working Paper 28, 1982.

C Lewis "Medical Treatment In the Absence of Consent" (1989) 86 Law Society Guardian 32.

C Lewis "Freedom of Choice" (1992) 46 Law Society Gazette 27.

The Living Will - Consent to Treatment at the End of Life A Working Party Report under the Auspices of Age of Concern Institute of Gerontology and Centre of Medical Law and Ethics Kings College London (Edward Arnold, London, 1988).

J Lynn & J F Childress "Must Patients Always Be Given Food and Water?" in T A Mappes & J S Zembaty (ed) *Biomedical Ethics* (3 ed, McGraw-Hill Inc., New York, 1991) 401.

R D MacKay "Terminating Life-Sustaining Treatment - Recent US Developments" (1988) 14 Journal of Medical Ethics 135.

J McLeod "Moral Maze" (1993) 90 Law Society Gazette 10.

D Mendelson *Legal and Ethical Ramifications of Withdrawal of Life Support Systems From Incompetent Patients* Law, Medicine and Criminal Justice Conference (Australian Institute of Criminology, Canberra, 1993).

D Morgan "The Greatest Danger" (1992) NZJ 1652.

R Paterson "The Right of Patients to Refuse Treatment" (1991) New Zealand Doctor 33.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical, and Behavioural Research *Deciding to Forgo Life-Sustaining Treatment* March 1993.

K P Quinn "The Best Interests of Incompetent Patients: The Capacity For Interpersonal Relationships as a Standard For Decision making" (1988) 76 California Law Review 897.

Robertson (ed) *Adams on Criminal Law* (Brooker & Friend, Wellington, 1993).

J E Ruark, T A Raffin and The Stanford University Medical Centre Committee on Ethics "Initiating and Withdrawing Life Support - Principles and Practice in Adult Medicine" (1988) 318 The New England Journal of Medicine 25.

L J Schneiderman "Exile and PVS" (1990) Hastings Centre Report 5.

R S Shapiro "The Case of LW: An Argument for a Permanent Vegetative State Treatment Statute" (1990) 51 Ohio State Law Journal 439.

P D G Skegg *Law, Ethics and Medicine - Studies in Medical Law* (Clarendon Press, Oxford, 1988).

P D G Skegg "The Edges of Life" (1988) 6 Otago Law Review 517.

D R Smith "Legal Recognition of Neocortical Death" (1986) 71 Cornell Law Review 850.

D Thalblum "Persistent Vegetative States and Immortality: If This Is Technical Life, The Legal Definition of Death Should Change" (1991) 59 UMKC 439.

D Tribe & G Korgaonkar "Withdrawal of Medical Treatment" (1992) Solicitors' Journal 1192.

D Wikler "The Definition of Death and PVS" in T A Mappes & J S Zembaty (ed) *Biomedical Ethics* (3 ed, McGraw-Hill Inc., New York, 1991) 396.

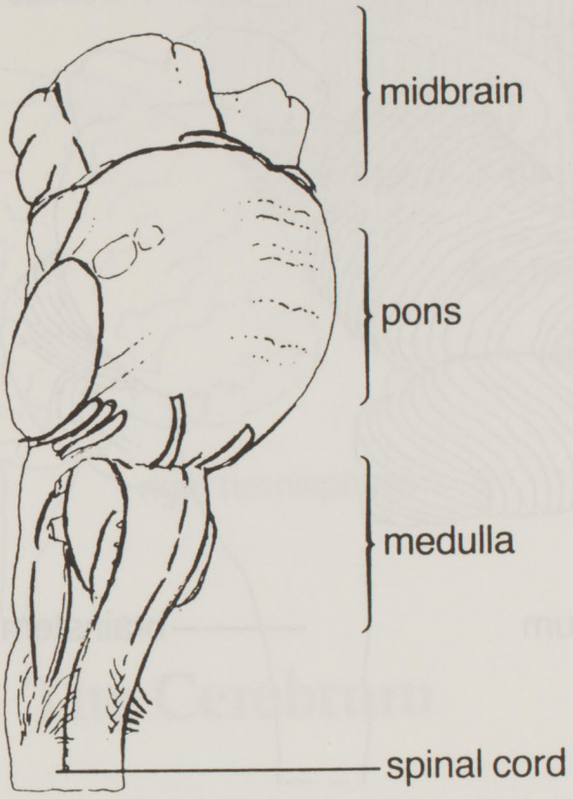
G Williams *Textbook On Criminal Law* (2ed, Stevens and Sons, London, 1983).

APPENDIX

R Ornstein & R F Thompson

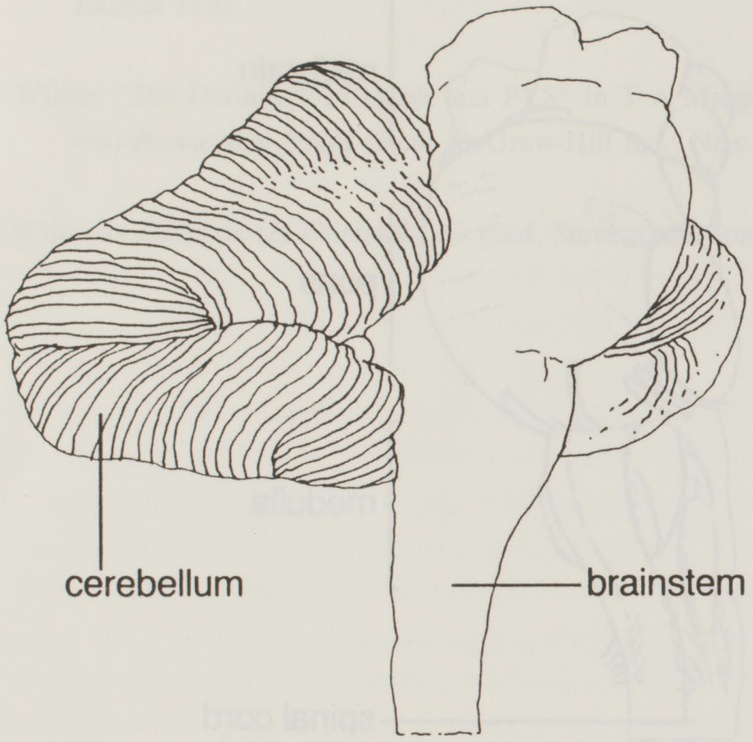
THE AMAZING BRAIN

(The Hogarth Press, London, 1985)



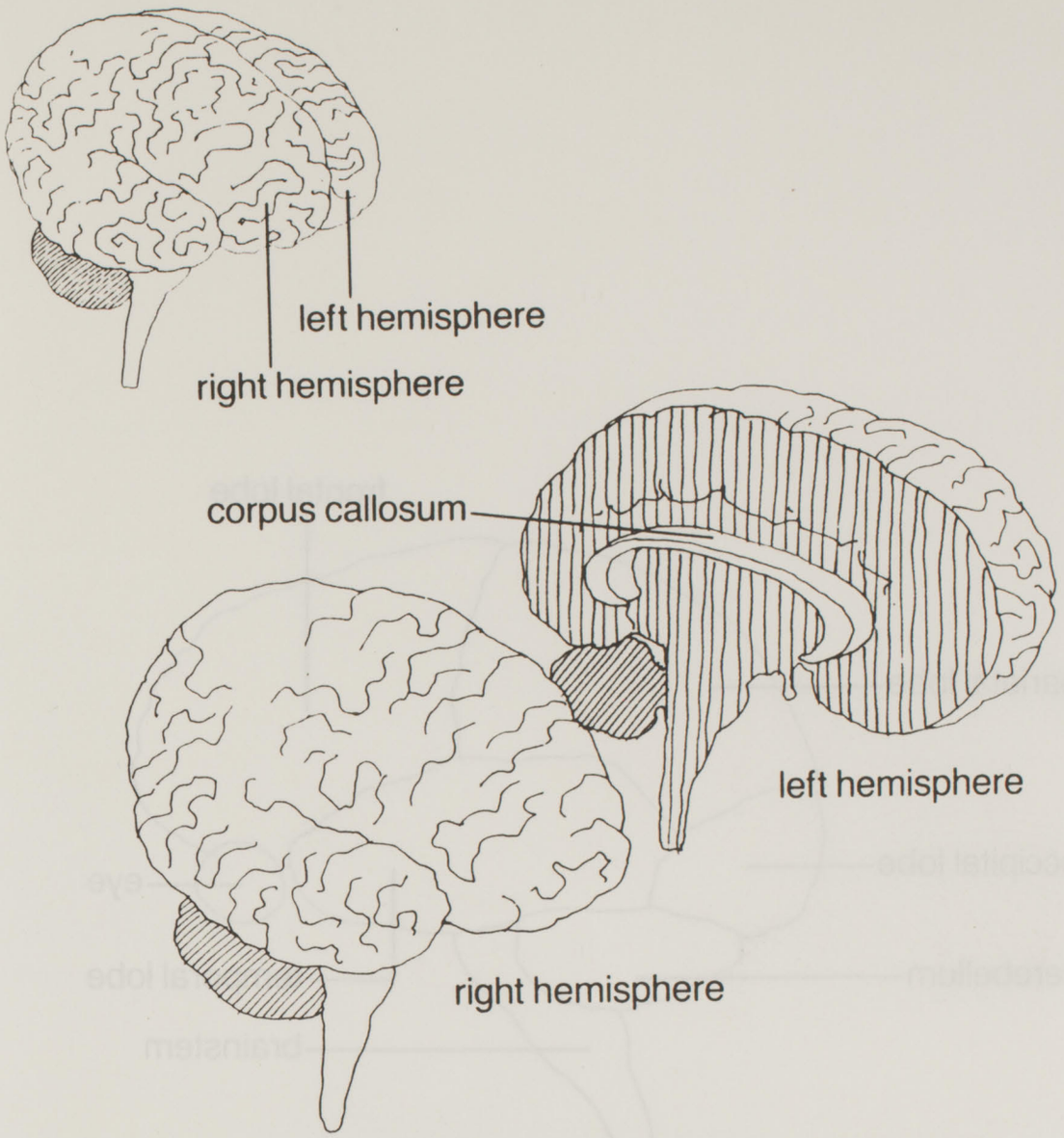
The Brainstem

The brainstem is the oldest part of the brain. It evolved more than five hundred million years ago. Because it resembles the entire brain of a reptile, it is often referred to as the reptilian brain. It determines the general level of alertness and warns the organism of important incoming information, as well as handling basic bodily functions necessary for survival—breathing and heart rate.



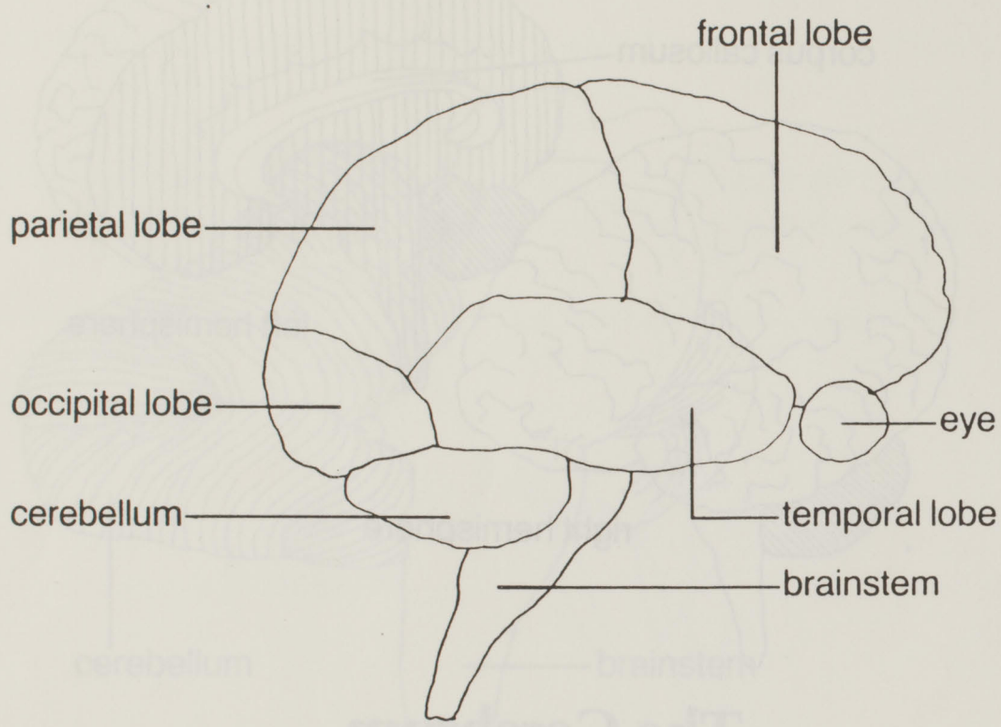
The Cerebellum

The cerebellum, or "little brain," is attached to the rear of the brainstem. Among other functions, the cerebellum maintains and adjusts posture and coordinates muscular movement. The importance of these functions is evident when we realize that the cerebellum in the human brain has more than tripled in size in just the last million years. It now appears that memories for simple learned responses may be stored there.



The Cerebrum

The largest part of the human brain is the cerebrum. It is divided into two halves, or hemispheres, each of which controls its opposite half of the body. The hemispheres are connected by a band of some three hundred million nerve cell fibers called the corpus callosum. Covering each hemisphere is a one-eighth-inch-thick, intricately folded layer of nerve cells called the cortex. The cortex first appeared in our ancestors about two hundred million years ago, and it is what makes us uniquely human. Because of it, we are able to organize, remember, communicate, understand, appreciate, and create.



The Lobes of the Cortex

The cortex of each hemisphere is divided into four areas called lobes. The frontal lobe is primarily involved in planning, decision making, and purposeful behavior. The parietal lobe represents the body in the brain. It receives sensory information from the body. Part of the occipital lobe is devoted to vision and is often called the visual cortex. The temporal lobe appears to have several important functions, including hearing, perception, and memory.